



STATE OF DELAWARE  
**STATE COUNCIL FOR PERSONS WITH DISABILITIES**

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March 28, 2014

Mr. Larry Morris  
Constituent Affairs Director  
Office of Congressman Carney  
233 North King Street – Suite 200  
Wilmington, DE 19801

Dear Mr. Morris:

The State Council for Persons with Disabilities (SCPD) has reviewed H.R. 3717 which is titled "Helping Families in Mental Health Crisis Act of 2013". SCPD respectfully requests that Congressman Carney not cosponsor the proposed legislation and endorses the attached commentary from Brian Hartman, Esq. of the Disabilities Law Program.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our perspective on the proposed federal legislation.

Sincerely,

A handwritten signature in black ink that reads "Daniese McMullin-Powell".

Daniese McMullin-Powell, Chairperson  
State Council for Persons with Disabilities

cc: Mr. Brian Hartman, Esq.  
Delaware Consumer Recovery Coalition  
Developmental Disabilities Council  
Governor's Advisory Council for Exceptional Citizens

P&L/HR 3717 mental health 3-28-14



## DISABILITIES LAW PROGRAM

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January 15, 2014

Larry Morris  
Constituent Affairs Director  
Office of Congressman John Carney  
233 N. King Street, Suite 200  
Wilmington, DE 19801

Re: Mental Health Legislation (H.R. 3717)

Dear Larry:

As a follow up to our phone conversation this afternoon, I write to request that Congressman Carney not cosponsor the above legislation introduced last month. I understand that you will forward this correspondence to the appropriate staff in your D.C. office.

As background, the Community Legal Aid Society, Inc. has served as Delaware's Protection & Advocacy for Individuals with Mental Illness (PAIMI) program since enactment of federal enabling legislation in 1986. The PAIMI law and regulations [42 U.S.C. §10801 et seq.; 42 C.F.R. Part 51] confer broad authority to engage in systemic, legislative, and individual advocacy. For perspective on the breadth of our work, I am attaching the 5-page "Most Significant Accomplishments" section from our PAIMI FY13 annual report. The above legislation would "gut" such advocacy as follows:

- slashing PAIMI funding by 85%;
- barring use of PAIMI funds "to engage in systemic lawsuits, or to investigate and seek legal remedies cases other than individual cases of abuse or neglect" (§141); and
- barring "lobbying...for the purpose of influencing a Federal, State, or local government entity or officer" (§141).

These changes would severely limit advocacy on behalf of individuals with mental illness. Consider the following examples.

In 2013, CLASI settled federal litigation against a private psychiatric hospital which refused to provide interpreter services to a Deaf individual seeking voluntary treatment. The hospital was prompted to adopt a formal policy on provision of interpreters, staff were trained, and arrangements with ASL interpreters were made. Such "systemic lawsuits" would be precluded under the bill.

Larry Morris  
January 15, 2014  
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In 2013, CLASI drafted State legislation (S.B. No. 100) to limit use of seclusion and restraint in public schools and participated in public hearings to promote its eventual enactment. CLASI also participated in a task force revising the mental health commitment code as a representative of the Delaware Bar. Such legislative work could easily run afoul of the ban on lobbying State government.

In 2013, CLASI prepared comments on dozens of State proposed regulations which would affect individuals with mental illness. Commenting on proposed regulations could be barred as an attempt to influence a State entity.

In 2013, CLASI represented many individuals with mental illness in housing; denial of public benefits (Medicaid; SSI); and special education. Since the bill only allows "abuse or neglect" advocacy, such legal assistance would be barred.

Apart from the above effects on PAIMI advocacy, the bill would result in other unfortunate consequences for the mental health system.

First, it makes mental health block grant funding contingent upon adoption of broad outpatient commitment laws (§705). This regressive mandate is at odds with current "best practice". Indeed, Delaware's use of outpatient commitment has been severely criticized by a federal court monitor. See attached April 3, 2013 Delaware News Journal article.

Second, it makes mental health block grant funding contingent upon adoption of a broad mental health commitment law intended to subject more individuals to institutional placement or coerced treatment (§704).

For the above reasons, I request that Representative Carney refrain from co-sponsoring this problematic bill.

Sincerely,



Brian J. Hartman  
Project Director

enc.

cc: William Dunne, Esq.

8g:paimi/115carney

## ATTACHMENT D

E. Most Important Accomplishments: Please identify what you feel were the PAIMI program's most important accomplishments in this fiscal year:

### Judicial and Administrative Advocacy

The DLP secured or maintained discharge of multiple DPC patients who had been determined not guilty by reason of insanity (NGRI) or incompetent to stand trial. These cases represent a continuing systemic initiative of the DLP to promote discharge of such forensic patients through petitions filed with the Superior Court supported by DPC treatment teams.

DLP represented mother with mental illness in dependency/neglect proceedings in Family Court. Court had awarded custody of her two children to Division of Family Services when DFS found children unattended and mother delusional. DLP facilitated visitation, development of case plan, and mental health treatment. Court then placed children with mother on trial basis and 3 months later returned full custody to mother. [11-3032434]

Forty four year old with depression resided with girlfriend in mobile home purchased with his funds. During period of hospitalization at diversion site, girlfriend filed eviction action against client which was granted by default when he failed to appear. DLP entered appearance, reopened judgment, and secured favorable decision based on lack of jurisdiction. [12-2035800]

Landlord filed eviction action for non-payment of rent when tenant was hospitalized in diversion site. Mental health case manager failed to transport client to eviction hearing and judgment was awarded to landlord. DLP secured letter from psychiatrist linking non-payment to mental health issues and filed to reopen judgment. Landlord agreed to reinstate lease upon payment of rent arrears. Mental health provider paid back rent and housing was preserved. [12-3035504]

Fourteen year old with diagnoses of bipolar disorder, ADHD and intellectual disability was former residential patient of Terry Center. He had been determined ineligible for SSI. DLP represented at ALJ level and secured a favorable decision finding him eligible for SSI and awarding \$4,300 in back benefits. [11-1032953]

Public housing tenant with schizophrenia received notice of eviction based on drinking alcohol in public areas and racial slurs directed at other residents. He had been hospitalized at DPC and diversion sites on three occasions within the last 15 months. DLP represented in informal hearing which was resolved by agreement to abandon eviction based on promise to move when SRAP voucher approved. This was expected to take several months. [12-1035671]

Thirty-two year old with diagnoses of bipolar disorder and borderline personality disorder had mental health provider as his SSDI representative payee. Friends persuaded him to present his SSI award letter to prospective landlord as proof of income and co-sign lease. Client never lived in leased premises. Landlord filed eviction action which included client as defendant and

demanded back rent. DLP worked with representative payee and negotiated settlement releasing client from eviction action and all liability for back rent. [12-1036324]

Twelve year old IDEA-classified student with mood disorder and ADHD was placed on homebound education following a behavioral incident without conducting a manifestation meeting. The DLP filed for a (due process) administrative hearing to address violation of student's rights. District settled with agreement to restore student's placement, provide testing, and provide compensator education. [12-2036843]

DLP represented seventeen year old with diagnoses of ADHD, ODD, mood disorder, and pervasive developmental disorder NOS. Student had Section 504 Plan but was performing poorly in school. Student had recently had inpatient hospitalization in diversion site. DLP prompted assessment, including neuropsychological evaluation, and student was determined eligible under IDEA with right to IEP. [11-1030363]

Nineteen year old with diagnosis of depression alleged suicidal ideation and was transferred from general hospital to Ellendale for mental health assessment as part of commitment process. Patient walked away from facility but later called police requesting mental health assistance. Patient was transported to diversion site where she was treated. However, she was charged with second degree escape from a detention facility, a felony. DLP contacted DSAMH Administration and Attorney General's Office and prompted withdrawal of charges. [12-1036714]

### **Investigations & Reviews**

The DLP Project Director and a DLP senior paralegal served on Division of Developmental Disabilities (DDDS) Human Rights Committees which reviewed use of restrictive procedures and psychotropic drugs for 173 upstate residential DDDS clients, 12 institution-based downstate DDDS clients, and 28 non-institutional downstate DDDS residential clients with dual diagnoses (intellectual disability; mental illness). The Committees ensured that such use conformed to up-to-date physician prescriptions, were accompanied by valid and up-to-date consent, and were consistent with medical and behavioral profiles. Several of the DDDS clients had recently been discharged from DPC or diversion sites. Rights restrictions "ran the gamut" from access to knives restriction, elopement safeguards, food and phone restrictions; and access to personal spending cash. The Project Director prompted the elimination or modification of privacy restrictions based on insufficient justification, including discontinuation of video monitoring of bedrooms, discontinuation of in-person bathroom monitoring, and modification of a phone monitoring protocol. The Project Director prompted the elimination of authorization to employ supine personal restraint to deter property damage in multiple plans. The Project Director supported recommendations to arrange for medical assessments for dementia and assistive technology and issuance of a letter to the DHSS Secretary regarding an individual recently transferred to DPC prescribed thirteen (13) psychotropic drugs. Finally, the Project Director participated in two (2) reviews of rights complaints. First, the HRC's criticism of a "line-of-sight" restriction on an individual residing in his own apartment based on questionable justification resulted in reversal of the restriction by the Division Director. Second, the HRC endorsed substantiation of a complaint that financial information related to a personal spending

account had been inappropriately withheld from a Division client.

The DLP Project Director participated in the review of the deaths of nine (9) residential DDDS clients with mental health diagnoses through the DDDS Mortality Review Committee. At the time of death, their residential status was as follows: Stockley Center - 2; group home - 6; and shared living (foster care) - 1. One individual was a former long-term DPC patient. Almost all deaths were from natural causes. One death linked to aspiration resulted in an investigation of possible staff non-adherence to dietary restrictions. Another death due to pneumonia resulted in investigation of staff delays in seeking medical care. In a third case, the DLP researched and prompted a referral to the DHSS medical director to assess whether a particular combination of medications could have contributed to cardiac arrest. The Committee prompted systemic reform as follows: 1) based on DLP clarification of law, education of DDDS Administration of requirement that Ombudsman witness advance health care directives in all long-term care settings, including group homes; 2) based on DLP research, review of shingles vaccination standards by Division nursing staff and distribution of CDC standards to provider nurses; 3) adoption of formal health care services policy outlining provider responsibility to actively monitor clients in hospital; 4) given elevation of risk of aspiration due to extraction of teeth and link between dental health and overall health, recommendation to support Medicaid coverage of adult dental care; and 5) request for report in FY14 of individuals enrolled in DDDS Medicaid waiver who received influenza vaccine.

### **Legislative Advocacy**

In 2012, the U.S DOE OCR issued the results of a national survey of public schools which found that of student restrained, 70% were students with disabilities. It also reported that of students subjected to seclusion, 61.7% were students with disabilities. The DLP drafted legislation (S.B. No. 100) on behalf of a coalition of agencies, including the Department of Education, to limit the use of seclusion and restraint in public schools. The DLP adopted a lead role in promoting enactment and negotiated amendments with the teacher's union and a private residential program for individuals with mental illness which initially opposed the bill. This legislation was enacted and signed by the Governor on June 26, 2013. The legislation will be effective in one year to permit the Department of Education to adopt implementing regulations. The bill has the following effects:

- 1) chemical restraint is banned;
- 2) seclusion and mechanical restraint are disallowed subject to a DOE waiver;
- 3) physical restraint is restricted to emergency situations and subject to safeguards;
- 4) a uniform data collection system will be created and results compiled in an annual report, including use of seclusion/restraint by disability classification; and
- 5) parents will receive notification of each use of physical restraint and any waiver-authorized seclusion and mechanical restraint.

In FY12, the DLP had adopted a lead role in opposing an expansion of immunity in the commitment process for injury to the individual being committed. In FY 13, working in conjunction with the H.J.R. 17 Study Group, the DLP assisted with the drafting of compromise legislation (H.B. No. 9) to limit the scope of immunity. Under the legislation, immunity would not apply to claims unrelated to mental health and medical negligence claims arising after an initial mental health

assessment and clinical decision to detain. The legislation was enacted and signed by the Governor on March 28, 2013.

The DLP prepared alternate drafts of legislation which would establish a TBI trust fund. Given indecision over funding, the prime sponsor opted to secure \$40,000 in "start-up" funds in the FY14 budget. The intent is to assist some select individuals with TBI to highlight in a report submitted to the Legislature in early 2014. In turn, the "success stories" would provide some justification for passing the enabling legislation in 2014 with additional funds. The DLP drafted eligibility standards and assisted with preparation of an application form in concert with DHSS and the State Council for Persons with Disabilities.

Delaware's Victims Compensation Assistance Program (VCAP) funds remedial services (mental health counseling; medical care) for victims of violent crime. Many individuals with mental health diagnoses linked to domestic violence (e.g. PTSD; TBI; depression) benefit from VCAP assistance. The Attorney General's Office proposed legislation to remove the authority of the VCAP Council to issue program regulations. The Council is comprised of victim advocates and mental health providers. The DLP negotiated amendments requiring advance review of proposed regulations by the Council and establishing the authority of the Council to issue its own annual report. The amendments were incorporated in the final legislation (H.B. No. 166) which was enacted and signed by the Governor on July 18, 2013.

### **Regulatory Advocacy**

DSAMH published a proposed regulation covering the credentials of mental health screeners in the commitment process and provider payment for voluntarily admitted patients. The DLP issued a lengthy critique with forty-five (45) comments. The DLP critique was adopted by multiple councils and shared with the Division. The Division adopted a final regulation with more than forty (40) amendments prompted by the commentary. [16 DE Reg. 611 (December 1, 2012) (proposed); 16 DE Reg. 992 (March 1, 2013) (final)]

DSAMH published a proposed regulation covering mental health screeners involved in the commitment process. The DLP issued a critique which was adopted by multiple councils and shared with the Division. The Division adopted a final regulation incorporating five (5) amendments prompted by the DLP commentary. [16 DE Reg. 1148 (May 1, 2013) (proposed); 17 DE Reg. 72 (July 1, 2013) (final)]

Legislation (H.B. No. 403) was enacted in 2012 to expand the role of the Division of Public Health in disease control and reporting to include long-term care facilities and psychiatric facilities. The DLP issued a critique of proposed implementing regulations published by the Division. Multiple councils adopted the critique and submitted concurring comments to the Division. The Division adopted a final regulation incorporating six (6) amendments prompted by the commentary. [17 DE Reg. 1255 (June 1, 2013) (proposed); 17 DE Reg. 320 (September 1, 2013) (final)]

The Department of Education maintains regulations covering services to students receiving instruction at home or in facilities, including psychiatric hospitals. In FY12, the DLP had issued a critique of a proposed regulation revising "homebound" standards which was adopted by multiple councils and shared with the Department. In FY13, the Department adopted a final regulation incorporating five (5) amendments prompted by the commentary, including clarification that the standards apply to charter schools and clarification that the standards may not be used to circumvent a statutory right of suspended/expelled students to enroll in an alternative school. [16 DE Reg. 160 (August 1, 2012) (proposed); 16 DE Reg. 412 (October 1, 2012) (final)]

# DPC report critical of state

## Monitor questions court commitments

**By Beth Miller**  
The News Journal

Delaware courts are ordering too many people with mental illness to out-patient commitment – an involuntary treatment status – and the rate of such orders increased in 2012, according to the court-appointed monitor of the state's progress in revamping its mental health services.

The practice – which dates back more than half a century – is vague, not covered by Delaware law and largely unsupervised, state officials acknowledged Tuesday. And its continuing use points to underlying problems in the system, according to Robert Bernstein, an expert in civil rights issues for those with disabilities who was appointed by U.S. District Court to evaluate Delaware's reforms.

Delaware has until 2016 to meet terms of a sweeping settlement with the U.S. Department of Justice, which sued the state after finding violations of civil rights at the Delaware Psychiatric Center. The DOJ's investigation was prompted by a series of reports in The News Journal about conditions at the

See REPORT, Page A2

# Report: Delaware's reform effort continues

Continued from Page A1

state's largest inpatient psychiatric hospital.

Overall, Bernstein has praised the state's comprehensive work in transforming mental health services, providing expanded resources in crisis response and community-based care, and helping long-term patients at DPC find new homes in the community.

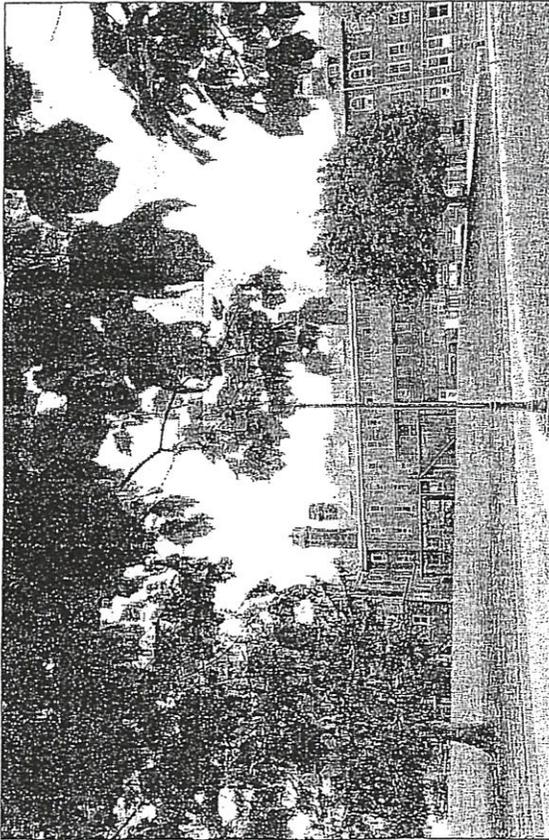
His most recent report – the third since the settlement was signed in July 2011 – calls the state's work innovative and diligent and notes “important progress” on several fronts.

Court-ordered treatment is off the charts, though – more than six times New York's rate – and it increased by 28 percent during the last half of 2012, he said.

Using the court to force treatment is an emergency-only approach elsewhere, Bernstein wrote, while the practice here suggests a variety of systemic incentives, including financial, convenience and the belief that discharging someone might help a provider avoid liability risks, he said.

Bernstein said interviews with court observers showed the commitment-related court hearings lasted about five minutes, relied on the recommendation of a doctor who had not treated the person, and often included an attorney who agreed to whatever that doctor said.

Also troubling was Bernstein's report that



The U.S. Department of Justice required changes in mental health treatment after abuses were uncovered at the Delaware Psychiatric Center. SUCHAT PEDERSON/NEWS JOURNAL FILE

patients often were not aware of their rights or what was happening in the hearing.

“They indicated that in some instances involuntary commitment occurred even though they had indicated a willingness to accept treatment voluntarily, and that they were denied opportunities for family members to be present at their hearings,” Bernstein wrote.

A study group, which includes specialists in psychiatry, law enforcement, the courts, social work and mental health treatment as well as those in recovery, has been working to review Delaware law and policies and build recommendations for systemic change.

Bryce Hewlett, director of the Delaware Consumers in Recovery Coalition, chairs that study

group's subcommittee on outpatient commitment. The practice, he said, relies on a “convalescent” status mentioned in Delaware law that – decades ago – provided care for those who were not considered ready for complete release.

“It's highly outdated and it's significantly overused,” Hewlett said. “We push for highly limited forced treatment in any capacity because that really isn't what is going to help the person recover. They only recover when they have an investment in their treatment and it takes an awful lot of outreach to

communicate with the person, engage with the person and get them to go along with treatment.” Hewlett said if a person is considered a threat to self or others they should be committed to inpatient care. Otherwise, he said, no one should be forced to submit to treatment.



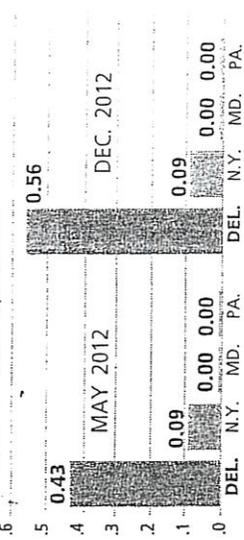
Kevin Huckshorn

Hewlett's view is controversial. Some psychiatrists and specialists argue that it is better to force a person into treatment – helping them get stabilized – than to let them get sicker until they must be hospitalized.

Kevin Huckshorn, director of the state Division of Substance Abuse and Mental Health, said the state is asking providers to identify those who are unnecessarily on outpatient commitment and to take them off the list.

## ACTIVE OUTPATIENT COMMITMENT ORDERS

Outpatient commitment is a court order for treatment of a mental illness. It is involuntary, as is inpatient commitment. Unlike three neighboring states, court-appointed monitor Robert Bernstein says Delaware's use of outpatient commitment is both far more common and increasing. Below are outpatient commitment orders per 1,000 people.



SOURCE: Robert Bernstein, Third Report of the Court Monitor on Progress Toward Compliance with the Agreement: U.S. v. State of Delaware

She said Horizon House was able to get 70 people off those lists.

Overall, more than 2,000 people were on such commitments at some point or another last year, Huckshorn said, with 500 to 600 at any given time.

The problem is worsened when someone is ordered, for vague reasons, into unspecified treatment without additional assistance to promote compliance.

“There is an assumption that there was oversight or special treatment,” she said, “when in truth, there really isn't. Only that in some specified time – two weeks, a month, six months – they must come back to court.”

When they don't show up in court – either because they don't realize they must or because they are still sick – their problems get worse.

Huckshorn said she was not surprised that Bernstein flagged the issue. It has been apparent to her since she arrived in the state in 2009 to work

on systemic reform. “Not until we started drilling down on the numbers and Bob was able to find data on the rates in other states did we become aware of how out of whack we were,” she said. “The chart was kind of shocking.”

The state will address the problem, she said. Likely changes would require that only treating psychiatrists can petition a court on behalf of their patients, would require clear descriptions of behaviors that demonstrate a danger to self or others and include clearly defined time periods.

The state's reform effort continues, largely with Bernstein's endorsement and applause.

“We're in a good place, working together,” Huckshorn said. “It's a messy, slow process. But that's the way system change happens.”

Contact Beth Miller at 324-2784 or bmillier@delawareonline.com. Follow on Twitter @BMiller57.