
# Behavioral & Mental Health Task Force Report

Final report submitted to the
President Pro Tempore,
Speaker of the House, and
Governor Jack Markell on May 31, 2016.

Created per Senate Concurrent Resolution 29
of the 148th General Assembly.

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# Task Force Members

| | Member | Affiliation |
|---|---|---|
| 1 | Co-Chair , Senator Patricia Blevins | President Pro Tempore |
| 2 | Co-Chair, Senator Bethany Hall-Long | Chairman, Senate Health and Social Services Committee |
| 3 | Representative Debra Heffernan | Chairman, House Health and Human Development Committee |
| 4 | Dr. Joshua Thomas | Executive Officer, National Alliance on Mental Illness |
| 5 | Erin Booker | President, Delaware Healthcare Association |
| 6 | Brenna Welker | Member of the public, appointed by the Governor |
| 7 | Secretary Rita Landgraf | Secretary, Department of Health and Social Services |
| 8 | Susan Cycyk | Secretary, Department of Services for Children, Youth and their Families |
| 9 | Dr. Marc Richman | Chief-Bureau of Correctional Healthcare Services, Department of Correction |
| 10 | Susan Jennette | Investigative Supervisor, Department of Insurance |
| 11 | Dr. Michael Barbieri | Division Director, Delaware Division of Substance Abuse and Mental Health |
| 12 | Jim Lafferty | Executive Officer, Delaware Mental Health Association |

# Task Force Support Team

*Caitlyn Gordon, Communications Assistant/Legislative Aide, Delaware State Senate,* organized and staffed Task Force meetings, wrote the meeting minutes for the Task Force, designed graphics for the purpose of this Task Force report, facilitated with writing, developing, and designing this report.

*Carling Ryan, Special Assistant to the President Pro Tempore, Delaware State Senate,* organized and staffed Task Force meetings, facilitated with writing and developing this report.

*Tanner Polce, Legislative Assistant, Delaware State Senate* organized and staffed Task Force meetings, wrote the "Executive Summary" section of this report.

*Bryan Gordon, Community Relations Officer, Division of Substance Abuse and Mental Health,* organized and staffed Task Force meetings, conducted and provided research to Task Force members, and developed the "Delaware Behavioral Health Services Continuum of Care Matrix" for Task Force review.

*Thomas Johnson, Director of Provider Relations, Division of Substance Abuse and Mental Health*, staffed Task Force meetings.

# Executive Summary

## BACKGROUND

In early spring of 2015, Christiana Care announced a shift in practice as it relates to behavioral and mental health. Christiana Care, Delaware's largest hospital provider, would close its Rosenblum Center, a day program for adolescents, and shift the mental health providers associated with the hospital to private practice. These providers would become embedded into private practices to provide short-term mental health care, with the ultimate result of seeing more patients for shorter periods of time. It is estimated that over 1,000 patients were impacted.

With these two changes, members of the General Assembly were flooded with calls, letters and e-mails from individuals and members of their families. They articulated their sense of abandonment, anger and confusion with the minimal notification they received. Senators Patricia Blevins and Bethany Hall-Long met with numerous Christiana Care executives to understand the reasoning behind these changes.

As the constituents from across the State continued to notify their elected officials of the vast impact such a closure and shift would have, many members of the General Assembly felt it necessary to learn more of the current challenges facing the field of behavioral and mental health. The Joint Health and Social Services Committee convened at two separate occasions to host numerous stakeholders in a forum discussion to identify entities' current challenges and gaps. Meetings were held on April 1st, 2015 and April 20th, 2015 and each lasted two and a half hours. Members from the hospital community, Department of Health and Social Service, Department of Correction, the Department of Children, Youth and Families, the Department of Education, several non-for-profit organizations, and numerous constituents spoke about where they see potential gaps and the current status of the behavioral and mental health system in the State of Delaware. The outcome of these meetings was an overwhelming feeling of the need for continued investigation and conversation around the current status of the system and its needs going forward.

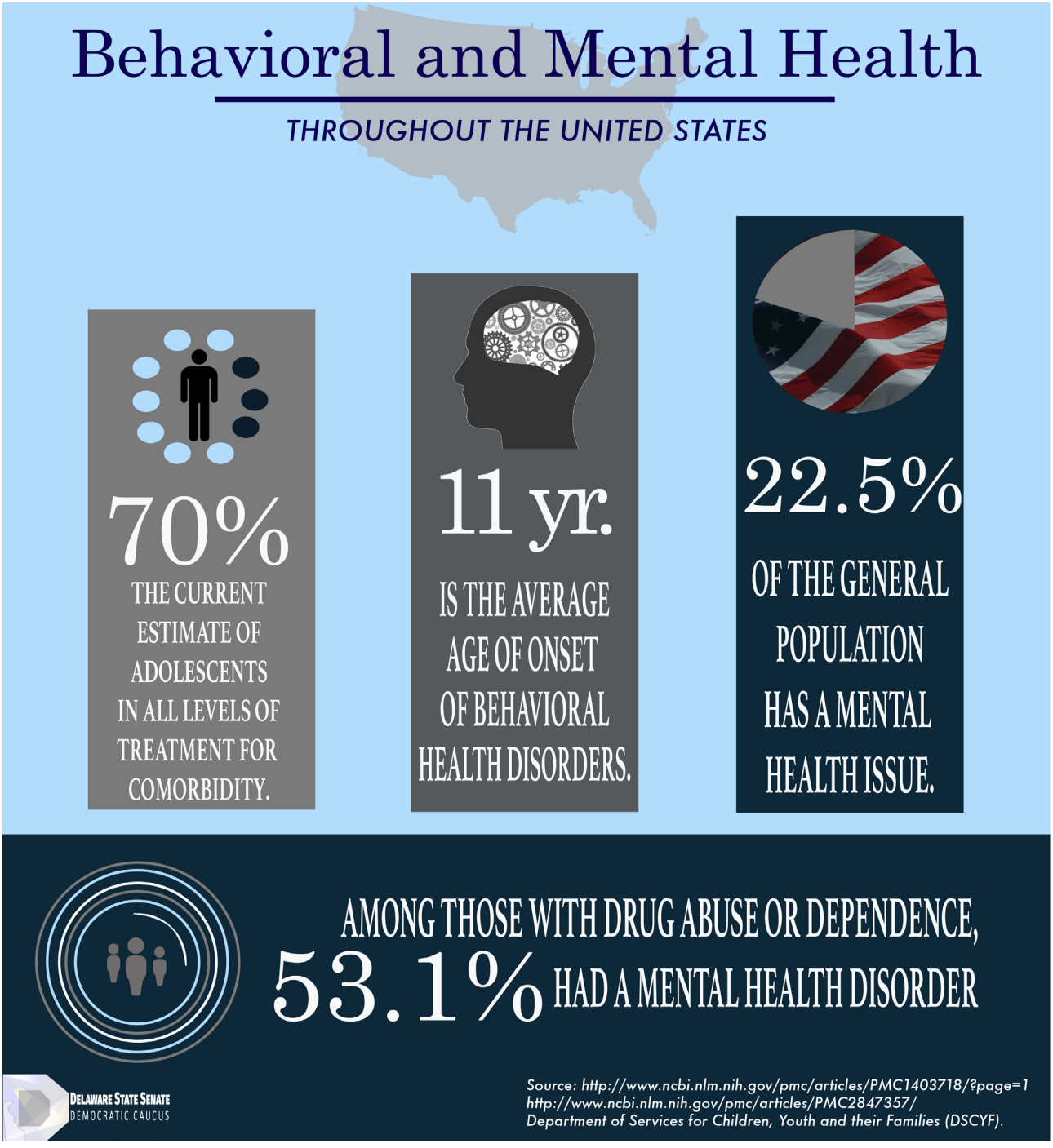
On June 24th, 2015, Senator Hall-Long, with support from Senator Blevins and former Representative Michael Barbieri, along with many of their colleagues, introduced Senate Concurrent Resolution 29, establishing the Behavioral and Mental Health Task Force. The Task Force comprised of a total of twelve members, including representation from the General Assembly, the Departments of Health and Social Services, Corrections, Children, Youth and their Families, Insurance, the Delaware Healthcare Association, numerous other advocacy groups, and a member of the general public. The first Task Force meeting convened on October 1st, 2015, and outlined the overall direction the group would take. The Task Force met a total of nine times, including a public hearing on February 3rd, 2016. The Task Force's final meeting was May 24th, 2016. Throughout the seven month period, topics of stigma, suicide, correctional issues, workforce gaps, insurance coverage and other relative themes were thoroughly discussed.

## PURPOSE

The report will identify the largest gaps as it pertains to behavioral and mental health in the State of Delaware, while considering the impact of better integrating behavioral health across multiple health care delivery settings and providers.

## BEHAVIORAL HEALTH COMMISSION

Recommendations are for further consideration and to continue the conversation on the critically important matter. Further, the formation of the Behavioral Health Assessment Commission is recommended. Senators Blevins and Hall-Long, in conjunction with Representative Debra Heffernan will introduce legislation that will create a standing Commission that will continue many of the works of the Task Force. Numerous Stakeholders will provide oversight of the state's behavioral health system and develop a strategic roadmap that will ensure quality delivery of patient care and access to necessary treatment. Strengths and weaknesses of the current system will be examined. The Commission will make annual recommendations to the Governor and the General Assembly.




*Comorbidity: describes two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both, according to the National Institue on Drug Abuse.*

Behavioral and mental health disorders are prevalent across the country. Without taking the correct steps to curb the stigma of suicide, improve care in the community, and prevent crime through early intervention, Delaware's prevelence of behavioral and mental health disorders may keep rising.

# Corrections

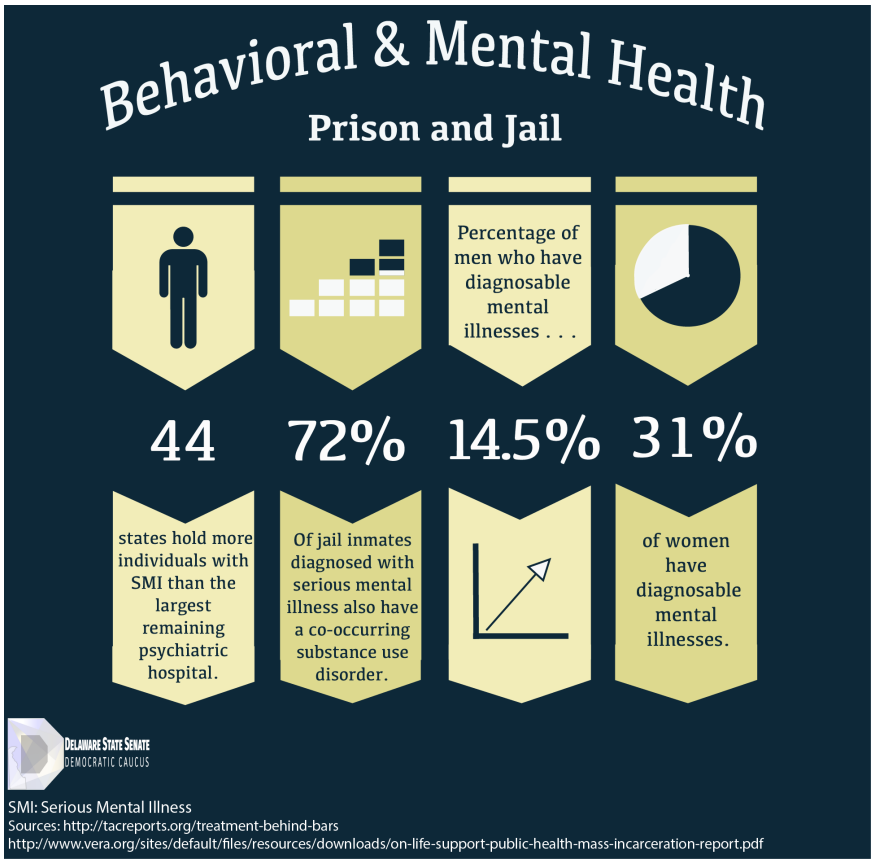
The old school "tough on crime" mindset and initiatives of the 1990's, where harsh sentencing and imprisonment was believed to fix crime, is beginning to surpass us. But, recidivism rates in Delaware are high and incarceration alone is not a deterrent to breaking the law.

In 2012, there were 356,268 individuals with a serious mental illness sitting in cold, dark prison cells. During the same year, only 35,000 people with a serious mental illness were receiving treatment in state hospitals; there are currently 10 times as many individuals with a severe mental illness in jail as there are in state hospitals (Torrey, E.F. et. al. 2014).

In Delaware, the mindset of fixing crime through incarceration alone is diminishing as state officials, judges, and behavioral health professionals are seeing that recidivism rates are high and the prevalence of inmates with mental illness, substance use disorder, or both, is escalating.

There is a profound correlation between mental illness and recidivism and there is currently a large portion of Delaware's offenders who are battling mental illness. For those individuals, getting access to treatment during incarceration, and after their release, will impact their overall recovery. Behavioral health professionals who work for the state find that many of their incarcerated patients, child and adult, have experienced massive amounts of traumatic events like shootings, murders, gang-related violence, and broken homes, which often effects their well-being throughout time. However, sitting in the general population of incarcerated individuals will only prolong the effects of a serious mental illness. This is why state officials have implemented co-occurring rehabilitation and incarceration programs into the state's correctional facilities.

Although these programs have seen success, the Delaware Department of Correction (DDOC) and the Department of Services for Children, Youth, and their Families (DSCYF) facilities are striving to treat every offender who needs care. However, they do not have enough resources to treat every inmate with a serious mental illness or substance use disorder. Therefore, many offenders may be in the general population waiting for proper treatment. For those who are identified, treatment for mental illness and substance abuse disorder is available and very well delivered. Others may not receive the treatment they need before they are released, only to find themselves back in the judicial system months later for committing the same crime.



# Corrections

### Child & Adolescent

At a vulnerable age, where every experience impacts a child's mindset, early intervention and detection for the need of behavioral and mental health services are a vital part of ensuring a positive future. Unfortunately, post-traumatic stress disorder (PTSD), acute stress disorder, mental health disorder, and substance use disorder are all prevalent in a portion of Delaware's child and adolescent population. Additionally, the signs that a child is developing a mental health disorder or substance use disorder are not being detected and treated early enough, leaving the child to continue down a dangerous path.

The Delaware Division of Prevention and Behavioral Health Services reported that 90% of admissions into the Ferris School for Boys had a mental health diagnosis. Ninety-six percent of those had a substance use diagnosis, and eighty-six percent have both a mental illness and a substance use diagnosis.

Proactive measures, like early intervention and care in the community, are tangible solutions that will move Delaware's youth towards a healthier mental state. With the implementation of effective early intervention programs, the needs of children will inevitably change over time.

*DRYS Residential Cottages.*

# Gaps

### RECRUITMENT AND RETENTION

DSCYF has staff or contracted psychologists, substance use specialists, and psychiatrists in their juvenile justice facilities. While they could use more staff support, their facilities are in better shape than most other states. However, as reported during Task Force meetings, DSCYF staff has recently been going through the recruitment process and only had one applicant who met the minimum requirements and was applicable for the position.

The core problem that DSCYF is facing, is recruiting psychologists. A large factor that creates problems with recruiting psychologists to work with DSCYF is the fact that DHSS (Department of Health and Social Services) pays their child psychologists more than DSCYF, which is creating competition between two state entities.

One long-term solution to this problem is to pay DSCYF psychologists similarly to DHSS child psychologists. A short-term solution is to reclassify DSCYF's positions so that, in the event they cannot find a psychologist, DSCYF can hire a person with an alternative license, such as an LCSW (Licensed Clinical Social Worker). This would provide DSCYF with needed flexibility in a situation where they cannot find a psychologist. Furthermore, DSCYF also faces challenges recruiting board certified psychiatrists, advanced practice nurses, prescribers, and other licensed behavioral health professionals. There needs to be a statewide effort to build the capacity of prescribers and behavioral health professionals in Delaware.

Additionally, working with youth in treatment programs at the Ferris School for Boys, New Castle County Detention Center, Stevenson House Detention Center, and their Residential Cottages has not been highly sought after by behavioral and mental health professionals. In addition to the general mental health psychiatrist recruitment problem that Delaware facilities are facing, recruiting professionals who want to help and care for kids in detention facilities has proven difficult as well.

While providing treatment in their facilities is necessary for the youth in the facility to cope with trauma and work through their mental illness, following up with care in the community has also been a significant factor for successful treatment. However, finding an adequate amount of board certified psychiatrists, APRN's (advanced practice registered nurses), and prescribers, in the community has been another barrier in Delaware. DSCYF is having trouble finding enough prescribers to treat their youth as they reenter the community. Therefore, when the child leaves the state facilitates after successful treatment, their services may be cut off in the community making it more difficult to maintain what they learned.

**Recommendations:**

- Incorporate telehealth throughout the state to ensure that individuals who are seeking treatment are able to find care.
- Build the behavioral health workforce in Delaware and implement programs to educate existing providers with a strong background and capacity of behavioral health treatment.

# Gaps

### HANDOFF PROCESS

After a successful treatment, children who are leaving DSCYF facilities may feel unbeatable and back to a healthy mental state. However, DSCYF has noticed that children who have been treated for substance use disorder, and believe they will not resort back to drugs, may return home to drugs on the kitchen table where the resistance becomes more difficult.

*Second Chance K-9 Progam. Partnership between Faithful Friends Shelter, the State Department of Animal Control, and YRS.*

Saying "no" to drugs while in the comfort of a treatment facility is only half the battle; reentering the community after treatment is a crucial step to recovery for most children. Moreover, the toxic stress of living in communities of violence is a large challenge that Delaware's youth faces.

Adults have the opportunity to reside in a halfway house while they work on reintegrating into their community, but children do not. Children have no other choice other than to transition from a treatment facility with physicians and a stable living situation, back into the unstable community that they often come from. What children in Delaware are missing is a transitional program, like a halfway house, and other intensive community based services, to help them transition back into their communities. Although services may not get completely cut off when a child enters back into the community, services may be delayed, especially when a youth has private insurance.

Without a halfway house, or transitional program, DSCYF staff has a process in place to lessen the burden that parents or family members have when a child is released from DSCYF detention facilities. DSCYF staff makes recommendations and works with families to get the child connected to care in their community. Their staff will also transport kids to their intake appointment from the detention center, hoping that this initial appointment will help the child build a relationship with the provider and confide in them.

However, after transporting them to their initial appointment, DSCYF has difficulty with following-up to see if the child is still getting treatment. With a halfway house, or a transitional program, in Delaware for children, their reintegration back into the community will not feel so challenging that they resort back to their old habits to cope with the demands of everyday life.

**Recommendations:**

- The state should develop a transitional program and intense community based services for children.
- Incorporate the aforementioned "Behavioral Health Commission's" oversight and monitoring role with monitoring the state's telehealth efforts.
- Implement inpatient substance abuse treatment for Delaware's youth.

# Gaps

### SCHOOL DISTRICT POLICIES

Inconsistent expulsion policies across the state are hurting Delaware's youth and diminishing their chances for future success. Currently, if a child is expelled from school for two years, and spends one of those years in a DSCYF facility, the time it takes for them to receive treatment is not counted towards their expulsion period. Although this policy only affects children in certain school districts throughout Delaware, children should not be penalized for seeking treatment. With this policy, a child cannot resume classes and continue learning until they have fulfilled their expulsion requirements at home, and only at home.

*Ferris School athletics.*

This policy inconsistency between school districts acts as a deterrent to graduating and only penalizes some children but not others. If a child is punished from returning to school for a specific length of time, and their treatment acts as an additional punishment, the child may have little desire to finish school and will have a higher probability of dropping out. Schools should not condemn kids by extending their expulsion period for taking positive steps towards mental health and substance use disorder treatment.

**Recommendations:**

- Require school districts to implement uniform standards statewide for calculating time spent in detention facilities towards expulsion.

# Gaps

### TERMINATION STATE V. SUSPENSION STATE

When a child in Delaware is sent to jail, their Medicaid coverage is turned off. However, Delaware does not have a policy set to reinstate the child's Medicaid coverage upon reentry into the community because Delaware is a termination state. Since Delaware is a termination state, rather than a suspension state, a child's legal guardian is responsible for reapplying for Medicaid coverage. Because of their legal guardian's responsibility to reapply, a child's reentry into the community has become a significant challenge in Delaware. Oftentimes, when the Department of Prevention and Behavioral Health Services (DPBHS) tries to connect a child who is leaving the system to the appropriate treatment, they never get treatment because their Medicaid coverage is terminated and their legal guardian has not reapplied for it.

**Recommendations:**

- Change Delaware from a Medicaid termination state to a suspension state for children.

# Corrections

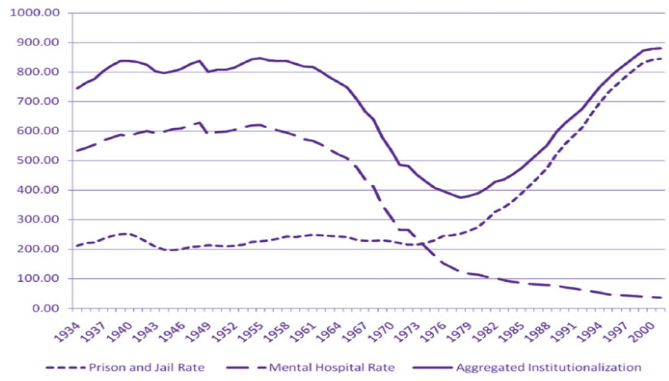
### Adult

Trauma plays a huge role in developing a substance use disorder and a serious mental illness. For example, an adult who struggles to cope with traumatic experiences they had as a child may resort to drug abuse to mend the pain. However, once they start using drugs to cope, the possibility for addiction is very high and stealing or selling drugs might be the only way to pay for them, leading to a long road of addiction and crime.

Currently, 8.7% of people nationally will meet the criteria for post-traumatic stress disorder (PTSD) at some point in their lifetime (American Psychiatric Association, 2013). However, if Delaware is not equipped with proper resources in correctional facilities, state hospitals, or in the community, those who are suffering from mental illness or substance use disorder that want to get treatment will not have the proper access to it.

Providing the state with more resources for Behavioral and Mental Health treatment is critical; and if the aforementioned Behavioral Health Commission reviewed improvements that the state makes, and the resources the state is using, there will be long-term success for the programs.

With enough resources to treat all inmates, the Delaware Department of Correction and Connections can increase the amount of inmates who are recieving behavioral health care.




*Rates of institutionalization, including jails, in the United States.*

# Gaps

### RECRUITMENT & RETENTION

The Delaware Department of Correction has faced difficulties with finding staff to provide treatment and services to incarcerated individuals. DDOC faces similar barriers that the children's detention facilities face when trying to recruit and retain behavioral health professionals.

It was reported during Task Force meetings that Connections has recently lost 4-5 potential physicians that would be willing to work at DDOC because of the length of time to obtain licensure in Delaware. Unfortunately, licensure for behavioral health professionals in Delaware takes longer than surrounding states, so DDOC has been providing the necessary clinical supervision needed to those who have master's degrees so they can achieve licensure. Once that person has received licensure, DDOC pays them more money to retain those clinicians in Delaware.

Additionally, the state system does not have enough positioned classes to accommodate the learning that a new clinician will need to be employed, there is no step ladder for someone studying to become a

clinician or a social worker for advancement into another position as they earn another degree or licensure. Currently, it is easier to hire from a contractor perspective than it is from the state system. If the state hires unlicensed workers into low-paying positions, they will leave as soon as they get licensed.

However, even when clinicians are licensed and practice in Delaware, the burnout rate for professionals working in correctional facilities and treating individuals suffering from behavioral and mental health issues is very high.

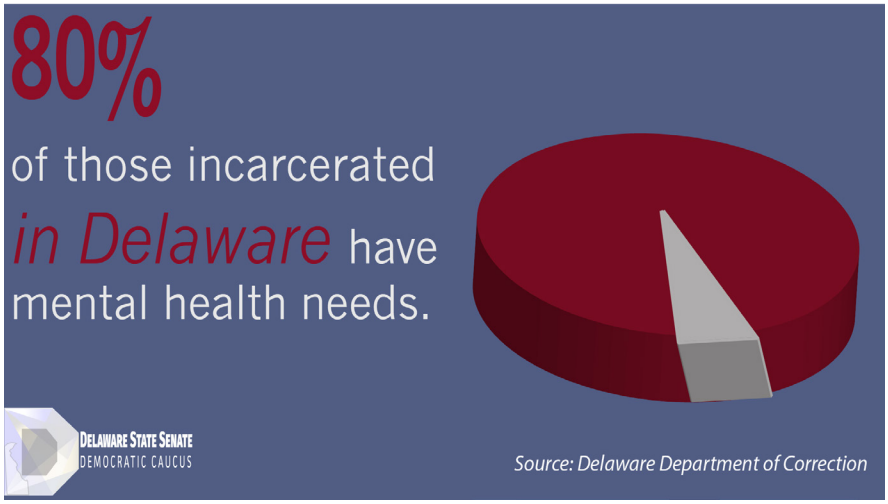
**Recommendations:**

- Incorporate telehealth throughout the state to ensure that individuals who are seeking treatment are able to find care.
- Expedite the licensing processes for hard to fill positions, such as physicians, for correctional facilities.

# Gaps

### LACK OF RESOURCES

With a lack of treatment resources in the community, oftentimes an offender in the Delaware correctional system has a much better chance of getting their substance abuse disorder and serious mental illness under control than if they were in the community. With that being said, community resources are over-subscribed and there remains unmet demand for Assertive Community Treatment Services.




A person may be battling a serious mental illness or substance use disorder for years. However, the lack of available treatment makes their battle unbearable. Sometimes, for a variety of reasons, that same person may find themselves in a prison cell one day; where he or she is substance abuse free and finally has access to the appropriate treatment.

Due to a lack of resources, Delaware's correctional facilities must use a triage model, whereby their inmates with a Serious Mental Illness (SMI) receive more resources than those with less severe diagnoses. Those diagnosed with a mental illness and needing services, will receive, at a minimum, a comprehensive mental health evaluation, psychiatric evaluation and medication management, monthly therapy sessions, and treatment planning every six months.

If appropriate and necessary, an offender may also have access to Special Needs Units, where daily group programming occurs, weekly therapy sessions, monthly psychiatry sessions, and treatment planning every 90 days. Additionally, intensive psychotherapy is also available by doctoral level psychologists and post-doctoral fellows, if necessary. All of these services could and should be expanded to provide additional treatment options to each of these levels of severity. However, Connections and DDOC's Bureau of Correctional Healthcare Services work daily to identify ways to bring additional treatment to individuals that are incarcerated.

**Recommendations:**

- The state should work towards increasing access to DDOC's special needs units for those offenders needing that level of specialized care and review existing programs. There are a high number of inmates in Delaware's correctional facilities who are in need of more levels of behavioral health care than are currently available.
- The state should set programs and initiatives to treat psychiatric disorders in the community before an individual commits a crime and receives treatment through incarceration. Contributing to the lack of space in Delaware's correctional facilities are the high numbers of incarceration and individuals who recidivate. To alleviate the pressure of limited resources in the state's correctional facilities, incarceration and recidivism rates must decrease. Minimizing incarceration and recidivism rates can be accomplished through early intervention in the community.
- With the high rates of behavioral health treatment needs in the state's correctional facilities, the state should work on providing correctional facilities with more resources to treat their inmates.
- Delaware should focus on a more seamless transition for offenders coming out of the prison system to avoid recidivism.
- Reimbursement rates for behavioral health care services needs to be increased so that all released offenders can continue to find quality care in their community to help individuals rehabilitate and ultimately avoid recidivism.

# Gaps

### TERMINATION STATE V. SUSPENSION STATE

Inmates are not allowed to use Medicaid for the duration that they are in prison. Other states, suspension states, have enacted a policy to suspend their inmate's Medicaid until they are released, so they can almost instantaneously start receiving treatment upon release, when the Medicaid is turned back on. However, Delaware is a termination state, so when an inmate is released they have to reapply for Medicaid, which will prolong the time before receiving any necessary treatment.

**Recommendation:**

- Change Delaware from a Medicaid termination state to a suspension state for adults.

# Gaps

### ELIGIBILITY AND ENROLLMENT UNIT (EEU)

The Eligibility and Enrollment Unit (EEU), housed within the Division of Substance Abuse and Mental Health (DSAMH) acts as a gateway to receiving services from DSAMH. The EEU process reviews potential clients for DSAMH services. This process includes filling out several forms and going through staff assessments to determine if the patient will fit into one of DSAMH's programs.

Individuals who are admitted into a psychiatric hospital for stabilization will go through this EEU process to continue care in the community after their release. However, the EEU process takes too long sometimes and patients are released before they are connected to care. Similarly, DDOC will use the EEU process to

connect inmates to services while they're waiting for release from prison. In both situations, either the patient or the inmate may be released into the community without care because the EEU process has taken too long. However, DSAMH has experienced trouble linking individuals up to treatment going through the EEU process because they do not have enough resources to link every applicant up to services.

Moreover, there have been situations in Delaware where a patient is released from a psychiatric hospital without care because they were waiting through the EEU process. However, during this waiting period, some individuals may find themselves in jail because the time between their release from the hospital to when they committed a crime was too long.

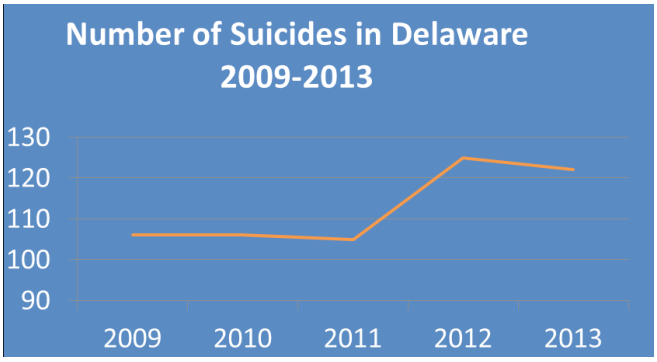
**Recommendations:**

- The state needs to speed up the EEU process; the wait time that it takes to get someone from an institution into services is too long.

# Suicide & Stigma

In 2013, nationally, there were 41,149 deaths by suicide and suicide was the 2nd leading cause of death for youth ages 15-24, reported the American Association of Suicidology.

National suicide prevalence is distressing, while efforts to curb the social stigma of suicide are increasing; the existence of suicide and stigma still prevail. However, suicide and stigma prevention efforts in the state are promising but lack the proper resources that are needed to advance their efforts.




*Source: American Foundation for Suicide Prevention.*

With suicide prevention efforts comes the need for education. Too many suicidal children are giving their friends, family, and teachers desperate pleas for help, but their efforts are flying under the radar until it is too late. Without increased education in schools, summer camps, and inside every home with a child, these patterns of preventable deaths by suicide will continue.

The excuse of "it's not my kid," needs to subside. Too many parents are ignoring the existence of suicide because they believe their kid isn't effected by it. However, without the proper education on whether a child may be suicidal, this excuse is only acting as a crutch to enable suicide by ignoring the problem. By increasing resources for suicide prevention programs, and by requiring suicide education to any individual who looks after a child, suicide rates in Delaware will decrease and save suicidal individuals statewide.

## Gaps

### EDUCATION

Education and awareness of suicide, stigma, and psychiatric disorders can prevent children from taking their lives. By educating parents, communities, teachers, and primary care physicians, a child's suicidal thoughts and actions will trigger a response rather than going unnoticed.

A study on follow-up clinical care for kids reported that 50% of parents whose children were identified as suicidal did not follow up for care. However, their parents neglected to follow-up for care partly because they were uneducated about suicide and didn't believe it was necessary for their child's well-being.

In Delaware, when emergency departments identify that a patient is suicidal, they will give their patient follow-up clinical care information and release them. But, it is up to that person to follow-up on their own. In a child's situation, it is up to their guardian to follow-up and get care for the minor. Some guardians may never take the steps to follow-up for continued care. With the rate of death by suicide increasing, more has to be done to educate the public of warning signs that tell when a person is suicidal, and what to do if they spot those signs. Although increased education is necessary, Delaware does not have the necessary capacity and resources for additional suicide education.

Insufficient education regarding suicide prevention is also prevalent with those in the mental health profession. There are a high number of mental health professionals who are not comfortable treating suicidal patients because they have not been trained for this type of treatment. Therefore, with a limited availability of workers within the behavioral health workforce, fewer children are receiving necessary care.

A widespread lack of education may cause numerous barriers for suicidal children. Although children should receive screenings for suicidal thoughts, actions, or psychiatric disorders, a lot of doctors are avoiding screenings because there are not enough behavioral health professionals to treat suicidal children.

Overcoming depression and psychiatric disorders are large enough barriers for children to face. However, without access to treatment and guidance from caretakers, these barriers become much more problematic for Delaware's youth.

**Recommendations:**

- Utilize existing training programs, led by mental health professionals that will provide education for psychiatric disorders to any individual who works with children like school teachers, nurses, camp counselors, and primary care physicians.
- Utilize the aforementioned "Behavioral Health Commission" to provide monitoring of the state's existing educational and training programs to ensure that they stay effective.
- Encourage a process for schools and communities to provide education to legal guardians about suicide.
- Develop a unified approach and message between agencies to provide the state with increased anti-stigma education through a website and social media techniques. Incorporate the pre-existing "Help is Here" website to include a section focusing on anti-stigma education, education on suicidal children, and information educating parents and legal guardians on how to care for youth who have a substance abuse disorder.

# Gaps

### DATA & RESEARCH

During Task Force meetings, the Mental Health Association expressed the need for "real-time" data related to suicide. They recommended that the Division of Public Health should collect day-to-day data related to suicide, including emergency department admissions and hospital admissions. This data will break down the age of the people at risk and provide the necessary epidemiological data to help target prevention efforts. Surveillance data is crucial for increased suicide education.

**Recommendations:**

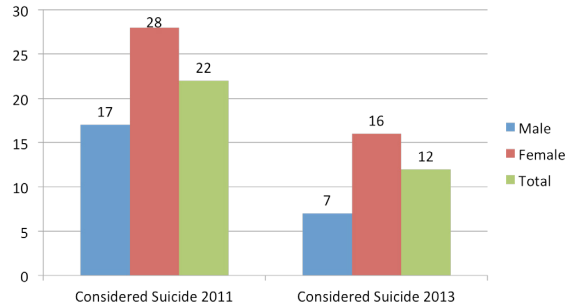
- The Division of Public Health should implement a day-to-day surveillance process of suicidal behavior for real-time data. The data should be collected from emergency department admissions and hospital admissions. The state should also incorporate a suicide risk database to keep track of at-risk youth.

# Gaps

## TREATMENT

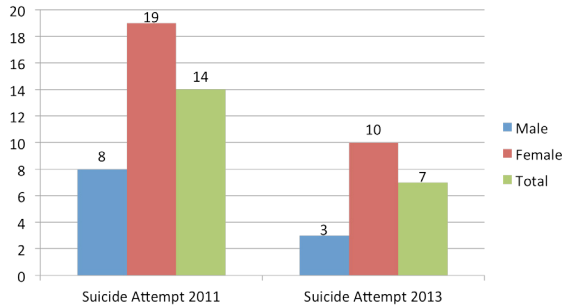
Delaware does not have instate residential treatment facilities for teens who have serious substance use disorders. To get Delaware's youth necessary residential substance abuse treatment, children must go out of state. The Division of Prevention and Behavioral Health Services (DPBHS) uses Mountain Manor Treatment Center in Baltimore or Delaware's hospitals for short stay residential treatment for children facing substance abuse disorders. However, two of DPBHS's contracted providers have gone through training for the "7 challenges" and are accepting adolescents who have substance use disorder. Although the state is moving towards providing its youth with substance abuse and addiction treatment, there are more steps that need to be taken.

In addition to finding appropriate facilities to treat children with substance abuse disorder and suicidal thoughts, the child must have access to care in the community once they are stabilized. Although stability is important, reimbursement rates are not consistently covering care in the community. However, if adequate resources are not available to stabilize within the community, the patient will end up going back into deep end services.




*Percentage of Midle School Delaware students who serioiusly thought about killing themselves, 2011 and 2013.*

*Source: Delaware Middle School Youth Risk Behavior Surveys, 2011 and 2013*




*Percentage of Midle School Delaware students who tried to seriously hurt or kill themselves, 2011 and 2013.*

*Source: Delaware Middle School Youth Risk Behavior Surveys, 2011 and 2013*

**Recommendations:**

- Since the only treatment for youth with substance abuse disorder is out of state, develop a residential treatment center to treat teens with substance abuse disorder.
- Develop a 30-day inpatient treatment facility for adults.
- Review current intensive outpatient or partial hospital treatment that our youth receive and determine if it meets their needs. Recommend the aforementioned "Behavioral Health Commission" to work with insurance companies to provide longer care for those who need it. This will minimize readmission into the program weeks later and ultimately save money for the insurance companies.
- Institute Emergency Department and hospital follow up after discharge of individuals who were treated for suicide attempts.

# Gaps

### HANDOFF PROCESS

The hand off process in Delaware needs to be strengthened. Currently, if a child or adult is admitted into a hospital over the weekend, but regularly sees a psychiatrist for treatment, there is no system put in place to notify their psychiatrist that they had been hospitalized or their medication has changed.

This same trend persists when it comes to notifying schools that a child had been hospitalized over the weekend. Since there is not a process in place to notify the schools when a child has been hospitalized, the minor is thrown back into their daily school schedule and the school is not aware that the child needs supervision. If there was a process to notify schools of these circumstances, school psychologists could give the child more attention and increase communication with their parents.

**Recommendations:**

- The state should look at centralizing data to improve its hand off process so all involved parties are aware of the child's well-being and mental state.
- Because of the gaps of communication between care providers, hospitals, schools, and parents, a child's quality of care is suffering and their treatment will be less effective. The state should work on improving the system of communication between providers, hospitals, parents, and schools.

# Gaps

### SUICIDE PREVENTION COALITION

The Delaware Suicide Prevention Coalition, which began its efforts in 2004, is chaired by the Division of Prevention and Behavioral Health Services, the Division of Substance Abuse and Mental Health, and the Mental Health Association in Delaware. The mission of this coalition is to raise awareness that suicide is a preventable public health problem and to promote the behavioral and social changes necessary to reduce suicidal ideation and attempts. The efforts of the coalition have been successful thus far, and have led to a 5-year suicide prevention plan developed in 2008, and revised in 2013. However, since this coalition is not formally legislated, if one of the co-chairs decides to leave, the coalition might shutdown. The coalition needs the opportunity to continue their efforts to prevent suicide long-term.

**Recommendations:**

- To ensure that the Delaware Suicide Prevention Coalition exists in years to come, the state should produce legislation to formally establish the Delaware Suicide Prevention Coalition as an entity supported by the Department of Health and Social Services and the Department of Services for Children, Youth, and their Families.

# Gaps

### TELEHEALTH

In southern Delaware, the average wait-time for a child to see a psychiatrist is 4-6 months. In northern Delaware, the average wait-time for a child to see a psychiatrist is 5 months. For a child suffering from suicidal thoughts and/or psychiatric disorders, this wait-time is too long.

Considering the recruitment and retention problems in Delaware, telehealth will increase the state's access to care. However, there are still gaps that surface through using telehealth. The largest issue that may

surface through this untraditional mode of treatment is the lack of knowledge about the technology and how to effectively use it.

However, in many instances children tend to accept the idea of telehealth very well. Ever since the vast increase of technology use and dependence, today's youth are more open to communicating with their psychiatrist through technology. Additionally, with the insufficient amount of child psychiatrists and other prescribers in the state, telehealth eases the burden of limited access to care.

| Facility | Total Clients | Total Visits |
|---|---|---|
| People's Place | 26 | 115 |
| Stevenson House Detention Center | 97 | 312 |

*Division of Prevention and Behavioral Health Services & Department of Services for Children, Youth and their Families - Clients Served Since Implementing Telepsychiatry.*

The Stevenson House Detention Center provides an example of successful telehealth. Before they implemented this program, DPBHS used to transport kids out of Stevenson House Detention Center because they could not find a doctor to come in and see the kids. The difficulty of transporting kids in and out of the detention center for treatment prompted a telehealth program. Although the program has been successful, it has not been easy to get there. There have been glitches and DPBHS is still working out these issues with the state.

**Recommendations:**

- Incorporate telehealth throughout the state to ensure that individuals who are seeking treatment are able to find care.
- The state should look into ways to improve the processes and protocol of telehealth to ensure the safety of the patient.
- Incorporate the aforementioned "Behavioral Health Commission's" oversight and monitoring role with monitoring the state's telehealth efforts.

# Workforce

In 2015, Christiana Care abruptly closed all of its adult and child outpatient mental health facilities, spurring public outcry that largely led to the formation of the Behavioral and Mental Health Task Force. These facilities included the Herman Rosenblum Center and the adult partial hospitalization program, which were replaced by small scale bridge programs with no fulltime psychiatrists or psychologists. Each of the aforementioned facilities provided outpatient services for more than 1000 patients who were impacted. Over the same time period, the state proceeded with its plan to close all of the state funded mental health clinics in addition to a marked reduction in inpatient beds at The Delaware Psychiatric Center (DPC). The state hospital previously provided care for the uninsured, those with severe mental illness, and the indigent. Unfortunately, the state's shortage of providers, the closure of public and private outpatient facilities, geographic constraints, and variable insurance coverage left many Delawareans without options for mental health care.

Over the last few years, Delaware has seen a large number of rapidly occurring changes to its mental health hospitals, partial programs and community clinics. These changes coincided with the implementation of the Affordable Care Act (ACA) and the expansion of integrated services, which in some cases, replaced traditional services. Delaware is a small state that relies heavily on Christiana Care, the state's largest medical provider, for much of its somatic and mental health care. A small state with relatively few

institutions means changes with any provider have the potential to profoundly impact patients. Christiana Care provides a significant amount of charitable care through its hospital and outpatient facilities, and the remainder of mental health care (outside the forensic system) is provided by the Delaware Psychiatric Center (DPC), in addition to several for profit providers including The Rockford Center, Meadowwood Hospital and Dover Behavioral Health. However, while the for profit providers accept both committed and voluntary patients, Christiana Care only provides inpatient care to voluntary patients in its psychiatric ward. Christiana Care's hospital based ward has more robust medical support services, and is an essential service to Delawareans with mental illness and comorbidities. The Christiana Care inpatient unit is capable of providing access to the variety of specialties that reside on that campus.

**Recommendations:**

- The Task Force may consider efforts to better quantify and examine the role of charitable care in Delaware.
- The Task Force may consider implementation of mandatory guidelines for healthcare facilities that intend to close wards or large-scale treatment centers.
- The Behavioral Health Commission should partner with the Department of Health and Social Services and the Department of Insurance to look at the certification and licensure issues of individuals and programs who provide behavioral health services. This should include requirements for supervision of non-licensed or certified individuals and reimbursement practices for such services.

# Gaps

### UNFORESEEN EFFECTS OF INTEGRATED CARE

While the Task Force recognizes the benefits of integrated care models, which are meant to augment/supplement rather than fully replace traditional mental health services, statistical outcome data is currently limited. Many Delaware providers have embraced this delivery model but have faced considerable challenges in implementing this model in its intended fashion, with unclear results.

In accordance with deinstitutionalization and the principles of recovery, the Task Force recognizes and appreciates attempts to reduce inpatient admissions, seclusion and restraints, and increase community based care. However, inpatient care remains the only safe modality of care when a patient is unable to be adequately managed in a community based setting. Additionally, while many patients in need of emergency care can be stabilized during a brief inpatient admission, there remains a significant percentage of patients who require longer lengths of stay to achieve the requisite stability necessary for successful community reintegration. Some patients also require greater levels of structure than can be provided by any outpatient environment, including a group home; factors contributing to additional needs include limited social supports, treatment refractory states, homelessness, noncompliance with treatment and a patient's stress/adaptive coping skillset. The need for inpatient services can be reduced, but cannot be eliminated by intensive outpatient support.

Despite attempts to reduce the reliance on inpatient treatment, the number of inpatient admissions grew considerably over the past year. Over the same time period, there has been an increase in suicide rates in Delaware, and a decrease in life expectancy for those with severe mental illness. Increased inpatient mental health admissions and the resulting demand for inpatient beds has strained the current system and resulted in increased ER boarding, and wait lists. The combination of increased inpatient utilization and rising suicide rates are a concerning public health trend that will need close monitoring.

**Recommendations:**

- The Task Force recommends further attention to developing information that will allow for timely and accurate oversight of the integrated care model.
- Implement more day-hospital services.

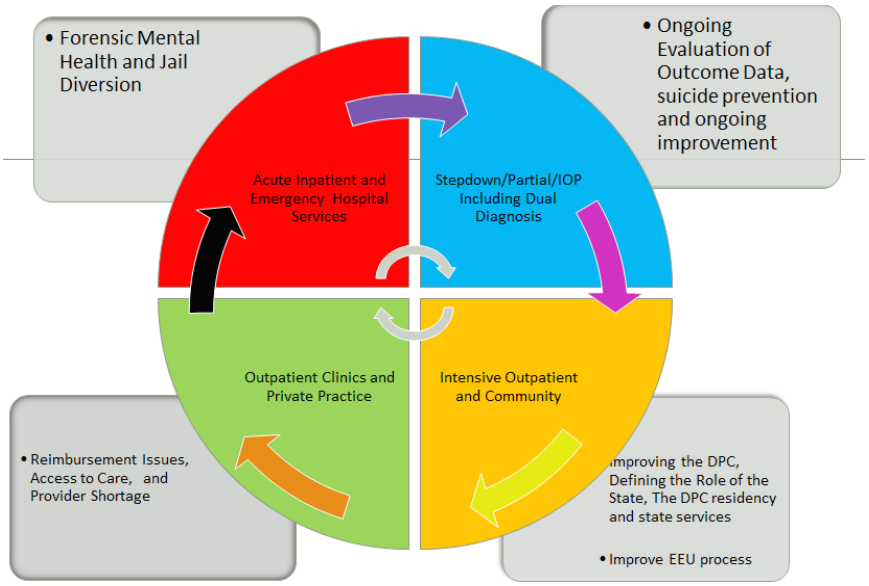
# Gaps

### AFFORDABLE CARE NOT AVALIABLE

It is apparent that private pay insurance companies are often unwilling to reimburse for protracted lengths of stay, dual diagnosis services and some step-down levels of care. For many indigent patients, private insurance policies have not proven an adequate or affordable alternative to state care. Some psychiatric patients with severe mental illness may have impairments that also affect one's ability to navigate the complex systems essential to their own well-being. For some insured Delawareans, the pharmacy copay policies and limited formularies, including unaffordable copays for psychotropic drugs and limited coverage of dual diagnosis services, make treatments inaccessible. For these patients, access to care and prescription drug coverage is even more limited with the closure of state clinics.

The Delaware Psychiatric Center, Delaware's only state hospital, provides a pivotal role in the care of indigent and patients in need of greater support or longer lengths of stay. However, the significant reductions in beds and changes to the State's admission policies have markedly limited access to these services even when no alternative exists.

The Task Force believes that we must better characterize and address the needs of this population. Currently, DSAMH is working to bolster its Restart Program, but the Division acknowledged that there needs to be a stronger effort to expand the network so that people can get into outpatient treatment more quickly. Premature discharge or lack of access to affordable outpatient care and prescription medications places patients at high risk of readmission, incarceration and sometimes death.




*Prepared by Dr. Adam Glushakow - Continuum of Care*

**Recommendations:**

- Increase private prescription drug coverage for a subset of indigent and underinsured Delawareans with severe and persistent mental illness.
- Charge a future Mental Health Commission with reviewing admissions data from private hospitals and the state hospital, including the percentage of involuntary to voluntary admissions, length of stay, referral source, admission diagnosis, readmission rates, EEU processing time and other outcome data.
- Make all efforts to streamline EEU processing, reduce turnaround time, and increase transparency of the process.
- In the case of hospitalization, for a mental illness, there should be mandatory communication between the inpatient and outpatient provider or mental health care professional regarding the hospitalization event, both on admission and on discharge.
- Implement more day-hospital services.
- Continue to strengthen and grow the availability of affordable outpatient care, and improve the hand off process to outpatient providers from inpatient treatment.

# Gaps

### LACK OF SKILLED WORKFORCE & TRAINING

No healthcare system can exist without skilled and dedicated healthcare providers. Like many surrounding states, Delaware has a considerable shortage of psychiatrists, and as a result, the state has struggled to provide psychiatric care to both children and adults in all treatment venues. While efforts are underway to expand access, the shortage of care providers remains concerning and inadequate. The use of telepsychiatry may help expand access to care, but remains of limited utility in several patient populations. The Task Force recognizes the need to recruit and retain qualified, skilled mental health care providers to the state. Combinations of many factors pose particular challenges to this state and warrant multipronged solutions.

**Current Challenges in Delaware**

| | Update |
|---|---|
| Fee-for-service environment | • The prevailing fee-for-service payment model impedes integration of behavioral health and primary care.<br>• Providers describe ambiguity and variance in reimbursement for a range of integrated care services. |
| Access | • In Delaware, there is a shortage of behavioral health clinicians, and specifically a shortage of psychiatric prescribers with significant variation in access across the state.<br>• Access issues limit the availability of behavioral health clinicians working with primary care practices to integrate, co-locate or build co-management agreements. |
| Structural Barriers | • Behavioral health and primary care clinicians typically do not work from common health records.<br>• General lack of understanding of federal and state policies about sharing behavioral health information across organizations. |
| Training | • Many of today's clinicians have not been trained to work on integrated primary care and behavioral health teams.<br>• Primary care clinicians may also need additional training to feel comfortable managing patients presenting with substance abuse or other behavioral health conditions |

*Delaware Center for Health Innovation. (DCHI)*

The Delaware Psychiatric Hospital (DPC) and its residency program struggle to attract competitive residency candidates who have graduated from American medical schools. Its residents often graduate and seek additional training and employment outside of the state. Currently, the program is understaffed, underfunded, and is not ranked among the top tier residencies. Further, it does not participate in the residency match system which is used by most programs. DPC does not have a full time residency director or a complement of full time teaching staff, which requires it to contract with outside programs to provide lectures and curricular support. Many of DPC's state funded residents are being utilized by out of state facilities, and the program can no longer provide community rotation sites, a key part of the program's mission. At the same time, it is therefore

unable to utilize residents to help train and provide care for the indigent. Currently, the program offers no fellowship training in child and adolescent psychiatry, consult liaison, substance use disorders, or geriatric psychiatry. With an increasing reliance on out of state rotation sites, the residency will have even greater difficulty remaining competitive. As a result, it increasingly fails to attract competitive teaching faculty, researchers and the academics that are needed while being unable to provide affordable resident community care.

Contributing to workforce shortages is the closure of several psychiatric facilities, and the recent decline in reimbursement rates for mental health related services. The rates negotiated in Delaware are below those of surrounding states and are inadequate. Brief medication check visits are often incompatible with good patient care as well as provider satisfaction. Given the closure of the state beds, clinics and Christiana Clinics, providers are faced with more complex patients and less reimbursement to care for them. Additionally, rates of reimbursement for dual diagnosis and substance abuse treatment have declined, resulting in large scale closures. Fewer providers are participating in various insurance programs. Christiana Care, the state's biggest employer and provider, has just 24 inpatient hospital beds out of greater than 1000 total beds, and currently has no residency for psychiatry training. However, Christina will be expanding to 28 inpatient hosptial beds. Additionally, plans for a Christiana Care Behavioral Health Residency Program are in the development stages. Furthermore, a new psychiatric facility in Bear, Delaware has been approved, which may help recruit staff to its facility. In 2017, Christiana Care is beginning their psychology internship program, and in 2018, the psychiatry residency program will be implemented.

Another barrier to Delaware's mental health workforce is its licensure requirement, including the application processing time and cost. Given Delaware's small size and its proximity to other surrounding states, with their own licensure policies, the state may want to consider allowing practitioners in the surrounding states to practice in Delaware or expedite their licensure. In doing so, a large pool of licensed providers in Pennsylvania and Maryland could more easily seek employment in Delaware. This would also help facilitate academic and health system partnerships. Currently, Delaware has difficulty recruiting staff from highly reputed systems with strong reputations such as University of Pennsylvania, Main Line Health, Thomas Jefferson University, and Sheppard Pratt. Opening up lines of communication between these educational institutions, while incorporating the University of Delaware's strong medical training programs, could attract a new wave of locally, highly educated professionals.

**Recommendations:**

- Focus on development and retention of board certified psychiatrists, advanced practice registered nurses, and other behavioral health professionals and prescribers in Delaware.
- Strengthen DPC's residency program, as it is integral to attracting talented mental health staff, education, and care for the indigent.
- Improve licensing requirements through the Division of Professional Regulation.

# Co-occurring Disorders

Much of determining how to address behavioral and mental health issues requires an understanding that these issues are frequently coupled with one or more additional disorders. The Task Force specifically noted that co-occurring disorders, or comorbidity, which involve a mental health condition and a substance use disorder or developmental/intellectual disability, can complicate a patient's ability to receive the proper care needed to address both conditions.

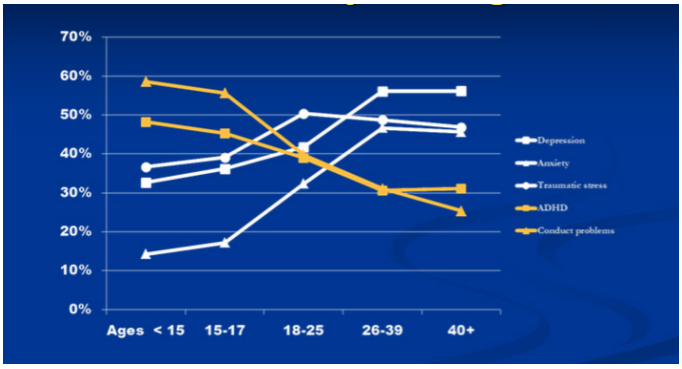
# Adult Comorbidity

## SUBSTANCE USE DISORDER AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY

Epidemiological surveys show that the prevalence of co-occurring disorders is relatively high; approximately 22% of the American population has a mental health issue, and of that 20%, 30% suffer from comorbidity. Additionally, there is a 30 times greater risk of having a substance use disorder if you also have an antisocial personality. In some conditions, there a genetic risk to having co-occurring disorders with substance abuse. Integrated treatment, where someone is being treated by the same team, or by different teams in the same setting, for each issue, has been proven to be most effective for adults.

Delaware's Division of Substance Abuse and Mental Health (DSAMH) was awarded a grant to try to address and treat co-occurring disorders in adults. Key accomplishments included the implementation of universal screenings for co-occurring disorders, and allowed for widespread trainings for mental health professionals to identify comorbidity and implement treatment strategies. The grant also allowed the agencies to start capturing data regarding those diagnosed with co-occurring disorders. However, the grant did not result in data demonstrating how many people suffering from co-occurring disorders have been successful in addressing their multiple syndromes and maintaining their conditions after receiving treatment.

Comorbidity with an intellectual or developmental disability (ID/DD) can be equally difficult to treat. There are multiple causes for these syndromes, such as infections and chromosomal abnormalities, and they can occur pre and post conception. However, in 75% of people with ID/DD, the cause is unknown. Today, in order to try to address treatable genetic issues that could lead to ID/DD, every newborn is required to undergo genetic testing.




*Comorbidity & Age.*
*Source: Journal of Substance Abuse Treatment.*

In persons with ID/DD, the prevalence of behavioral health disorders is much higher than the rest of the population, and many of these patients fall through the cracks in terms of receiving proper treatment and access to care. Despite the high prevalence of behavioral disorders, there are still issues in diagnosing and treating the comorbidity, as those with ID/DD may suffer from deficient or a complete lack of communication skills, resulting in cognitive overshadowing and intellectual distortion. Additionally, it can be difficult to determine if a certain behavior should be attributed to an ID/DD or to a behavioral health issue.

Those with intellectual disabilities are often prescribed psychotropic drugs that control behavior, but some patients are unable to take this medication due to a psychiatric illness. The Division of Developmental Disabilities has been tracking those medications so that the issue of polypharmacy (issuing 4 or more prescription medications per patient) can be tracked and studied, to ensure that drug symptoms don't negatively affect cognitive ability.

In the spring of 2016, Delaware plans to launch the Assertive Community Integration and Support Team (ACIST), which would feature a low staff to client ratio, case management to assist clients in accessing elements of the program, a crisis intervention component, and a behavioral analysis for ID/DD patients. The client base will come from those receiving DDDS services who have received 3 or more psychiatric hospitalizations within the last 12 months. The program will serve approximately 50-100 clients initially, and the startup funding will be allocated from general funds, with hopes that a process for billing providers will be put in place in the future. The Task Force expressed strong support for the program, but cautioned that limiting participation based on hospitalizations, rather than emergency room visits, could bar some from receiving necessary treatment.

# Gaps

### LIMITED ACCESS TO INPATIENT/LONG-TERM CARE

Access to various types of care and treatment were limited for a number of reasons, including availability of facilities, poor reimbursement rates between insurers and providers, and long waits for appointments with medical professionals most capable of addressing comorbidity. For adults, the most obvious gap was a lack of reimbursement from insurers for community based care on an integrated model. Families who have faced obstacles and barriers in getting help for individuals with behavioral health and substance use disorders have asked for greater coordination with community and faith based organizations that provide supplemental services and access to care. These organizations and state agencies can mutually benefit from a more formalized partnership in combatting comorbidity.

**Recommendations:**

- The Task Force may consider increasing day hospital services for comorbidity treatment.
- Determine methods to ensure that patients continue taking necessary medications for all associated disorders.
- Work with reimbursement rates for ongoing treatment after leaving the prison system.
- Consider future inclusion of more ID/DD comorbid patients into the new ACIST program.
- The Task Force recommends that DHSS and DSAMH create an office to coordinate community and grassroots initiatives that provide safety nets and resources for families and individuals with behavioral health and substance use needs.

# Gaps

### MATERNAL DEPRESSION

Mental and behavioral health issues are prevalent in women during childbearing years. However, providing these women with treatment and screening to avoid a public health issue is not a high enough priority in Delaware. After delivering a child, the occurrence of postpartum depression or feelings of depression, anger, anxiety, and guilt are far too common. This presents problems not only for the mother, but also for the child, because the mental health of a mother affects the child's physical and emotional development.

The development of statewide strategies and distribution of materials and information are crucial to help combat the lack of awareness and education regarding maternal depression. Legislation should be created to encourage the education regarding the signs and symptoms of maternal depression. Additionally, screening tools and community resources should be made available to the mother via her health care provider. However, health care providers should implement better screening practices for childbearing mothers to detect maternal depression early on.

**Recommendations:**

- Improve education about the signs and symptoms regarding maternal depression and screening practices.
- Encourage the communication between health care providers and mothers experiencing maternal depression.
- Improve screening of post-partum females on OBGYN inpatient wards for depression.

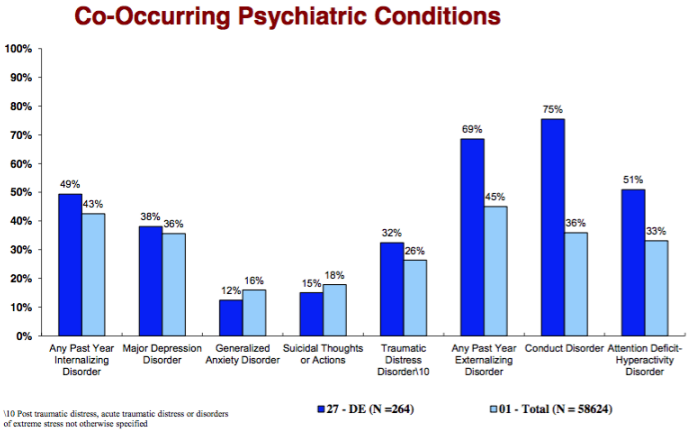
# Youth and Adolescent Comorbidity

### SUBSTANCE USE DISORDER AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY

The current estimate of adolescents in treatment, at all levels, for comorbidity is about 70 %, which is significantly higher than adults. The Task Force noted that many children who are treated for comorbidity often come to the Department of Children Youth and their Families Services (DSCYF) through the juvenile justice system.

In children, comorbidity risk factors are divided into four separate groups: fear, distress, behavior, and substance abuse. When comorbidity happens within a single risk factor, it is easier to treat. But, when it happens across multiple categories, it is difficult to develop a system of care to address disorders across the broader spectrum.

Adolescents treated by DSCYF for comorbidity are categorically different from the adults treated by DSAMH for the same affliction. Adolescents deal with more behaviorally disruptive issues, while adults deal with more emotionally internalizing issues. Treatments developed for children on a programmatic level are very different from those developed for adults, as a key focus is on prevention and early intervention. However, the Task Force learned that most model treatments are first developed for adults, then tweaked and modified for children.




*Department of Services for Children, Youth and their Families (DSCYF); Division of Prevention and Behavioral Health Services (DPBHS); Office of Evidence-based Practices (OEP).*

The DSCYF Division of Prevention and Behavioral Health Services has a program to standardize a substance abuse assessment across providers in order to identify children that have comorbidity. Most control studies are moving towards an integrated model of treatment, so that treatment for all disorders occurs concurrently. There is a consensus that integrated, community based interventions, with the support of day/residential treatment, have the best chance of being successful. While residential treatment is still utilized, the focus of treatment is on successful reintegration into a stable social environment. The Task Force noted that clinicians are finding difficulty in taking time away from billing services in order to become trained in new treatment methods.

Short term, residential treatment is still effective in terms of stabilizing individuals. However, for children, there are no licensed in-state substance abuse treatment centers; hospitalization, or out of state contactors that are used to address Delaware's needs. For those children who are not in the state system, and depending on insurance, there may not be any options for residential treatment.

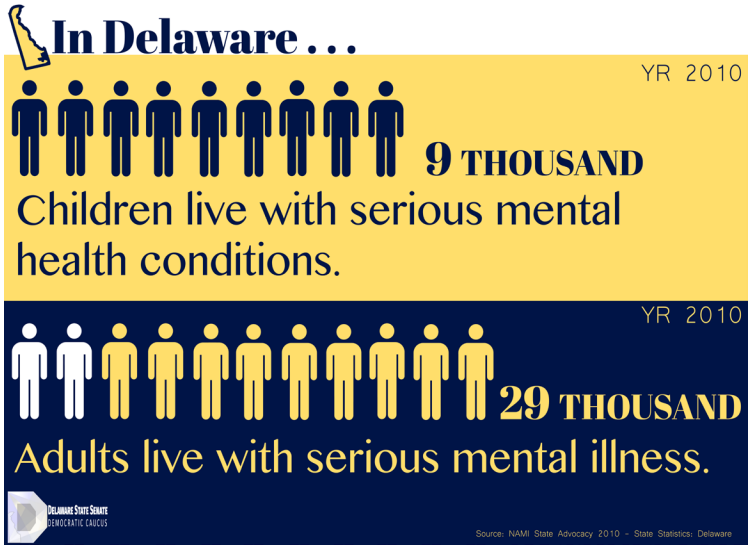
Nationwide, schools have become the main provider of behavioral health services for children, but Delaware doesn't utilize that model for treatment. The importance of addressing behavioral disorders in the class room extends past each individual child, as it provides a better learning environment for the whole class.

It was determined that one of the major issues surrounding children with ID/DD and a behavioral health disorder is that those children are not receiving treatment early enough. It was noted that, in order to better serve this population, entities needed to gather a list of who these children are, and how many there are, in order to start serving them at a younger age than the state does now. Those children who do not receive services early usually end up unemployed and in jail later in their lives.

# Gaps

## COMPREHENSIVE TREATMENT ACROSS DEPARTMENTS NEEDED

Currently, DSCYF and the Department of Education are the two agencies most central to the treatment of youth with comorbidity. The State is having difficulty locating residential treatments for teens who are suffering from heroin addiction and suicidal tendencies. With the onset of behavioral health disorders occurring at 11 years, or younger, the importance of increasing services provided in school, so that early intervention can occur, is critical. The Task force noted that there needs to be clarification as to what agency is responsible for behavioral health management of children, and at what level of care. Educators don't have the necessary training or resources to identify needs past what the student may demonstrate in an IEP, and there aren't enough behavioral health professionals in schools now who can identify comorbidity and take steps to address it.




**Recommendations:**

- The State should create an in state residential treatment facility for adolescents with a substance use disorder.
- The Task Force may consider efforts to better quantify and examine the role of charitable care in this state.
- Improve reimbursement rates for children's behavioral health services.
- Review behavioral health efforts currently provided in the school setting to determine feasibility of expansion.
- The Task Force recommends an intensive outpatient/partial hospitalization program for children for a minimum of 14 days.

# Appendix A

## Final Recommendations from the Behavioral and Mental Health Task Force

*Below is an outline of recommendations mentioned by the Co-Chairs, Task Force members, and other stakeholders from the public.*

## Behavioral Health Commission

### Creation of a Behavioral Health Commission

**Recommendation:** The formation of the Behavioral Health Commission is recommended. Senators Blevins and Hall-Long, in conjunction with Representative Debra Heffernan will introduce legislation that would create a permanent Commission that will continue many of the works of the Task Force, but with numerous stakeholders will develop a strategic roadmap that will ensure quality delivery of patient public/private care, access to necessary treatment and overall strengths and weaknesses of the system. The Commission will also encompass an oversight and monitoring role of the state's behavioral health system. The Behavioral Health Commission will make recommendations to not only the General Assembly, but different departments as needed and deemed fit.

## Corrections

### Recruitment and Retention

**Recommendation:** Incorporate telehealth throughout the state to ensure that individuals who are seeking treatment are able to find care.

**Recommendation:** Build the behavioral health workforce in Delaware and implement programs to educate existing providers with a strong background and capacity of behavioral health treatment.

**Recommendation:** Expedite the licensing processes for hard to fill positions, such as physicians, for correctional facilities.

### Handoff Process

**Recommendation:** The state should develop a transitional program and intense community based services for children.

**Recommendation:** Incorporate the aforementioned "Behavioral Health Commission's" oversight and monitoring role with monitoring the state's telehealth efforts.

**Recommendation:** Implement inpatient substance abuse treatment for Delaware's youth.

### School District Policies

**Recommendation:** Require school districts to implement uniform standards statewide for calculating time spent in detention facilities towards expulsion.

### Termination State v. Suspension State

**Recommendation:** Change Delaware from a Medicaid termination state to a suspension state for adults and children.

### Lack of Resources

**Recommendation:** The state should work towards increasing access to DDOC's special needs units for those offenders needing that level of specialized care and review existing programs. There are a high number of inmates in Delaware's correctional facilities who are in need of more levels of behavioral health care than are available currently.

**Recommendation:** The state should set programs and initiatives to treat psychiatric disorders in the community before an individual commits a crime and receives treatment through incarceration. Contributing to the lack of

space in Delaware's correctional facilities are the high numbers of incarceration and individuals who recidivate. To alleviate the pressure of limited resources in the state's correctional facilities, incarceration and recidivism rates must decrease. Minimizing incarceration and recidivism rates can be accomplished through early intervention in the community.

**Recommendation:** With the high rates of behavioral health treatment needs in the state's correctional facilities, the state should work on providing correctional facilities with more resources to treat their inmates.

**Recommendation:** Delaware should focus on a more seamless transition for offenders coming out of the prison system to avoid recidivism.

**Recommendation:** Reimbursement rates for behavioral health care services needs to be raised so that all released offenders can continue to find quality care in their community to help individuals rehabilitate and ultimately avoid recidivism.

### Eligibility and Enrollment Unit

**Recommendation:** The state needs to speed up the EEU process; the wait time that it takes to get someone from an institution into services is too long.

## Suicide & Stigma

### Education

**Recommendation:** Utilize existing training programs, led by mental health professionals that will provide education for psychiatric disorders to any individual who works with children like school teachers, nurses, camp counselors, and primary care physicians.

**Recommendation:** Utilize the aforementioned "Behavioral Health Commission" to provide monitoring of the state's existing educational and training programs to ensure that they stay effective.

**Recommendation:** Encourage a process for schools and communities to provide education to legal guardians about suicide.

**Recommendation:** Develop a unified approach and message between agencies to provide the state with increased anti-stigma education through a website and social media techniques. Incorporate the pre-existing "Help is Here" website to include a section focusing on anti-stigma education, education on suicidal children, and information educating parents and legal guardians on how to care for youth who have a substance abuse disorder.

### Data and Research

**Recommendation:** The Division of Public Health should implement a day-to-day surveillance process of suicidal behavior for real-time data. The data should be collected from emergency department admissions and hospital admissions. The state should also incorporate a suicide risk database to keep track of at-risk youth.

### Treatment

**Recommendation:** Since the only treatment for youth with substance abuse disorder is out of state, develop a residential treatment center to treat children with substance abuse disorder.

**Recommendation:** Develop a 30-day inpatient treatment facility for adults.

**Recommendation:** Review current intensive outpatient or partial hospital treatment that our youth receive and determine if it meets their needs. Recommend the aforementioned "Behavioral Health Commission" to work with insurance companies to provide longer care for those who need it. This will minimize readmission into the program weeks later and ultimately save money for the insurance companies.

**Recommendation:** Institute Emergency Department and hospital follow up after discharge of individuals who were treated for suicide attempts.

**Handoff Process**

**Recommendation:** The state should look at centralizing data to improve its hand off process so all involved parties are aware of the child's well-being and mental state.

**Recommendation:** Because of the gaps of communication between care providers, hospitals, schools, and parents, a child's quality of care is suffering and their treatment will be less effective. The state should work on improving the system of communication between providers, hospitals, parents, and schools.

**Suicide Prevention Coalition**

**Recommendation:** To ensure that the Delaware Suicide Prevention Coalition exists in years to come, the state should produce legislation to formally establish the Delaware Suicide Prevention Coalition as an entity supported by the Department of Health and Social Services and the Department of Services for Children, Youth, and Their Families.

## Workforce

**Recommendation:** The Task Force may consider efforts to better quantify and examine the role of charitable care in Delaware.

**Recommendation:** The Task Force may consider implementation of mandatory guidelines for healthcare facilities that intend to close wards or large-scale treatment centers.

**Recommendation:** The Behavioral Health Commission should partner with the Department of Health and Social Services and the Department of Insurance to look at the certification and licensure issues of individuals and programs who provide behavioral health services. This should include requirements for supervision of non-licensed or certified individuals and reimbursement practices for such services.

**Unforeseen Effects on Integrated Care**

**Recommendation:** The Task Force recommends further attention to developing information that will allow for timely and accurate oversight of the integrated care model.

**Recommendation:** Implement more day-hospital services.

**Affordable Care Note Available**

**Recommendation:** Increase private prescription drug coverage for a subset of indigent and underinsured Delawareans with severe and persistent mental illness.

**Recommendation:** Charge a future Mental Health Commission with reviewing admissions data from private hosptials and the state hospital, including the percentage of involuntary to voluntary admissions, length of stay, referral source, admission diagnosis, readmission rates, EEU processing time and other outcome data.

**Recommendation:** Make all efforts to streamline EEU processing, reduce turnaround time, and increase transparency of the process.

**Recommendation:** In the case of hospitalization, for a mental illness, there should be mandatory communication between the inpatient and outpatient provider or mental health care professional regarding the hospitalization event, both on admission and discharge.

**Recommendation:** Implement more day-hospital services.

**Recommendation:** Continue to strengthen and grow the availability of affordable outpatient care, and improve the hand off process to outpatient providers from inpatient treatment.

**Lack of Skilled Workforce & Training**

**Recommendation:** Focus on development and retention of board certified psychiatrists, advanced practice registered nurses, other licensed behavioral health professionals, and prescribers in Delaware.

**Recommendation:** Strengthen DPC's residency program, as it is integral to attracting talented mental health staff, education, and care for the indigent.

**Recommendation:** Improve licensing requirements through the Division of Professional Regulation.

### Workgroup

**Recommendation:** Form a workgroup to discuss the state's residency programs, internships, APN (Advanced Practice Nurses) program, social workers, behavioral health professionals, and psychologists in conjunction with DCHI's efforts.

## Co-occurring Disorders

### Limited access to inpatient/long-term care

**Recommendation:** The Task Force may consider increasing day hospital services for comorbidity treatment.

**Recommendation:** Determine methods to ensure that patients continue taking necessary medications for all associated disorders.

**Recommendation:** Work with reimbursement rates for ongoing treatment after leaving the prison system.

**Recommendation:** Consider future inclusion of more ID/DD comorbid patients into the new ACIST program.

**Recommendation:** The Task Force recommends that DHSS and DSAMH create an office to coordinate community and grassroots initiatives that provide safety nets and resources for families and individuals with behavioral health and substance use needs.

### Maternal Depression

**Recommendation:** Improve screening of post-partum females on OBGYN inpatient wards for depression.

**Recommendation:** Improve the education of the signs and symptoms regarding maternal depression and screening practices.

**Recommendation:** Encourage the communication between health care providers and mothers experiencing maternal depression.

### Comprehensive Treatment Across Departments Needed

**Recommendation:** The State should create an in state residential treatment facility for children and adolescents with a substance use disorder.

**Recommendation:** The Task Force may consider efforts to better quantify and examine the role of charitable care in this state.

**Recommendation:** Improve reimbursement rates for children's behavioral health services.

**Recommendation:** Review behavioral health efforts currently provided in the school setting to determine feasibility of expansion.

**Recommendation:** The Task Force recommends an intensive outpatient/partial hospitalization program for children for a minimum of 14 days.

## Additional Recommendations

**Recommendation:** Consider revising commitment law to allow for 72-hour observation for rapid stabilization which may reduce the need for inpatient beds.

# Appendix B

## Delaware Behavioral Health Continuum of Care Matrix

| Delaware Behavioral Health Services Continuum of Care Worksheet | | | | | |
|---|---|---|---|---|---|
| | **Inpatient** | **Partial Hospitalization/IOP** | **Outpatient** | **Case Management** | **Residential** |
| **Adult** | •State Hospital (DPC)<br>•Private IMD Hospitals<br>•Christiana Care Inpatient<br>Gaps/Considerations: Access for uninsured and underinsured, rapid placement for high risk patients, Subacute services, access to ECT and TMS | •Private IMD Hospitals<br>•IOP Co-occurring Clinics statewide<br>Gaps/Considerations: Limited partial options for uninsured and variable coverage by private payers. No state based programs, no DBT options | •Co-Occurring IOP, OP, OBOT, OTP Clinics<br>Gaps/Considerations: Consider state-run clinic w/ subsidized medications, workforce issues, limited access to providers and services, lower reimbursement | •ACT,ICM,CRISP,TCM<br>Gaps/Considerations: handoff communication from hospitals, eliminate barriers to receiving timely care, consider adding state run services | •Group Homes for MH<br>•SUD residential treatment<br>•Sober living residences for men and women<br>•Oxford Houses |
| **Young Adult** | •State Hospital (DPC) for 18+<br>•IMD's for under 18 and 18+<br>Gaps/Considerations: Communication with parents, schools, other providers. Improve access to DBT, ECT and TMS | •Private IMD Hospitals<br>•IOP Co-occurring Clinics statewide<br>Gaps/Considerations: programs, limited provider statewide, training/working with institutions of higher education | •Co-Occurring IOP, OP, OBOT, OTP Clinics statewide<br>Gaps/Considerations: Consider state-run clinic w/ subsidized medications, workforce issues, limited access to providers, lower reimbursement | •ACT,ICM,CRISP,TCM<br>Gaps/Considerations: handoff communication from hospitals, eliminate barriers to receiving timely care | •Residential opiate/SUD tr-eatment<br>•Sober living residences for men and women<br>•Oxford Houses |
| **Adolescent** | •State Crisis (Terry Center)<br>•Private IMD Hospitals<br>Gaps/Considerations: Consider suicide risk database, access to education while hospitalized | •Day treatment for MH and SA<br>•OP and IOP services for MH and SA statewide<br>Gaps/Considerations: DOE collaboration with DSCYF, limited dual diagnosis services | •OP and IOP services available for both MH and SA statewide<br>Gaps/Considerations: Lower reimbursement | •Wraparound<br>•ACT for CORE grant<br>•Clinical Services Mana-gement | •Residential Treatment for SUD and Mental Health<br>•Transition Bed Service<br>Gaps/Considerations: Insurance coverage, transportation |
| **Pregnant Women** | •No inpatient programs specifically for pregnant women<br>Gaps/Considerations: Consider screening for depression, suicidality | N/A | N/A<br>Gaps/Considerations: Limited intensive social services | N/A | •Sober living residences for women, but not for pregnant women specifically |
| **Corrections** | •State Hospital Forensic Unit-DPC<br>Gaps/Considerations: Medicaid pays for any hospital stay past 24 hours. 65+ not covered now per ACA. Delaware is a medicaid termination state for inmates. Working with special pops such elderly, dealing with court ordered patients in prison awaiting treatment | N/A | N/A | •Key Program<br>•Crest Program<br>•Reflections<br>•Transitions<br>•6 for 1 | •New Expectations- SUD residential facility |
| **Geriatric** | •Private IMD Hospitals in NCC<br>Gaps/Considerations: Limited acces to inpatient care, Limited dementia services & access to DBT, different sets of health challenges with population | N/A | N/A<br>Gaps/Considerations: Limited intensive social services | N/A | N/A |

## Acronym Key For Matrix

MH- Mental Health

SA- Substance Abuse

BH- Behavioral Health

SUD- Substance Use Disorder

ACA- Affordable Care Act

IMD-(Institute for Mental Disease)- These are privately run psychiatric hospital's

DPC-(Delaware Psychiatric Center)- The state's psychiatric hospital

IOP-(Intensive Outpatient)

OP- Outpatient

OBOT- Office based opioid treatment

OTP- Opioid Treatment Program

ACT- Assertive Community Treatment Team

ICM- Intensive Case Management

CRISP- Community Re-integration Support Program

TCM- Targeted Care Management

DBT- Dialectical Behavior Therapy

ECT- Electroconvulsive Therapy

TMS- Transcranial Magnetic Stimulation

# Appendix C

## Senate Concurrent Resolution 29

SPONSOR: Sen. Hall-Long & Sen. Blevins & Rep. Barbieri
Sen. Henry; Reps. Bolden, Briggs King, Heffernan,
Hensley, Jaques, Lynn

DELAWARE STATE SENATE
148th GENERAL ASSEMBLY

SENATE CONCURRENT RESOLUTION NO. 29

ESTABLISHING THE BEHAVIORAL AND MENTAL HEALTH TASK FORCE TO EXAMINE MENTAL HEALTH IN THE STATE OF DELAWARE AND MAKE RECOMMENDATIONS FOR THE IMPROVEMENT OF SERVICES AND THE MENTAL HEALTHCARE SYSTEM.

WHEREAS, recent healthcare system changes have resulted in shifts in mental healthcare access and insurance coverage for inpatient and outpatient care; and

WHEREAS, the prevalence of mental and behavioral health disorders is widespread across the United States; and

WHEREAS, 1 in 5 adults experiences a mental illness in any given year and 4% of those live with a serious mental illness; and

WHEREAS, approximately 13% of youth ages 8-15 and 20% of youth ages 13-18 experience severe mental disorders in a given year; and

WHEREAS, approximately 9.2 million adults have co-occurring mental health and addiction disorders in the U.S.; and

WHEREAS, 82% of inmates in Delaware have mental health conditions or related issues; and

WHEREAS, approximately 29% of the incarcerated population in Delaware is prescribed psychotropic medications; and

WHEREAS, in Delaware, approximately 29,000 out of nearly 730,000 adults who reside in Delaware live with a serious mental illness; and

WHEREAS, approximately 9,000 children who reside in Delaware live with serious mental health conditions; and

WHEREAS, identified gaps in mental healthcare services affect long term care for patients; and

WHEREAS, the demand for the mental healthcare workforce has increased; and

WHEREAS, the stigma surrounding mental and behavioral health can impede access to health care services for patients;

NOW, THEREFORE:

BE IT RESOLVED by the Senate of the 148th General Assembly of the State of Delaware, the House of Representatives concurring therein, that the Behavioral and Mental Health Task Force ("Task Force") is hereby established



LC : HVW : RAY
5081480054

Jun 23, 2015

to examine mental health in the State of Delaware and make recommendations for the improvement of services and the mental healthcare system.

BE IT FURTHER RESOLVED that the Task Force shall be comprised of the following members or a designee appointed by the member serving by virtue of position:

(1) The Secretary of the Department of Health and Social Services.

(2) The Secretary of the Department of Services for Children, Youth and Their Families.

(3) The Commissioner of the Department of Corrections.

(4) The Commissioner of the Department of Insurance.

(5) A representative of the Delaware Healthcare Association appointed by the President and Chief Executive Officer.

(6) A representative of the Delaware Mental Health Association appointed by the Executive Director.

(7) A representative of the Delaware National Alliance on Mental Illness appointed by the Executive Director.

(8) A representative of the Delaware Division of Substance Abuse and Mental Health appointed by the Division Director.

(9) One joint appointment of both the Senate Health and Social Services Committee and House Health and Human Development Committee Chairpersons.

(10) A member of the Delaware State Senate, to be appointed by the President Pro Tempore.

(11) A member of the Delaware House of Representatives, to be appointed by the Speaker.

(12) A member of the public appointed by the Governor.

BE IT FURTHER RESOLVED that the Speaker of the House of Representatives shall appoint a co-chair and the President Pro Tempore of the Senate shall appoint a co-chair.

BE IT FURTHER RESOLVED that the Task Force shall convene in August 2015 and conclude its investigation by December 1, 2015.

BE IT FURTHER RESOLVED that the co-chairs shall set the date, time, and place for the initial meeting.

BE IT FURTHER RESOLVED that the staff of the chairs and a member from the Division of Substance Abuse and Mental Health shall assist the Task Force.

BE IT FURTHER RESOLVED that the Task Force shall submit a report of its findings and recommendations to the Speaker of the House of Representatives and the President Pro Tempore of the Senate no later than January 30, 2016, with copies submitted to the Governor, Director of the Division of Research of Legislative Council, Delaware Public

Archives, Department of Health and Social Services, Department of Corrections, and Department of Services for Children, Youth and Their Families.

SYNOPSIS

This concurrent resolution establishes the Behavioral and Mental Health Task Force to examine mental health in the State of Delaware and make recommendations for the improvement of services and the mental healthcare system.

Author: Senator Hall-Long



LC : HVW : RAY
5081480054

Jun 23, 2015

# Appendix D

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# Appendix E

**Meeting Minutes, October 1, 2015**

Behavioral and Mental Health Task Force Meeting
Thursday, October 1st, 2015
2:00 PM – 4:00 PM
Buena Vista Conference Center
Buck Library

**Meeting Attendance**

Task Force Members

| **Present** | **Email** |
|---|---|
| Co-Chair Senator Patricia Blevins | Patricia.Blevins@state.de.us |
| Co-Chair Senator Bethany Hall-Long | Bethany.Hall-Long@state.de.us |
| Representative Debra Heffernan | Debra.Heffernan@state.de.us |
| Brenna Welker | Brg002@gmail.com |
| Susan Cycyk | Susan.Cycyk@state.de.us |
| Dr. Marc Richman | Marc.Richman@state.de.us |
| Susan Jennette | Susan Jennette@state.de.us |
| Erin Booker, LPC | Erin.Booker@christianacare.org |
| Joshua Thomas | JThomas@namide.org |
| Dr. Michael Barbieri | Michael.Barbieri@state.de.us |
| Jim Lafferty | JLafferty@mhainde.org |

| **Absent** | |
|---|---|
| Secretary Rita Landgraf | Rita.Landgraf@state.de.us |

Task Force Staff

| **Present** | **Email** |
|---|---|
| Caitlyn Gordon | Caitlyn.Gordon@state.de.us |
| Tanner Polce | Tanner.Polce@state.de.us |
| Bryan Gordon | Bryan.Gordon@state.de.us |
| Thomas Johnson | Tom.Johnson@state.de.us |

| **Absent** | |
|---|---|
| Carling Ryan | Carling.Ryan@state.de.us |

Public Attendees

| **Name** | **Affiliation** |
|---|---|
| Jesse Chadderdon | Delaware State Senate |
| John McKenna | Rockford Center |
| Charles Constant | Dover Behavioral Health |
| Neil Kaye | PSD/MSD/NAMI |
| Steve Yeatman | DSCYF |
| Jamie Nutter | Parkowski, Guerke, & Swayze |
| Traci Bolander | MABH |

*Appendix E Continued:*

| | |
|---|---|
| Bill Mason | MeadowWood BHS |
| Wayne Smith | DHA |
| Emma Radulski | UD Student |
| Mandell Much, PhD. | Aquila Behavioral Health/ARGO |
| Pam Price | Highmark |
| Kim Gomes | Byrd Group |
| Christine Schiltz | Parkowski, Guerke, & Swayze |
| Thomas Cook | DelARF |
| Dr. Adam Glushakow | |
| Ken Christie | |

The meeting was called to order at 2:12 pm

**Welcome and Introductions**

Senator Blevins and Senator Hall-Long welcomed everyone to the first Behavioral and Mental Health Task Force meeting and thanked them for coming. Senator Hall-Long informed members that Secretary Landgraf sent her regrets that she could not make the meeting. Senator Hall-Long emphasized the importance of meeting preparation for efficient and effective Task Force meetings.

Senator Blevins initiated introductions for the Task Force members. In addition to introducing themselves, Task Force members were asked to touch on behavioral and mental health topics they would like to see covered. Furthermore, Senator Hall-Long asked members with a clinical background to please clarify that during their introductions.

Topics that members included in their introductions:

- Adolescent mental health needs/developmental disabilities
- Services for pregnant woman
- Follow-up on suicidal attempts
- Correctional facilities
- Adult mental health needs
- Treatment through the whole state - gaps in service
- Stigma of mental health disorders
- Co-occurring disorders
- Private market insurance
- Payment for services
- In-patient and out-patient treatment

Senator Blevins emphasized the importance of taking a look at mental health in the prison system. She noted that many individuals are facing mental illness prior to incarceration and their lack of treatment is what leads them there. The Senator also stated that if the Task Force finds a way to treat these individuals prior to incarceration, the population of incarcerated people will hopefully decrease.

Senator Hall-Long noted that this Task Force is not the first of its kind. The Senator referenced House Resolution 93 which looked at this topic. She also emphasized the importance of picking tangible issues.

When introductions were completed, Senator Hall-Long moved the meeting to the second topic on the agenda.

*Appendix E Continued:*

**Determine behavioral and mental health subcategories for in depth discussion**

Senator Blevins opened this portion of the agenda by asking the Task Force to narrow down topics to discuss during the following meetings. Furthermore, she asked members to think about how we would like to discuss their chosen topics in terms of experts, research, etc.

Senator Hall-Long asked the Task Force whether their discussions should follow the categorical topics, or if the Task Force should break them into specific populations such as, age, corrections, etc.

Jim Lafferty suggested that the Task Force should look at each topic by age, from youth to geriatric care. However, Brenna Welker responded that breaking each category into age could cause some confusion. She mentioned that some kids are going home to mental illness so the Task Force should look at ages together.

Dr. Marc Richman suggested to structure conversation by looking at the levels of care, and analyzing it back into the population. He presented an example: the Task Force would look at what is available for intensive out-patient care, and then look at whether this care is for children, adults, etc. Dr. Richman suggested this tactic as opposed to looking at each age in silos. The Task Force collectively agreed on his approach.

Senator Blevins reminded the Task Force of two agreed upon topics:

1. Suicide follow-up
2. What is available for each level of service

Senator Blevins also touched upon the plan of having 6 total meetings and talking about 2 topics each meeting.

Dr. Michael Barbieri mentioned that the Task Force also needs to talk about work force issues. He stated that Delaware does not have adequate providers to respond to the level of need. Susan Jennette added that parents are taking their children out of the state because there are not beds for inpatient care available.

Senator Hall-Long followed by stating the importance of the Task Force clarifying not only what type of care is available, but if people are able to access in-patient and out-patient care. For instance, the state hospital does not take admissions after 3:00 p.m. or on weekends and they only take a specific category of people, which precludes some individuals from getting treatment. Dr. Barbieri responded that the Task Force should have a template of all the services that are available and how they are accessed, so the Task Force can see where there are gaps.

Senator Hall-Long mentioned House Resolution 93, which includes some recommendations worth considering. She noted that we will make a copy of HR 93 to have as a reference.

Susan Cycyk mentioned that the Task Force should look into what the private insurance plans actually provide. Ms. Jennette added that the ACA (Affordable Care Act) states mental health and behavioral health services are under the 10 essential health benefits that need to be covered.

Mr. Lafferty responded that medical necessity is usually the valve that shuts off services. Ms. Jennette agreed and mentioned that many medical necessity cases are based off a book's analysis and not the actual person. Additionally, the standard of services that a patient receives is based off of trial and error. If a patient fails one type of service, then they progress on to receiving a different type of service until they find the right fit. Ms. Jennette stated that she would like to see this changed, instead of basing medical necessity off of a book, it should be determined by looking at the person. She added that we should look at legislation from other states to determine the best legislation for Delaware.

Senator Hall-Long opened the floor to public comment during this conversation.

Dr. Glushakow, member of the public, stated that the Task Force should consider what the minimum requirements are that someone should have from their insurance. He added that the Task Force needs to confirm that the neediest individuals, who cannot speak for themselves, are getting the care they deserve. Dr. Glushakow referenced recent changes which are making it almost impossible to afford the most commonly used medications.

Traci Bolander, member of the public, mentioned some topics discussed during the Task Force meeting already has data and are in the works. She stated that we need to refer to work that has already been done and coordinate with that, instead of repeating it.

Senator Blevins listed the topics of interest stated during this discussion:

1. Work force
2. Lack of providers
3. Residency program possibilities
4. Suicide follow-up
5. Levels of service and creating a matrix
6. Access to care
7. Dual-diagnosis
8. Stigma

Jim Lafferty emphasized new findings on the importance of telehealth and telepsychiatry. Some advantages of telepsychiatry noted by the Task Force are:

- Clients who do not have access to transportation still receive care.
- Depressed clients who mentally cannot leave their home still receive care.

Dr. Glushakow emphasized the drawbacks to telehealth and telepsychiatry:

- This type of care cannot be used for everyone and each method of care needs to be addressed on a patient by patient basis
- EX: A patient with schizophrenia would not do well with telepsychiatry.

Senator Blevins asked for additional comments on subjects the Task Force should identify. She added that corrections should be discussed, if there were no objections. There were none. Jim Lafferty added that we need to expand corrections to the justice system.

John McKenna, member of the public, wanted to prompt the Task Force to look at quadruple-diagnosis. Mr. McKenna noted that individuals with quadruple-diagnosis do not necessarily have a place to go.

Neil Kaye, member of the public, emphasized access to the correct care, not just care in general.

Senator Hall-Long reminded the Task Force that at the end of their meetings, the Task Force can recommend an ongoing council or work group that would address specific issues.

Ms. Jennette reminded the Task Force to keep HIPAA (Health Insurance Portability and Accountability Act) in mind when discussing each topic. Dr. Richman added that the Task Force should have a CFR 42 expert come in to clarify what doctors can and cannot share.

Senator Hall-Long closed the discussion by asking for additional comments by Task Force members. There were none, so she changed the topic of discussion to the third item on the agenda.

**Discussion of Public Hearing Date**

Senator Blevins opened this item of discussion by noting the next meeting might be a good time to hold a public

hearing. The Senator then asked for any thoughts or input on this idea.

Jim Lafferty responded that the Task Force should nail down the matrix before a public hearing.

Senator Hall-Long asked if the public hearing during third or fourth meeting was more favorable to the Task Force. The Task Force members agreed. Additionally, Ms. Welker added that we should call it a "Town Hall."

Senator Hall-Long added that the Task Force should set up tours to see what type of care is available at different facilities.

Senator Hall-Long closed discussion on the public hearing date and moved the meeting to the fourth item on the agenda.

Planning and Scheduling of Future Meetings
Senator Blevins opened scheduling of future meetings with a tentative date and location, October 19th at Buena Vista.

The Task Force discussed further meeting dates and agreed on October 27th, at Buena Vista at 2:00pm.

**Public Comment**
Senator Hall-Long moved the discussion to public comment and asked if there were any members of the public who would like to speak.

Thomas Cook suggested that the Task Force looks at the shift that occurred between state funded services that DSAMH (Department of Substance Abuse and Mental Health) has provided in the past under cost reimbursement models to systems of managed care for certain services and the outcomes from these changes.

Mr. Cook also referenced a personal matter and related it to HIPAA. He noted that because of perceived HIPAA barriers, his family was not aware of important medical information about another family member. Mr. Cook noted that HIPAA clarification is important.

Charles Constant referenced gaps in services and stated there also needs to be a focus on awareness of services in place right now.

Bill Mason offered a tour of MeadowWood Behavioral Health Hospital, if anybody was interested. He also referenced the transportation issues that occur when they need to get patients from Sussex County to New Castle County. Mr. Mason mentioned that the state needs to find a way to fix these transportation issues.

Ken Christie emphasized the importance of not putting the public in a box during the Public Hearing with outlined topics.

Senator Hall-Long and Senator Blevins ended public comment and thanked everyone for coming out to the meeting.

There was no further business of the Task Force so the meeting was adjourned at at 3:47pm.

# Appendix F

**Meeting Minutes, October 27, 2015**

Behavioral and Mental Health Task Force Meeting
Thursday, October 27th, 2015
2:00 PM – 4:00 PM
Buena Vista Conference Center
DuPont Room

**Meeting Attendance**

Task Force Members

| **Present** | **Email** |
|---|---|
| Co-Chair Senator Patricia Blevins | Patricia.Blevins@state.de.us |
| Co-Chair Senator Bethany Hall-Long | Bethany.Hall-Long@state.de.us |
| Representative Debra Heffernan | Debra.Heffernan@state.de.us |
| Brenna Welker | Brg002@gmail.com |
| Susan Cycyk | Susan.Cycyk@state.de.us |
| Dr. Marc Richman | Marc.Richman@state.de.us |
| Susan Jennette | Susan Jennette@state.de.us |
| Erin Booker, LPC | Erin.Booker@christianacare.org |
| Joshua Thomas | JThomas@namide.org |
| Dr. Michael Barbieri | Michael.Barbieri@state.de.us |
| Jim Lafferty | JLafferty@mhainde.org |
| **Absent** | |
| Secretary Rita Landgraf | Rita.Landgraf@state.de.us |

Task Force Staff

| **Present** | **Email** |
|---|---|
| Caitlyn Gordon | Caitlyn.Gordon@state.de.us |
| Carling Ryan | Carling.Ryan@state.de.us |
| Tanner Polce | Tanner.Polce@state.de.us |
| Bryan Gordon | Bryan.Gordon@state.de.us |
| Thomas Johnson | Tom.Johnson@state.de.us |

Public Attendees

| **Name** | **Affiliation** |
|---|---|
| Neil Kaye | PSD/MSD/NAMI |
| Jamie Nutter | Parkowski, Guerke, & Swayze |
| Traci Bolander | MABH |
| Pam Price | Highmark |
| Dr. Adam Glushakow | |
| Gabrielle Koury | School Psychologist – Red Clay |
| Dale McKenzie | School Counselor – Red Clay |
| Richard Margolis | Prevention & Behavioral Health |

| | |
|---|---|
| Irene Waldron | DE Healthcare Facilities Association |
| Deb Hamilton | Cozen O'Connor |
| Drew Wilson | Medical Society of Delaware |

The meeting was called to order at 2:08 pm.

Senator Hall-Long opened the Task Force meeting by welcoming everyone back. Following her welcoming comments, the Senator asked Task Force members and members of the public to go around and introduce themselves.

**Consideration of Meeting Minutes**
Senator Blevins asked members to consider the meeting minutes and asked Task Force members if they had any objections to the minutes. Task Force members did not have changes or objections to the meeting minutes so the minutes were approved. Senator Hall-Long moved the discussion to the matrix.

**Discuss the Matrix of Behavioral Health Services**
Senator Hall-Long introduced Dr. Glushakow who gave a presentation to Task Force members.

*During the presentation, the following topics were discussed:*

Susan Cycyk noted that the Terry Children's Psychiatric Center has a child psych fellowship. Additionally, these fellows rotate through Jefferson and Rockford during six-month blocks. She added that most of the fellows do not stay in Delaware at the completion of their fellowship. Senator Hall-Long replied that Delaware needs the fellows to stay when their fellowship is over.

Susan Jennette asked where people with traumatic brain injuries would fall on the continuum of care. Dr. Glushakow replied that these people would need specialized services; they would probably fall under the outpatient service line.

Susan Cycyk referenced one of Dr. Glushakow's comments that access to hospital inpatient care is difficult. She added that a new hospital has just been approved and will be built within a year in Sussex County. She continued by asking if Dr. Glushakow knows who exactly is having trouble getting inpatient care because they are not having trouble getting an inpatient bed for children. Susan Cycyk responded that they are having the most trouble finding beds and facilities to take teens that have a heroin addiction and suicidal thoughts.

Dr. Marc Richman added that the problem does not lie with stabilization. Problems arise when they are trying to provide ongoing treatment to individuals who need more than outpatient treatment, because insurance will not pay for it. Dr. Richman also stated that there is a difference between crisis stabilization and ongoing long-term treatment.

Senator Blevins asked Dr. Richman to inform members who exactly is having trouble getting access to ongoing treatment. Dr. Richman responded that both Medicaid recipients and the privately insured are having trouble finding long-term residential treatment.

Susan Cycyk added that the Kids Department has residential treatment for mental health services, with a provider in Dover and one in Seaford. Ms. Cycyk clarified that these are not substance abuse residential services. There are no substance abuse residential services for youth in the state of Delaware. She added that the private insurers do not cover these services and this is a big problem.

*Appendix F Continued:*
Senator Blevins asked Dr. Michael Barbieri how many beds the State hospital has. Dr. Barbieri answered that they have 120 beds. Dr. Barbieri added that the State is trying to put some of these individuals out into the community with an ACT (Assertive Community Treatment) team to provide them with necessary daily services, this way the State is not keeping these people in institutions. He added that some people are transitioning out of the institutions and will not receive a follow-up for at least 3 weeks, and these timelines need to be changed. He continued by saying that the State is trying to implement more day hospital services.

Senator Blevins asked Dr. Barbieri to clarify the protocol for admissions. Dr. Barbieri replied that the state hospital takes admissions 24/7, but transfers should be scheduled. Dr. Marc Richman added that there are no regulations for admission into the state hospital.

Jim Lafferty added that if something happens to a person who already has a psychiatrist and that person is admitted into a hospital, their own psychiatrist will not know that this person has been hospitalized and that their medications have changed. Mr. Lafferty added that the State needs to improve their handoff process.

Dr. Richman noted that a scheduled discharge is the most efficient route of action to ensure a follow-up appointment. However, sometimes the hospital is notified that they must discharge a patient in 20 minutes. Erin Booker agreed and added that in some instances, Christiana will not discharge a patient and continue to provide services unfunded.

Senator Hall-Long moved the meeting along to the presentation and discussion of the Matrix of Behavioral Health Services. Bryan Gordon presented the matrix to Task Force members.

Susan Cycyk clarified that there are detox and opioid treatment services for adolescents but they are paid for by the Medicaid office. Ms. Cycyk added that although PBH (Prevention and Behavioral Health) does not have instate residential treatment for substance abuse, the State's inpatient hospitals help by detoxing adolescents and will keep them stabilized until PBH can get them into a long-term residential provider out of state.

Senator Hall-Long clarified that the services listed on the matrix are only for uninsured individuals and Medicaid recipients.

Senator Blevins asked if there are behavioral health programs for the adjudicated adolescent population. Susan Cycyk confirmed that there are programs in line for this population. Dr. Marc Richman added that there are psychologists and psychiatrists working in the State's juvenile justice facilities.

Dr. Barbieri emphasized the importance of ensuring that the quality of service is evaluated.
Susan Cycyk added that there are not enough prescribers in the State. She continued by saying that the State should work on bringing in more physicians, advanced practice nurses, and telemedicine. Susan Jennette followed these comments by stating that the Task Force should focus on the handing off process as well. Senator Blevins added that if the handoff is done efficiently, some patients will not have to be readmitted, which would be a cost saver.

Gabby Koury, member of the public and school psychologist, stated that the transition from long-term residential care to care in the school system is important. She added that in many cases, students are going into long-term residential care and out of schools consecutively, which is impacting their level of education. Ms. Koury added that schools need more psychologists and counselors. Her national organization recommends one psychologist for every 500-700 kids. If there are too many kids per every one psychologist, the psychologist cannot provide as many mental health services.

Jim Lafferty responded to Ms. Koury's comments by adding that some students will spend the weekend in the hospital and come back to school on a Monday, but the school was not aware that the student had been hospitalized. Mr. Lafferty added that if schools were aware of these occurrences, psychologists could put a little more attention on the child and communicate with their parents. Ms. Koury agreed, and added that some students cannot handle transitioning from being in a hospital all weekend to going back into a full school schedule on Monday. If school psychologists were made aware of this, they could modify this student's schedule.

Dale McKenzie, member of the public and school counselor, asked if any Task Force member could answer why Rosenblum was able to provide a longer transition program, while MeadowWood Behavioral Health and Rockford are not able to.

Erin Booker answered Ms. McKenzie's question by stating that Rosenblum was keeping kids longer for the transition process without funding. Ms. Booker added that this is why there is a difference.

Representative Heffernan added that Rosenblum provided educational services. Ms. McKenzie continued by saying that education, transportation, and the incorporation of families were added perks of Rosenblum. She added that other treatment facilities provide education options which are crucial.

**Discuss Topics and Speakers for Next Meeting**
Senator Blevins moved the discussion to the next portion of the agenda and started to review the topics up for discussion during the Task Force's future meetings. The Senator stated that she wants Task Force members to discuss the order of these topics and possible experts for each topic of discussion.

Jim Lafferty pointed out the "co-occurring disorders" topic on the agenda and added that this should include those with developmental disabilities who need mental health care. Additionally, it should include those who are elderly and have a medical problem but also have a psychiatric problem, or dementia. Mr. Lafferty added that if the Task Force includes those people into the discussion, the conversation will have more depth. Senator Blevins responded that those topics will be added to co-occurring disorders.

Susan Jennette cleared up questions about the HIPAA (Health Insurance Portability and Accountability Act) age of consent that Task Force members asked about at the last meeting. Ms. Jennette stated that in the Delaware Code, under Title 13, it states that consent to receive healthcare for minors is 18 years of age. Under Title 16, the code states that informed consent is 12 years of age. She added that Delaware's code is conflicting.

Jim Lafferty added that there is a workforce subcommittee done by Delaware Center for Health Innovation (DCHI). Traci Bolander responded by saying that the psychiatric residency issue has been addressed by DCHI as well, in collaboration with the Healthcare Commission. Jim Lafferty added that Jerry Gallucci, the Medical Director of DHSS, has done a lot of work on this and would be helpful.

Senator Blevins asked Task Force members if Delaware has residency programs for those who are studying for their PHD in psychology. Dr. Marc Richman added that the Kids Department has an APA (American Psychological Association) internship. Susan Cycyk continued by saying that the Kids Department has 3 APA interns at any given time. However, these interns are in Delaware for a year and since there are not enough psychologist jobs in Delaware, they leave the State. She added that they would provide more internships but the Department does not have the money to do that.

Traci Bolander added that she takes doctoral interns who are APA approved, however it is very cost prohibitive. She continued saying there are legislative matters to be addressed as it relates to post graduate studies in Delaware that are not barriers in other states. Senator Hall-Long asked Ms. Bolander to share these legislative matters with her at some point.

*Appendix F Continued:*
Neil Kaye, member of the public, added that UD has a counseling PhD program that takes interns.

Senator Blevins asked Task Force members to brainstorm experts to speak about the "correctional issues" topic. Dr. Marc Richman responded by saying he would be happy to speak on this topic and will bring in other experts to add to his presentation. Senator Blevins asked Susan Cycyk if someone from the Kids Department would be willing to talk about correctional issues, as well.

Dr. Joshua Thomas asked if the Task Force can include another topic to the correctional portion, he added that the Task Force should discuss diversion efforts so individuals do not end up in the correctional system to begin with.

Jim Lafferty added that MHA (Mental Health Association in Delaware) would be willing to organize speakers to come talk about suicide and suicide prevention. Senator Blevins also asked Susan Cycyk if the Kids Department has done some work with suicide.

Senator Hall-Long asked Task Force members their thoughts on incorporating "stigma" throughout the discussion of the other topics. Dr. Joshua Thomas agreed that this would be a good idea; this way the Task Force could discuss how stigma impacts each area of discussion.

Senator Blevins asked Task Force members who should speak about co-occurring disorders, Dr. Mike Barbieri mentioned that DSAMH can find some experts to talk about this. Susan Cycyk also offered to bring people to talk from the Kids Department.

**Discuss Public Meeting Dates and Public Hearing**
Senator Blevins asked if two meetings in November and two in December would work for the majority of Task Force members, most members agreed that this schedule was best.

**Public Comment**
Neil Kaye brought up the unintended consequences of the Attorney General's interpretation of the Bradley Bill and mandatory reporting. He added that this case negatively impacted people's willingness to get treatment. He added that young adults will come in for treatment, but if they mention sexual abuse, there is mandatory reporting that provokes these individuals to leave the office. This interpretation is acting as a barrier to treatment, even though it was not the intent of the interpretation. Dr. Kaye added that there are a lot of people asking for another interpretation of mandatory reporting. Traci Bolander agreed with these concerns and said there is a Town Hall Meeting in the works to discuss this issue.

Drew Wilson with the Medical Society of Delaware referenced the death of a local doctor. He added that there are a lot of providers who want to get more involved in the Task Force group. Mr. Wilson offered to connect members to anyone who can be of help to the Task Force's goals. He continued by saying that they can also help the Task Force come up with ways to further protect the workforce and their safety.

Traci Bolander stated that this Task Force should not let the work that DCHI is doing go unnoticed. Furthermore, Ms. Bolander mentioned that Secretary Rita Landgraf recently presented on where DCHI is with behavioral health and this would be a useful presentation.

Senator Hall-Long asked Task Force members and the public if they had any more comments; there was no further business of the Task Force so the meeting was adjourned at 3:55 pm.

# Appendix G

**Meeting Minutes, November 23, 2015**

Behavioral and Mental Health Task Force Meeting
Thursday, November 23rd, 2015
2:00 PM – 4:00 PM
Buena Vista Conference Center
Buck Library

**Meeting Attendance**

Task Force Members

| **Present** | **Email** |
|---|---|
| Co-Chair Senator Patricia Blevins | Patricia.Blevins@state.de.us |
| Co-Chair Senator Bethany Hall-Long | Bethany.Hall-Long@state.de.us |
| Susan Cycyk | Susan.Cycyk@state.de.us |
| Susan Jennette | Susan Jennette@state.de.us |
| Erin Booker, LPC | Erin.Booker@christianacare.org |
| Joshua Thomas | JThomas@namide.org |
| Dr. Michael Barbieri | Michael.Barbieri@state.de.us |
| Jim Lafferty | JLafferty@mhainde.org |
| Dr. Marc Richman | Marc.Richman@state.de.us |

| **Absent** | |
|---|---|
| Representative Debra Heffernan | Debra.Heffernan@state.de.us |
| Brenna Welker | Brg002@gmail.com |
| Secretary Rita Landgraf | Rita.Landgraf@state.de.us |

Task Force Staff

| **Present** | **Email** |
|---|---|
| Caitlyn Gordon | Caitlyn.Gordon@state.de.us |
| Carling Ryan | Carling.Ryan@state.de.us |
| Tanner Polce | Tanner.Polce@state.de.us |
| Bryan Gordon | Bryan.Gordon@state.de.us |
| Thomas Johnson | Tom.Johnson@state.de.us |

Public Attendees

| Name | Affiliation |
|---|---|
| Neil Kaye | PSD/MSD/NAMI |
| Richard Margolis | Prevention & Behavioral Health |
| Drew Wilson | Medical Society of Delaware |
| Christine Schiltz | Parkowski, Guerke, & Swayze |
| Jerry Gallucci | DHSS |
| Liz Proctor | Rockford Center |
| Chuck Webb | PBH |

*Appendix G Continued:*
The meeting was called to order at 2:10 pm.

Senator Patricia Blevins, Co-Chair, opened the Task Force meeting by welcoming everyone back. She also noted that although Dr. Marc Richman could not make the meeting, he was listening in through a conference call. Following her welcoming comments, the Senator asked Task Force members and members of the public to go around and introduce themselves.

**Approval of Meeting Minutes**
Next, Senator Blevins asked if members had changes that they would like to see made in the Meeting Minutes from October 27th. Seeing none, Senator Blevins asked for motions to approve the October 27th Meeting Minutes. The first motion to approve the Meeting Minutes was made by Susan Cycyk, this motion was seconded by Susan Jennette. The Meeting Minutes from October 27th were approved unanimously.

**Adult Co-occurring Disorders Presentation**
Senator Blevins introduced Dr. Gerard Gallucci who presented on Co-occurring Disorders to Task Force members.

*During and after the presentation, the following questions were asked:*

Senator Blevins asked Dr. Gallucci to define anti-social personality. He responded by explaining that it is a personality vulnerability. Anti-social personality may be characterized by behaviors influenced by lack of conscious, unstable personality type, risk taking tendencies, and impulsiveness. Dr. Gallucci added that anti-social personality is one of the more serious personality disorders. Additionally, borderline personality disorder is similar in extremity to anti-social personality disorder.

Senator Bethany Hall-Long, Co-Chair, asked how anti-social personality disorder falls on the DSM (Diagnostic and Statistical Manual of Mental Disorders) categorization with sociopathic. She related this to the Department of Correction's high comorbidity. Dr. Gallucci stated that with Correction there is an overrepresentation of anti-social personality disorder. He noted that acts like cruelty to animals or firesetting by children are risks for development during adulthood and could lead to personality disorders.

Senator Blevins asked if there were results of individuals who succeeded from therapy and learned to live with their mental health disorder while possibly controlling their substance abuse disorder. Dr. Gallucci responded to the Senator's question by explaining what the Delaware Co-Occurring State Incentive Grant did. It created a system that was more responsive to people coming in the front door, whether it was a substance abuse program or a mental health program. Dr. Gallucci added that prior to individuals coming into either of those systems, the State had not previously addressed co-occurring disorders.

Previously, individuals did not get screening for co-occurring disorders. Now, there is universal screening for co-occurring disorders at the entry level so individuals will be identified immediately. Additionally, because of the ability to screen for co-occurring disorders, DHSS (Delaware Department of Health and Social Services) staff has felt more capable and competent to treat it.

Dr. Michael Barbieri agreed that there have been improvements with identifying and treating co-occurring disorders but there are still gaps. He provided an example of when a person comes in for treatment of co-occurring disorders. This individual usually wants to choose which disorder to treat rather than getting treatment for both. Dr. Barbieri stated that DHSS is also struggling on how to make sure these patients are sticking to their medications.

*Appendix G Continued:*
Senator Hall-Long prompted Dr. Gallucci to start his second presentation on Psychiatric Services for Persons with Developmental and Intellectual Disabilities.

*During and after the presentation, the following questions were asked:*

Senator Hall-Long referenced a figure that Dr. Gallucci presented: 46% of individuals with severe intellectual disabilities also have schizophrenia. She added that this is a large percentage, and wondered if it was an outlier. Dr. Gallucci responded by saying most people with severe intellectual disabilities do not have schizophrenia. He added that it is difficult to assess those with high ID/DD (Intellectual Disabilities/Developmental Disabilities) because these individuals have a lack of communication skills. Sometimes intellectual disabilities will overshadow psychiatric symptoms and sometimes conditions will be either under diagnosed or over diagnosed.

Jim Lafferty asked about the effective service models that Dr. Gallucci presented and asked if there would be a new appropriation or if the general funds were already available. Dr. Gallucci answered that they already have the funds available from the Department; the money was built into the budget.

Jim Lafferty also asked when the Delaware's ACIST (Assertive Community Integration and Support Team) project will start. Dr. Gallucci answered that it should start this spring. Additionally, Mr. Lafferty asked if there were previous services that have existed prior to this program for adults with developmental disabilities. Dr. Gallucci answered that there have been no specialized services for adults. He added that DHSS has a psychiatrist who is working with the Division of Developmental Disabilities. However, they have not had a formalized program to address adults with special needs and ID/DD mental health needs.

Dr. Joshua Thomas asked Dr. Gallucci if they have a target number of people they would like to address with the ACIST project. Dr. Gallucci answered that their initial target will be 50 adults and they hope to raise that number to 100 statewide.

Senator Hall-Long asked Dr. Gallucci if the State is going to limit itself with this program by using the word "hospitalizations" as opposed to "ER visits." She continued to state that she was concerned on what a "psychiatric hospitalization" exactly means. When looking at the Medicaid data, ED (Emergency Department) visits are substantially higher and equally as important. The Senator added that maybe this data should be considered when developing their definition for "psychiatric hospitalizations."
Dr. Gallucci responded by saying that their criteria is not set in stone.

Jim Lafferty mentioned children with intellectual and developmental disabilities. Through discussion with the Task Force, one of the big problems with these children, is they are not receiving treatment early enough. Susan Cycyk noted that the Task Force needs to gather a list of who these children are, and how many there are, to start serving them at a younger age than the State does now. She added that there is a lot the State could be doing to prevent tragic events with these children. Dr. Barbieri noted that these children usually end up unemployed and in jail later in their lives. He added that this is a population of people that the State is not intervening with early enough and not providing enough support services to.

**Adolescent Co-occurring Disorders Presentation**
Senator Blevins introduced Mr. Chuck Webb who presented on Adolescent Substance Abuse and Comorbidity to Task Force members.

*During and after the presentation, the following questions were asked:*

Susan Jennette restated Mr. Chuck Webb's findings that he presented saying that community intervention is more effective than residential treatment. She asked him to expand on this comment. He stated that treatment is

certainly heading in that direction. Mr. Webb added that a big problem when comparing the two is the State cannot randomize kids to residential and outpatient. So, there is a consensus that integrated intensive community based interventions, with the support of residential and outpatient treatment, have the best probability of making lasting changes.

Dr. Barbieri stated that stability is important, but reimbursement rates do not follow that. Care in the community does not always get supported outside clinical intervention. However, if the State does not stabilize within the community, the patient will end up going back into deep end services.

Senator Blevins asked if short-term treatment is effective, or if most people with severe and persistent mental illness and substance abuse disorders need a lifetime of professional support. Mr. Webb answered that relapse usually happens several times in a person's life but there is hope that these individuals will reach a plateau where they are able to abstain for a long period of time. At this point, periodic after care will work as a reinforcement of what the patient learned in a restricted or community based setting. Mr. Webb added that this will provide the patient with a better chance of offsetting deterioration and from returning to their substance abuse habits.

Senator Blevins followed Mr. Webb's comments with another question. She asked if patients with mental illness should also continue periodic aftercare. Dr. Barbieri answered that long-term care and periodic check-ins are always helpful.

Senator Hall-Long mentioned how difficult reimbursement has been. She continued to add that she receives phone calls on a weekly basis from families who cannot get inpatient residential treatment. She asked what the status of instate treatment is for substance abuse. The Senator continued to ask if most of the substance abuse treatment for 18-years and younger is found out of State. Ms. Cycyk responded by saying that Delaware does not have any licensed instate substance abuse treatments centers for children. She added that the State either uses Mountain Manor Treatment Center Baltimore or Delaware's hospitals for short stay residential treatment. Ms. Cycyk stated that two of Delaware's contracted providers have gone through training for the "7 challenges" and are accepting adolescents who have substance use. She added that depending on what the child's insurance is, may create a real problem.

Dr. Barbieri stated that most insurance companies will cover the residential treatment programs that Ms. Cycyk mentioned. He added that the problem with having these treatment centers in Delaware is because the State does not have the volume of potential patients that would sustain the program over time. Dr. Barbieri suggested that maybe Delaware should look at a transitional service for this State.

Senator Hall-Long stated that she experienced a challenge with the Department of Education first hand. There is a child who has a mental health disorder and was acting out in the school district. She continued by saying that the school was afraid to report this because there are certain requirements. She asked Task Force members if there are issues at the Department of Education that jump out at them.

Ms. Cycyk responded by saying that there are two populations in schools that are challenging for school districts. The first population is the children who have an IEP (Individualized Education Program) because the district needs to make sure they are fulfilling the IEP. She added that there are also children who are not special education who make up the second population that are being connected to treatment. Ms. Cycyk added that if children are going to be kept in school, rather than at home, there needs to be services in the school. But, school districts do not have all of the resources that they need. Dr. Barbieri noted that those in the behavioral health system are the ones who need to bring these services to the schools rather making educators create their own.

Senator Blevins asked if there were any comments from the public. As there were none, the Task Force meeting was brought to a close at 4:01 pm.

# Appendix H

**Meeting Minutes, December 8, 2015**

Behavioral and Mental Health Task Force Meeting
Thursday, December 8th, 2015
2:00 PM – 4:00 PM
Buena Vista Conference Center
Buck Library

**Meeting Attendance**

Task Force Members

| **Present** | **Email** |
|---|---|
| Co-Chair Senator Patricia Blevins | Patricia.Blevins@state.de.us |
| Co-Chair Senator Bethany Hall-Long | Bethany.Hall-Long@state.de.us |
| Susan Cycyk | Susan.Cycyk@state.de.us |
| Susan Jennette | Susan Jennette@state.de.us |
| Erin Booker, LPC | Erin.Booker@christianacare.org |
| Dr. Michael Barbieri | Michael.Barbieri@state.de.us |
| Jim Lafferty | JLafferty@mhainde.org |
| Dr. Marc Richman | Marc.Richman@state.de.us |

| **Absent** | |
|---|---|
| Representative Debra Heffernan | Debra.Heffernan@state.de.us |
| Brenna Welker | Brg002@gmail.com |
| Joshua Thomas | JThomas@namide.org |
| Secretary Rita Landgraf | Rita.Landgraf@state.de.us |

Task Force Staff

| **Present** | **Email** |
|---|---|
| Caitlyn Gordon | Caitlyn.Gordon@state.de.us |
| Carling Ryan | Carling.Ryan@state.de.us |
| Tanner Polce | Tanner.Polce@state.de.us |
| Bryan Gordon | Bryan.Gordon@state.de.us |
| Thomas Johnson | Tom.Johnson@state.de.us |

Public Attendees

| **Name** | **Affiliation** |
|---|---|
| Jen Rini | The News Journal |
| Harvey Doppelt | DPBHS/DSCYF |
| Neil Kaye | PSD/MSD/NAMI |
| Bill Mason | Meadowwood BHS |
| Sarah Wootten | House Staff |
| Drew Wilson | Medical Society of Delaware |
| Linda Brittingham | CCHS |
| Christine Schiltz | Parkowski, Guerke, & Swayze |
| Adam Glushakow | |

*Appendix H Continued:*
The meeting was called to order at 2:14 pm.

Senator Patricia Blevins, Co-Chair, opened the Task Force meeting by addressing the first item on the agenda, approval of the meeting minutes.

**Approval of Meeting Minutes**
Senator Blevins asked if members had changes that they would like to see made in the Meeting Minutes from November 23rd, 2015. Seeing none, Senator Blevins asked for motions to approve the November 23rd Meeting Minutes. The first motion to approve the Meeting Minutes was made by Jim Lafferty, this motion was seconded by Susan Jennette. The Meeting Minutes from November 23rd, 2015 were approved unanimously.

**Suicide and Stigma Presentations and Questions**
Senator Blevins introduced Jim Lafferty, Emily Vera, Jennifer Seo, and Jennifer Smolowitz, from the Mental Health Association in Delaware, who presented on suicide and stigma.

During the presentation, a video clip titled Suicide Prevention PSA was shown.
Below is a link to the video:
https://vimeo.com/139404264

Following the first presentation, Senator Bethany Hall-Long, Co-Chair, introduced Susan Cycyk and Harvey Doppelt from the Delaware Department of Children, Youth, and their Families, who presented on Suicide Prevention.

**Open Discussion**
Carling Ryan, Task Force staff, asked Mr. Doppelt about parental consent for suicide assessment screenings and how this consent is given in schools and primary care physician offices, etc. Mr. Doppelt responded that it depends on what kind of setting the screening takes place in. In many instances, if the screening is considered a customary standard operating procedure, one would not need parental consent. Additionally primary care offices are able to decide on their own based off of how they want to run their practice.

Dr. Glushakow, member of the public, asked if an individual is identified as high-risk during a screening, how the person screening them could communicate that information to another care provider who may see the patient as well. Mr. Doppelt stated that this also depends on the setting. If the patient is high-risk, HIPPA (Health Insurance Portability and Accountability Act) allows care providers to immediately communicate this information without a release. Additionally, much of what the primary care doctors do is based off of how they want their practices to run. However, crisis services will communicate this information to a provider with parental consent.

Neil Kaye, speaking on behalf of Joshua Thomas, National Alliance of Mental Illness, noted that there is an insufficient amount of child psychiatrists in Delaware and that is a problem. Because of the gap of psychiatrists, patients are waiting months to get the help that they need. He added that the Task Force should also work on recruiting and maintaining child psychiatrists in the State.

Telepsychiatry was mentioned during discussion of Task Force members. Mr. Lafferty mentioned that a study done in British Columbia proved that kids seem to accept telepsychiatry very well. Susan Cycyk added that the Kids Department uses telepsychiatry and they have found success using it at the Stevenson House Detention Center, because the Department could not find a doctor to come in. She added that to transport the Center's patients to see a physician, they would need to shackle the patient and drive them to an off-site location.

Erin Booker noted that Mid-Atlantic has been seeing success with telepsychiatry on children and adults. Additionally, hospital systems as a whole are all looking at telepsychiatry. However, Ms. Booker added that there are many parts of telepsychiatry that need to be looked into further.

Neil Kaye mentioned some concerns that need to be resolved with telepsychiatry. He noted that there is a difference between conducting an initial assessment and follow-up care in terms of emergency backups. Dr. Kaye added that if a physician is conducting an initial assessment through telepsychiatry, and their patient mentions that he or she is suicidal and continues to take out a gun during treatment, the physician does not have a physical way to stop the patient from shooting themselves.

Dr. Barbieri referenced issues that Dr. Kaye has brought up regarding mandatory reporting. He asked members if there is a need for legislation to modify mandatory reporting. Dr. Kaye responded that he is working with a group on draft language to amend the current mandatory reporting law. He noted that they would love to see the Task Force get behind this legislation.

Jim Lafferty emphasized the importance of educating parents on the seriousness of different psychiatric disorders so they can understand their child's actions and words. Erin Booker agreed, adding that another area that needs education is summer camps and camp counselors. She added that these counselors do not realize how serious a child's remarks and actions could be. Ms. Booker stated that any individual who works with children on a consistent basis should get proper education. Ms. Cycyk highlighted that the State really does not have the capacity in this area that they need.

Senator Hall-Long noted that with the closing of the Rosenblum Center, it is important to highlight during meetings, and in the Matrix, where the gaps are following the closing. The Senator asked members if there were unlimited resources, what their dream world consist of for mental health in Delaware.

Mr. Lafferty noted that in a "dream world" he would have a kids program that was longer than 2 weeks of intensive outpatient or partial hospital. He added that it must be extremely difficult to work with kids for only two weeks and efficiently treat their problems.

Senator Hall-Long mentioned that working with reimbursement rates to get the right providers for children is also important. Dr. Barbieri added that there are many dynamics that go into working with kids like: dysfunction in the home, depression, failures in school, and easy access to drugs. He noted that a big challenge in treating kids, is treating all of these issues. Dr. Barbieri said when family support is there, it is helpful, but they do not receive the necessary family support with all of their child patients.

Senator Hall-Long stated that early intervention in a child's life would be beneficial to their future. She continued to ask Susan Cycyk if she likes the idea of middle school wellness centers. Ms. Cycyk responded saying that this would be very beneficial but the school would need to be careful of what they put in them. She added that actions to keep kids in school as long as possible is much needed, and providing that child with services to keep them in school would be extremely helpful.

Senator Hall-Long asked Task Force members if they had any recommendations that they would like to make for the Task Force.

Mr. Doppelt added that getting parents to the table to help with their children is important. He stated that parents are not as engaged as they should be.

Dr. Richman noted that the "Help is Here" website has been very helpful with DHSS (Department of Health and Social Services) around substance abuse issues. He added that although the website is extremely helpful, it does

not address children's issues. Dr. Richman stated that if the State was able to have a dovetail of the "Help is Here" website, this would be a way to help children.

Senator Hall-Long asked members and the public if they had additional questions or comments. As there were none, the Task Force meeting was brought to a close at 3:30 pm.

# Appendix I

**Meeting Minutes, January 4, 2016**

Behavioral and Mental Health Task Force Meeting
Tuesday, January 7th, 2016
2:30 PM – 4:30 PM
Buena Vista Conference Center
Buck Library

**Meeting Attendance**

Task Force Members

| **Present** | **Email** |
|---|---|
| Co-Chair Senator Patricia Blevins | Patricia.Blevins@state.de.us |
| Co-Chair Senator Bethany Hall-Long | Bethany.Hall-Long@state.de.us |
| Susan Cycyk | Susan.Cycyk@state.de.us |
| Dr. Michael Barbieri | Michael.Barbieri@state.de.us |
| Dr. Marc Richman | Marc.Richman@state.de.us |
| Representative Debra Heffernan | Debra.Heffernan@state.de.us |
| | |
| Absent | |
| Jim Lafferty | JLafferty@mhainde.org |
| Brenna Welker | Brg002@gmail.com |
| Joshua Thomas | JThomas@namide.org |
| Erin Booker, LPC | Erin.Booker@christianacare.org |
| Susan Jennette | Susan Jennette@state.de.us |
| Secretary Rita Landgraf | Rita.Landgraf@state.de.us |

Task Force Staff

| **Present** | **Email** |
|---|---|
| Caitlyn Gordon | Caitlyn.Gordon@state.de.us |
| Carling Ryan | Carling.Ryan@state.de.us |
| Tanner Polce | Tanner.Polce@state.de.us |
| Bryan Gordon | Bryan.Gordon@state.de.us |
| | |
| **Absent** | |
| Thomas Johnson | Tom.Johnson@state.de.us |

Public Attendees

| **Name** | **Affiliation** |
|---|---|
| Chris Devaney | Connections |
| Edwina Bell | Inspirational Speaker |
| Rebecca Richmond | DPBHS |
| Julie Leusner | DPBHS |
| Drew Wilson | Medical Society of Delaware |
| Neil Kaye | PSD/MSD/NAMI |
| Bill Mason | Meadowwood BHS |

*Appendix I Continued:*

| | |
|---|---|
| Jen Rini | The News Journal |
| Christine Schiltz | Parkowski, Guerke, & Swayze |
| Nancy Dietz | DYRS |
| Jack McDonough | DYRS |
| Vanessa Bennifield | DOC |
| Judith Caprio | DOC |

The meeting was called to order at 2:09 pm.

Senator Bethany Hall-Long, Co-Chair, opened the Task Force meeting by wishing everyone a happy New Year. Next, she asked Task Force members and members of the public to introduce themselves.

**Presentations**

Senator Hall-Long introduced Dr. Rebecca Richmond, DPBHS (Division of Prevention and Behavioral Health Services), who presented on the DPBHS Behavioral Health System in the DYRS Facilities.

During Dr. Richmond's presentation, Dr. Neil Kaye, on behalf of Joshua Thomas and NAMI (The National Alliance on Mental Illness), asked Dr. Richmond if she could tell him why members of youth are going down. She responded that some initiatives are taking out kids who should not have been detained in the first place. For example, kids who were arrested for things like offensive touching, where previously they would be detained but now they are not. This is because there are a lot more kids being arrested on murder charges, attempt of robbery, and offenses involving guns.

Since children are facing more serious charges, they are being sentenced to places like Ferris and the Department of Correction (DOC). Additionally, since there are more kids who are involved in the Superior Court System and this process takes more time than the Family Court System does, youth are staying detained for a longer period of time. In detention the child's average stay is 30-40 days. However for kids involved in Superior Court, they are being detained from 6 months – 2 years before transferring over.

Senator Patricia Blevins, Co-Chair, asked Dr. Richmond if DPBHS has been able to easily find doctors in the community for their programs. Dr. Richmond replied that finding doctors has been difficult, but it is ultimately up to the family what agency they go through. However, in Delaware as a whole they have not been able to find a lot of board-certified psychiatrists to treat children and adolescents. Senator Blevins noted that a lack of board-certified psychiatrists to treat the Delaware population has been an underlying theme running through each Task Force meeting discussion thus far.

Dr. Richmond noted that when they contact parents, the parents often explain that they have not been able to get the medicine that their kids are prescribed to. Some parents even have had to wait on a 3-month wait list to see their psychiatrist for another prescription. She added that much of Delaware's detained youth are receiving better treatment than if they had not been detained.

Senator Blevins asked Dr. Richmond if she has noticed a problem with State personnel not sending every qualified candidate along. Dr. Richmond noted that in some situations that occurs, the basic requirement is that the psychologist should hold a license to practice in Delaware. Sometimes, a psychologist will hold a license in other states; this is when they work with Human Resources and the Office of Management and Budget to look at them.

Dr. Kaye noted that the time to get a license, like a PhD, in Delaware is much longer than surrounding states. Senator Hall-Long replied that the Task Force needs to look at that.

*Appendix I Continued:*
Nancy Dietz, member of the public on behalf of DYRS (Division of Youth Rehabilitative Services), mentioned that when she started working at DYRS years ago, half of their treatment specialists were working day shifts which did not make sense considering kids were in school. After noticing where the gaps in treatment were, DYRS moved specialists to fill gaps during the night shift. Ms. Dietz noted that working at night may be a recruitment problem for the State because treatment specialists get tired of working during the evening.

Next, Senator Hall-Long introduced Nancy Dietz and Jack McDonough from DYRS. Both Ms. Dietz and Mr. McDonough presented on YRS (Youth Rehabilitative Services.)

During the presentation, Representative Debra Heffernan, member, asked where the "Opportunity to Change" (OTC) program that Ms. Dietz mentioned takes place. Ms. Dietz answered that the entire program takes place at the Ferris School.

Senator Blevins referenced kids who come into the detention centers with an addiction to alcohol and/or drugs and are suffering from withdrawal symptoms. The Senator asked how DYRS handles those situations. Ms. Dietz answered that the detention center's psychologists evaluate the kids. All of the kids are also evaluated by the Medical Department within 24 hours, if the Department comes across a child who is going through withdrawal, there are precautions in place. Additionally, depending on where the child is headed to next, they would make sure that child is hooked up to the appropriate services and programs. Lastly, program coordinators set up follow-up care when the child goes back out into the community.

Senator Blevins also asked about what the treatment is for children experiencing withdrawal.
Dr. Richmond replied that their Medical Department has a process for them that can take up to 4-weeks to manage symptoms. Additionally, the child is monitored very closely by the Medical Department to ensure their safety.

Senator Hall-Long asked if there is data on how many child offenders who are at Ferris ultimately end up in the State adult correction center. Ms. Dietz answered that the Delaware Statistical Analysis Center tracks their youth. She added that DYRS has just started a Quality Improvement Unit with a Data Manager, and DOC did the same thing a year earlier. This unit allows them to track kids over longer time periods instead on depending on a single agency to track them. This way, the right kids are matched to the right services, for the right amount of time.

Senator Hall-Long asked if they see any gaps in their programs and facilities. Mr. McDonough replied that they need a halfway house, the State does not have a true halfway house for kids and this is the point where they see the most recidivism occur. He continued to say that kids do very well in the secure care, the problems occur when they return home. However, if there were a halfway house to help them transition, recidivism rates would probably decrease.

Ms. Dietz added that they have a re-entry program where kids transition out of Ferris into the community. She referenced Mr. McDonough's point and added that they need something in between Ferris and the community, to give them appropriate oversight but lets the kids go out into their community and to school during the day.

Susan Cycyk, DPBHS and member, referenced the way school districts interpret the amount of time that the youth spends in YRS differently. Some school districts who expel a child, will not count the time that they spent at Ferris towards their expulsion time. In this case, if a child has been at Ferris for a year, then their expulsion lasts for an additional year or more. This is a very long period of time that a child is kept from their education. Senator Hall-Long noted that the Task Force needs to look at this.

Lastly, Senator Hall-Long introduced Dr. Marc Richman form DOC and Chris Devaney from Connections to present on the Delaware Department of Correction's Behavioral Health Services.

*Appendix I Continued:*
During the presentation, Senator Hall-Long referenced an outstanding statistic, 82% of Delaware inmates have mental health disorders or substance abuse disorders. Dr. Richman agreed that a large number of inmates suffer from either a mental health disorder, substance abuse disorder, or both, but the number constantly fluctuates. Senator Hall-Long noted that youth and adults in Corrections is where the Task Force can make their largest and most impactful initial steps.

Additionally, Dr. Richman noted that there is not a step ladder for individuals who are studying to become a psychologist or a social worker who then could automatically advance into another position when they receive there degree, and then again when they get their license. He added that it is easier to hire from a contractor perspective than from the State system. Senator Hall-Long noted that this is something the State needs to look into. Dr. Richman agreed. He continued to say they need to get individuals who are licensed or not. If the State is hiring non-licensed individuals into low-paying positions, the second they get licensed they are gone.

During the presentation, Mr. Devaney stated the amount of beds correctional facilities in the State have available. Howard R. Young Correctional Institution has 80 beds, Baylor Women's Correctional Institution has 72 beds, and 50% of the population on any given day could benefit from more beds and programs than they can currently staff and serve. Therefore, these individuals who need treatment are not receiving it.

Senator Blevins asked how many people are not receiving treatment from the Special Needs Units but need it. Mr. Devaney answered that on any given day about 230 people are not getting needed treatment from the Special Needs Unit.

Dr. Richman noted a gap in Delaware during his presentation. Delaware inmates cannot utilize Medicaid because they are in prison, and some states do no terminate their Medicaid, they suspend it so the inmate will not have to reapply for it. Then, when that inmate comes out of level V incarceration, their Medicaid is almost instantaneously turned back on. However, Delaware does not have this system in place, it is a termination State and it would be much better if Delaware was a suspension state. Senator Hall-Long asked that when an inmate gets transferred to the hospital, who picks up the cost. Dr. Richman answered that 24-hours after that inmates stay in the hospital, it gets picked up by Medicaid. The first 24-hours is paid for by Connections, if they need to stay longer, they can get the pending Medicaid approval, then the hospital picks it up.

Ms. Cycyk noted that the children have the same problem. Additionally, a child cannot apply for Medicaid so to get them reconnected, they have to contact the parents to reapply.
Senator Blevins asked if the New Expectations program is 24/7, or if the pregnant women go back to Baylor at night. Mr. Devaney answered that the program is 24/7, its an unlocked building staffed 24 hours a day, the woman an leave for medical appointments and treatment with staff support, and they get drug tested.

Senator Blevins asked about preventing the child's probability of being born addicted to Methadone. Mr. Devaney is looking to receive an approval to use Suboxone because the withdrawal period for the baby off of Suboxone is much less than it is for Methadone. He added that if a person is actively withdrawing off of Methadone, they cannot take them off until the baby is born, it must be replaced with an opiate.

Senator Hall-Long asked Vanessa Bennifield, member of the public on behalf of DOC, to mention some gaps that she sees. Ms. Bennifield mentioned that there are a large number of people who do need services, and Connections has been doing a lot of great work and one of their goals is to broaden access to care for offenders and to strengthen their reintegration into the community.

Judy Caprio, member of the public on behalf of DOC, noted that it is important to look at their entire screening process because the screening process starts the ball rolling for the continuum of care. She added that they have a proper screening process now and have been able to get to that point in a short period of time.

Senator Hall-Long referenced the State referral with the EEU (Eligibility and Enrollment Unit) process. She noted that it would be fascinating to see how many inmates have been on the EEU waitlist and have fallen through the cracks. Additionally, the Task Force should discuss the Mitchell System.

Mr. Devaney noted that he can speak to the EEU issue. Additionally, he can send Dr. Barbieri and Dr. Richman information by the end of the week on the amount of people they have served inside level V facilities who have come in on the deep-end services, which the EEU is the gatekeeper for. Additionally, he can provide information for how many people they have referred from level V and level IV to the EEU.

Senator Hall-Long asked if someone is sent from Mitchell to the emergency room (ER), and had previously been an inmate at some point, if the ER sends them back to Mitchell or to prison. Mr. Devaney answered that if they leave the ER, they go back to Mitchell. If they are admitted for an inpatient stay, they will go back to the infirmary of the level V facility that they came from until they are medically cleared.

Senator Hall-Long asked if it would make more sense to move Mitchell to DOC or keep it with DHSS (Department of Health and Social Services). Dr. Barbieri answered it has been a thought but it is a lower priority.

Representative Heffernan added that she does not think the State's problem is not having enough mental institutions, but it is more that there are not enough services in the community to keep people out of Corrections. She noted that it seems like once an inmate is in the correctional system they have a much better chance of getting their substance abuse disorder and serious mental illness under control. Representative Heffernan added that the State needs the same level of care available for individuals before they end up in Corrections.

Senator Hall-Long asked the public if they had additional questions or comments.

Edwina Bell, member of the public, mentioned some additional ideas:

- Include more self-dependence through teaching empowering skills and techniques in rehabilitation centers and prisons. One example of a program that makes this empowering process easier is CHANGE.
- Preventative measures could decrease future generations from being incarcerated.
- Hire dual-diagnosis clinicians.
- Emphasize a qualitative life v. a quantitative life to the State's youth.

**Approval of Meeting Minutes**

Senator Blevins asked if members had changes that they would like to see made in the Meeting Minutes from December 8th, 2015. Seeing none, Senator Blevins asked for motions to approve the December 8th Meeting Minutes. The first motion to approve the Meeting Minutes was made by Dr. Barbieri, this motion was seconded by Dr. Richman. The Meeting Minutes from December 8th, 2015 were approved unanimously.

Senator Hall-Long reminded members of the next Task Force meeting on January 7th, 2016 from 2:30 PM – 4:30 PM in the Buck Library. The Task Force meeting was brought to a close at 4:04 pm.

# Appendix J

**Meeting Minutes, January 7, 2016**

Behavioral and Mental Health Task Force Meeting
Tuesday, January 7th, 2016
2:30 PM – 4:30 PM
Buena Vista Conference Center
Buck Library

**Meeting Attendance**

Task Force Members

| **Present** | **Email** |
|---|---|
| Co-Chair Senator Patricia Blevins | Patricia.Blevins@state.de.us |
| Co-Chair Senator Bethany Hall-Long | Bethany.Hall-Long@state.de.us |
| Susan Cycyk | Susan.Cycyk@state.de.us |
| Dr. Marc Richman | Marc.Richman@state.de.us |
| Representative Debra Heffernan | Debra.Heffernan@state.de.us |
| Jim Lafferty | JLafferty@mhainde.org |
| Joshua Thomas | JThomas@namide.org |
| Susan Jennette | Susan Jennette@state.de.us |

| **Absent** | |
|---|---|
| Brenna Welker | Brg002@gmail.com |
| Erin Booker, LPC | Erin.Booker@christianacare.org |
| Dr. Michael Barbieri | Michael.Barbieri@state.de.us |
| Secretary Rita Landgraf | Rita.Landgraf@state.de.us |

Task Force Staff

| **Present** | **Email** |
|---|---|
| Caitlyn Gordon | Caitlyn.Gordon@state.de.us |
| Carling Ryan | Carling.Ryan@state.de.us |
| Tanner Polce | Tanner.Polce@state.de.us |
| Bryan Gordon | Bryan.Gordon@state.de.us |
| Thomas Johnson | Tom.Johnson@state.de.us |

Public Attendees

| **Name** | **Affiliation** |
|---|---|
| Richard Margolis | DPBHS |
| Daphne Warner | DPBHS |
| Edwina Bell | Author |
| Adam Glushakow | |
| Traci Bolander | MABH |
| James Nutter | Parkowski, Guerke, & Swayze |
| Neil Kaye | PSD/MSD/NAMI |
| Kathy Janvier | DCHI |

| | |
|---|---|
| Leslie Tremberth | PCG |
| Wayne Smith | DHA |
| Tom Olson | PBH |
| Julane Miller-Armbrister | DCHI |
| Tim Collins | |
| Bill Mason | MWBHS |
| Kim Gomes | Byrd Group |
| Irene Waldron | DHCFA |

The meeting was called to order at 2:33 pm.

Senator Bethany Hall-Long, Co-Chair, opened the Task Force meeting by welcoming and thanking Task Force members and members of the public for coming. Next, she asked Task Force members to introduce themselves.

**Approval of Meeting Minutes**
Senator Hall-Long asked if members had changes that they would like to see made in the Meeting Minutes from January 4th, 2016. Seeing none, Senator Hall-Long asked for motions to approve the January 4th Meeting Minutes. The first motion to approve the Meeting Minutes was made by Jim Lafferty; this motion was seconded by Susan Cycyk. The Meeting Minutes from January 4th, 2016 were approved unanimously.

**Workforce Presentations – DPC Residency Program**
Senator Hall-Long introduced Dr. Gerard Gallucci who presented on the DPC (Delaware Psychiatric Center) Residency Program.

There is not a hard copy of Dr.Gallucci's presentation. Therefore, his main points are summarized below:
DPC Residency Program

1. Residents Accepted
    - 1000 applications – 20 interviews - 4 are accepted
    - Students from all over the U.S. and abroad
        - o Students who travel from other states have been less likely to stay in Delaware after the residency program.
        - o Many graduates go on to do fellowships.
2. Program Details
    - o First year- inpatient work
    - o Second year-child/adolescent psychiatry at the Terry Center
        - Many residents will leave after their third year to do the 2-year child fellowship.
    - o Third Year-outpatient rotations
        - Substance treatment sites
        - Christiana
        - Union Hospital-Maryland

After explaining the DPC Residency Program, Dr. Gallucci asked Task Force members if they had any questions.

Senator Hall-Long asked if there was a discussion about Christiana Hospital, or other places around the state, having a residency program. The Senator asked how can elected officials and members of the public help make these programs happen. Dr. Gallucci answered that there has been conversation and Christiana was eager about the idea of taking over the Delaware Psychiatry Residency Program. He added that when Christiana looked into this possibility, they learned that they did not have the funding for a residency program.

*Appendix J Continued:*
Next, Senator Hall-Long referenced Dr. Gallucci's affiliation to Johns Hopkins and asked how Delaware can get the state's residency to have that true academic affiliation. Students who graduate from Delaware high schools and colleges want to start a career in psychiatry but do not even apply to DPC. Dr. Gallucci answered that DPC needs to strengthen their affiliations with the academic centers. DPC is a freestanding program, which is not linked to a big medical center. For instance the University of Maryland residency program is linked to their health system, which is linked to the state hospital. Dr. Gallucci added that one way to create academic affiliations is to identify a program, like the one at Drexel, Hopkins, or the University of Maryland. Then, see if DPC could become an affiliate program where both programs could rotate faculty and residents. With this, DPC could improve relationships with multiple programs.

Senator Hall-Long asked what percentage of students who come to DPC are from other countries. Dr. Gallucci answered that the majority of students are from foreign medical schools, although there are still students who come from U.S. medical schools.

Susan Cycyk noted that Delaware pays less to those who provide behavioral health treatment than surrounding states do. She added that this adds another layer of difficulty when trying to recruit psychiatrists to practice in Delaware.

Richard Margolis stated that the number one shortage area in medicine is child psychiatry. The number two shortage area is general psychiatry. Therefore, there is a smaller workforce to begin with, which the State has been trying to recruit from.

Dr. Neil Kaye noted that he is shocked that DPC has a list of 1000 physicians who are willing to move to Delaware for residency, he asked if this list of people would be willing to practice primary care in the State as well.

Dr. Adam Glushakow noted that many clinics cannot afford to exist anymore. Therefore, even if there are physicians in the State, some cannot afford to practice and provide the care that the State needs, this is probably the biggest barrier to retaining talented clinicians. Additionally, there is more of a burden on residents because they provide valuable services to indigent citizens. However, with the closure of state/community clinics, this has become more of a challenge.

Jim Lafferty asked if the salary that DPC provides to residents is competitive with other states or other programs. Dr. Gallucci stated that residents make in to 40s-50s but they have not compared this rate with other states. However, this has not come up as an issue for whether or not a resident has decided to come to Delaware or not. He added that within the 1000 applications that DPC receives, applicants are eager to come to the state.
Senator Patricia Blevins, Co-Chair, stated that it seems the supply and demand is both there. She noted that it seems practical to create a small workgroup when the Task Force is finished to talk about how the State can better achieve residency programs all over Delaware.

Senator Hall-Long asked what the selection process is for the DPC Residency Program. Dr. Gallucci answered that the applicants apply through an electronic record and they are screened and reviewed before looking at them. Once the 20 applicants are selected, they come for an interview, which four people are selected from. He added that almost 100% of accepted applicants choose to commit to the program.

Senator Hall-Long asked Dr. Gallucci why DPC does not use the Match Program. Dr. Gallucci answered that DPC would probably not be as competitive in the Match Program. The Senator followed this statement by asking if Delaware developed a more competitive program, if they could consider using the Match Program. Dr. Gallucci agreed and noted that DPC has gotten to the point where the program is competitive enough for the Match Program but the residents that they have had in the past were very talented.

Dr. Margolis noted that since Delaware does not have a medical school, recruiting residents is more difficult. Medical students tend to do their residencies where they train.

**Workforce Presentations – DCHI Workforce and Education Committee**
Senator Hall-Long introduced Dr. Traci Bolander and Dr. Kathy Janvier who presented on the DCHI (Delaware Center for Health Innovation) Workforce and Education Committee.

Mr. Lafferty asked what the highest number of Spanish speaking psychiatrists was; Dr. Kathy Janvier noted that she would get him that number at a future time.

Senator Hall-Long asked Dr. Bolander why other institutions in Behavioral Health do not use the DHIN (Delaware Health Incentive Network) Dr. Bolander noted that she uses DHIN. However many Behavioral Health institutions do not use DHIN because the only value is in labs, she added that she would not be able to put her discharge summaries on there. Dr. Bolander stated that it costs her $7,000 a month for her electronic health record and was a $300,000 investment initially.

Dr. Bolander also noted that DCHI has money earmarked from a grant, which is specifically for behavioral health practices becoming electronic to start sharing data.

Senator Hall-Long referenced Delaware's hospital system that has gone to integrated care and asked if they are seeing more patients, and if patients are not getting seen. Dr. Bolander replied that they are working on trying to see more patients, but the patients are still being seen regardless.

Dr. Adam Glushakow, member of the public, asked why there is more focus on patients who have higher physical needs and less mental health needs. Dr. Bolander replied that physical needs are the focus of training at the time, because that is where the need is. However, the others are not being ignored.

Mr. Lafferty noted that an important point Dr. Bolander referenced was education and training for the physicians, nurse practitioner, and the mental health professional that is in the office. This way, each of those individuals knows what the other does and they can communicate together. Integration should not be confused with communication.

**Workforce Presentations – DPBHS: Workforce Development**
Senator Hall-Long introduced Dr. Richard Margolis, Dr. Tom Olson, and Daphne Warner, LCSW, who presented on DPBHS (The Division of Prevention and Behavioral Health Service) – Workforce Development.

Senator Hall-Long noted that she has been looking at the identifiers of the age of 6-10 where early prevention could start. Senator Hall-Long asked Daphne Warner what her thoughts were on early prevention in the schools or in the community. Ms. Warner responded that if they could implement prevention work in elementary schools, she would be extremely happy. She noted that prevention works and it is important. If Delaware could start in elementary schools, it would help with the FCTs (Family Crisis Therapists) in the elementary schools. However, FCTs help a small number of students, and schools would benefit from having programs like FCTs on a larger scale with licensed therapists. Additionally, high schools need them as well.

Representative Debra Heffernan asked if Delaware has reciprocity for licensing in Delaware, like a lot of other states. Ms. Warner noted that there is some; however she is not sure the details. Additionally, Delaware is having problems with how much they pay compared to surrounding states. Delaware pays a lot less than Pennsylvania and New Jersey.

Representative Heffernan also asked if there are state colleges and universities in Delaware that offer a master's

degree in social work. Ms. Warner replied that Delaware State University offers a master's degree in social work. Additionally, West Chester and Widener has MSW (Master's in Social Work) programs. Wilmington University has the Master's in Counseling and the University of Delaware has a program too. Dr. Bolander noted that there are loan forgiveness programs in Delaware; however, the States licensure requirements are more stringent than in other states.

After the presentations, Senator Blevins reminded Task Force members, and members of the public, about the Public Hearing coming up, on February 3rd at 6:30 PM, at Legislative Hall in the Senate Chamber.

**Public Comment**
Edwina Bell, member of the public, asked what impact the publicity of the federal and state governments has had on the retention of DPC (Delaware Psychiatric Center) workers and recruiting new staff to the State. Senator Hall-Long replied that the Task Force should wait to answer that when
Dr. Barbieri is present.

Ms. Bell also asked how the State will follow measures suggested by the outcome data studying effectiveness of treatment. Dr. Richman replied that the measuring outcome for services dove-tail with DCHI in regard to a value based and performance based payment system. This is a very complicated system with a lot of moving parts.

Ms. Cycyk followed that the children's system has one consistent measure, which is not the best. However, the measure is based on whether or not they are able to step down a child to a less restrictive level of care and if the child is able to sustain in that level of care. Mr. Lafferty noted that from the adult side, the U.S. Department of Justice settled on an agreement that has resulted in a lot of additional data collection, filtering the data, and reporting on their progress. However, there is a lot more data collection needed.

Dr. Margolis noted that DPBHS has a system of care grant, and they have access to technical systems through it. There are different instruments that they are now using to determine whether or not a system is appropriate for each child.

Irene Waldron, on behalf of Delaware Healthcare Facilities Association and member of the public, stated that it is important to be careful when looking at hospitalizations and re-hospitalization data because more individuals have started receiving healthcare insurance within the past 2 years because of the Affordable Care Act. Therefore, part of the reason that the data may have risen is because more people now have coverage.

Tim Collins, member of the public, referenced his passion to fight for those who were wrongly accused of sexual offenses in Delaware.

- Asked if someone could look into his situation of being wrongly accused of sexual offenses.
- Addressed SB 133 of the 144th General Assembly, a law created to remove custody of children from sex offenders. Mr. Collins stated that the law is not written correctly.
    - o Noted that the Bill was never put through a committee.
    - o Blamed this law for the reason why he is not allowed to see his children.

Bill Mason, on behalf of MeadowWood Behavioral Health and member of the public, stated that if this Task Force constructs a Work Force Committee, he would like to be a part of it. At MeadowWood, they have four nursing schools and receive several requests for nurse practitioners and physician assistants. But, because of funding requirements there are many additional steps that take a lot of time out of the student's working and learning day.

Senator Hall-Long asked if there were any more questions from Task Force members. As there were none, the Task Force meeting adjourned at 4:29 PM.

# Appendix K

**Public Hearing Attendance, February 3, 2016**

## Behavioral and Mental Health Task Force
## Public Hearing

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Thursday, February 3rd 2016
6:30 PM
Legislative Hall
Senate Chamber

### Meeting Attendance

1. Dr. Steve Eichel - Psych & Law Committee, DE Psychological Association
2. Paul Shady - Cabela's Retail
3. David S. Esbock- Family Physician
4. Tim Collins - Advocate for the Falsely Accused
5. Sharon Kurfuerst - Christiana Care Health System
6. Mark Borer - Delaware Council of Child & Adolescent Psychiatry
7. Joan Chatterton - Aquila
8. Linda Lang - Christiana Care
9. Edwina Bell
10. Joe Connor

*A recording of the Public Hearing audio can be found within the Divison of Research.*

# Appendix L

**Meeting Minutes,March 4, 2016**

Behavioral and Mental Health Task Force Meeting
Friday, March 4th, 2016
2:30 PM – 4:30 PM
Buena Vista Conference Center
Buck Library

**Meeting Attendance**

Task Force Members

| **Present** | **Email** |
|---|---|
| Co-Chair Senator Patricia Blevins | Patricia.Blevins@state.de.us |
| Co-Chair Senator Bethany Hall-Long | Bethany.Hall-Long@state.de.us |
| Representative Debra Heffernan | Debra.Heffernan@state.de.us |
| Susan Cycyk | Susan.Cycyk@state.de.us |
| Erin Booker, LPC | Erin.Booker@christianacare.org |
| Dr. Michael Barbieri | Michael.Barbieri@state.de.us |
| Jim Lafferty | JLafferty@mhainde.org |
| Dr. Marc Richman | Marc.Richman@state.de.us |
| Secretary Rita Landgraf | Rita.Landgraf@state.de.us |
| Joshua Thomas | JThomas@namide.org |
| **Absent** | |
| Brenna Welker | Brg002@gmail.com |
| Susan Jennette | Susan Jennette@state.de.us |

Task Force Staff

| **Present** | **Email** |
|---|---|
| Caitlyn Gordon | Caitlyn.Gordon@state.de.us |
| Carling Ryan | Carling.Ryan@state.de.us |
| Tanner Polce | Tanner.Polce@state.de.us |
| Thomas Johnson | Tom.Johnson@state.de.us |

Public Attendees

| **Name** | **Affiliation** |
|---|---|
| Edwina Bell | Author |
| Helen Hall | |
| Neil Kaye | PSD/MSD/NAMI |
| Timothy Collins | |
| Sandra Billops | Temple University |
| Dale McKenzie | Cab Calloway |
| Christine Schiltz | Parkowski, Guerke, & Swayze |
| Traci Bolander | MABH/DPA |
| Drew Wilson | MSD |

*Appendix L Continued:*
The meeting was called to order at 2:10 pm.

Senator Bethany Hall-Long, Co-Chair, opened the Task Force meeting by addressing the first item on the agenda, approval of the Meeting Minutes.

**Approval of Meeting Minutes**
Senator Hall-Long asked if members had changes for the January 7th, 2016 Meeting Minutes. Seeing none, Senator Hall-Long asked for motions to approve the January 7th 2016 Meeting Minutes. The first motion to approve the Meeting Minutes was made by Erin Booker, this motion was seconded Jim Lafferty. The Meeting Minutes from January 7th, 2016 were approved unanimously.

**Discussion of the Final Report Draft Recommendations**
Senator Hall-Long started by thanking the Senate and DSAMH (Division of Substance Abuse and Mental Health) staff for helping with the Task Force and working to put together the draft recommendations discussed during the meeting.

Senator Hall-Long also informed members that they will need to extend the Task Force final reporting deadline given the additional time needed to finish the final report. Additionally, if any Task Force members had additional thoughts, edits, or recommendations, Senator Hall-Long asked them to relay that information to Senate staff.

BEHAVIORAL HEALTH COMMISSION
Secretary Rita Landgraf noted that she is very happy with the recommendation of the Behavioral Health Commission.

Dr. Michael Barbieri addressed the functions set forth for the Behavioral Health Commission. Secretary Landgraf noted that the critical role of the Behavioral Health Commission should be an oversight and monitoring role. This way, the commission can ensure that the state's behavioral and mental health system will not resort backwards. Therefore, Dr. Barbieri advised that the functions of the commission should also include an oversight and monitoring role in addition to developing a "strategic roadmap" to ensure the quality of services delivered.

Jim Lafferty added that the commission should be given the opportunity to take the recommendations that this Task Force makes, and develop a timeline incorporating feasibility and execution plans.

HALFWAY HOUSE FOR KIDS
Dr. Marc Richman noted that a traditional "halfway house" is used for substance abuse disorder. However, the recommendation that comes out of the Task Force should focus on the transition and reintegration of a child into the community. Therefore, Dr. Richman suggested changing the title from "Halfway House" to "Transition Program" or "Reintegration Program." Susan Cycyk seconded Dr. Richman's comments. Senator Hall-Long noted that a "halfway house" could be used as an example for the program that they recommend.

Jim Lafferty noted that Dr. Gerard Gallucci is a member of the American Psychiatric Association (APA) and heads a committee who presented an innovation award to Brookline, Massachusetts because of the transitional program that they have developed for kids, which is very similar to what the Task Force would like to accomplish with this program.

Secretary Landgraf referenced the gaps in levels of care for substance abuse disorder; there are more services for adults than there are for children. Additionally, there are "target markets" where some target markets are more vulnerable than others. For instance, there are individuals who are coming out of Level V incarceration, and there needs to be appropriate levels of care to accommodate their needs at the most vulnerable time in their life.

*Appendix L Continued:*
Some individuals will need a different level of care with varying intensities depending on where that individual is transitioning from.

WORKFORCE

Recruitment and Retention of the Workforce
In this section, Ms. Cycyk referenced a recommendation: "Focus on development and retention of board certified psychiatrists in Delaware." She wanted to add "psychologists, social workers, and licensed mental health practitioners to this recommendation."

Ms. Cycyk also addressed another recommendation: "Improve practices to keep fellows in Delaware after they complete their fellowship." She wanted to expand this recommendation to: "Expand the behavioral health workforce via improved practices including but not limited to: Improve practices to keep fellows in Delaware after they complete their fellowship, strengthen internship and other opportunities."

Secretary Landgraf and Ms. Cycyk would like efforts and recommendations within the "Workforce" section in the Task Force report to coordinate with the work that the Delaware Center for Health Innovation's (DCHI) Workforce Committee is doing.

Workforce & Telepsychiatry
Secretary Landgraf asked to change the terminology used in the recommendation. Instead of referencing "telepshchiatry," the Task Force should address "telehealth," which incorporates other disciplines, not just medicine oriented. Additionally, DHSS's (Department of Health and Social Services) Office of the Secretary has a staff person who is responsible for supporting telehealth initiatives.

Ms. Cycyk recommended that the Task Force should look into the Stevenson House Detention Center's telepshychiatry challenges and progress prior to recommending it. Secretary Landgraf noted that the Behavioral Health Commission would also be a good source to monitor telehealth efforts.

Workforce Workgroup
Dr. Richman and Dr. Barbieri stated that this workgroup should study more than just residency programs. The workgroup should also study the APN (Advanced Practice Nurses) program, social workers, behavioral health, and psychology in conjunction with DCHI's efforts.

Workforce & Education
Ms. Cycyk addressed the recommendation to put wellness centers in middle schools. She noted that if the State cannot find money to implement this recommendation in the short-term, an alternative approach would be to assure health for children in schools.

Senator Hall-Long noted that she was at Eisenberg Elementary School earlier in the day, who is working with limited money from the Department of Education (DOE) to incorporate a Wellness Center, which is a crucial and impressive addition to their school. The school is in a high-risk community, and their Wellness Center will be open to families in addition to their kids. The Wellness Center will also incorporate mental health and behavioral health treatment and comprehensive care.

Mr. Lafferty referenced the recommendation to incorporate behavioral health professionals in the schools. He added that although middle schools have been doing a great job, the Task Force should also focus on early intervention in the State's elementary schools. Dr. Barbieri added that the Task Force should incorporate public-private partnerships to develop Wellness Centers in the State's schools.

CORRECTIONS

Corrections & Ongoing Treatment
Dr. Richman referenced the recommendation in the "Ongoing Treatment" section, which states that "released inmates do not have access to continued care in their community because their insurance will not cover it." However, Dr. Richman noted that "do not" should be changed to "needs more." Secretary Landgraf added that there are certain target populations who are vulnerable during this point in their lifespan, so the transition also needs to be seamless.

Uniform Standards Across School Districts
Dr. Richman advised that this recommendation gets moved to a different section of the report, like under the "Education" section.

Increased Access to Special Needs Unit in DOC
Dr. Richman recommended changing "Special Needs Unit" to "Special Needs Units." Because the State needs more specialized units for individuals with behavioral health needs.

Beds in Correctional Facilities
Dr. Richman asked to change "Beds in Correctional Facilities" to "Treatment in Correctional Facilities." Additionally, for the recommendation under this section, instead of writing behavioral and mental health treatment, just writing behavioral health treatment would suffice.

SUICIDE & STIGMA

Education
Mr. Lafferty recommended changing the language in the first recommendation under the "Education" section. Instead of writing "develop training programs," the recommendation should say "utilize existing training programs." (Lifelines, Adolescent Depression and Awareness Program, ACIST, Safetalk, and the teacher education program.) Secretary Landgraf noted that there may be an oversight role in ensuring that these programs are staying effective. Senator Hall-Long noted that if the commission is created, oversight of these programs could be a part of their role.

Senator Blevins advised changing the language in the second recommendation listed under the "Education" section. She noted that the recommendation should be changed to "encourage a process for schools to provide education to legal guardians about suicide." Erin Booker recommended broadening this recommendation to more than just schools, but for any individual who works with kids so they can identify and help children at risk.

Senator Hall-Long noted that the fourth and fifth recommendations under the "Education" section could be integrated into one recommendation as both involve developing a website and an application. Secretary Landgraf also noted, that instead of developing a whole new "Help is Here" website for kids, as the fourth recommendation states, the Task Force should recommend building onto the "Help is Here" website to add a section targeting kids.

Data & Research
Senator Hall-Long advised that the two recommendations under this section could be combined into one.

Treatment
Ms. Cycyk noted that she supports the first recommendation under the "Treatment" section. Last time DPBHS (Division of Prevention and Behavioral Health Services) tried to find a bid for a residential treatment center, they

were seeking someone to bid on a substance abuse residential treatment center for kids and nobody did. Additionally, Ms. Cycyk advised changing the language in this recommendation by taking out "Delaware should" and "state run."

Mr. Lafferty commented on the second recommendation under the "Treatment" section, because this was something that he recommended. He noted that his comments were to look at the treatment that kids are currently receiving, and seeing if there is a need to prolong their typical partial hospital program for an adolescent, which is two weeks. He continued to say, that there seems to be a pattern where kids are in the partial hospital program for two-weeks, and after two more weeks out, they are back into the program because their original treatment was not long enough. Mr. Lafferty noted that if the State's children require longer-term care, the State should make sure that type of care is available.

Ms. Booker noted that a large barrier blocking a long-term partial hospital program for children is the insurance companies. The average length of stay for an insurance company to cover a child's partial hospital treatment is two-weeks. Ms. Booker noted that it is not always the provider who is controlling that two-week deadline, it is the insurance company.

Secretary Landgraf advised that this recommendation is rewritten and based off of the needs of the child and recognizes that their needs to be more work with the payers relative to the patient's needs.

CO-OCCURRING DISORDERS

Increase Reimbursement Rates

Senator Hall-Long noted that the Task Force cannot mediate reimbursement rates alone, but making recommendations involving reimbursement rates for the commission is crucial

**Public Comment**

Neil Kaye, commented that the substance abuse treatment recommendations should not just encompass youth. The State is also having a big problem with 30-somethings who have become addicted to opiates after being prescribed to them for a legitimate medical reason. He concluded that this is also something that should be included, because it is a growing problem.

Dale McKenzie referenced the Delaware Code, and a term that is used to identify students who need special education services. The current terminology that is used is "emotional disturbance." She stated that she would like this changed to an "emotional disability" or an "emotional behavioral health disability."

Edwina Bell, asked Task Force members to include measurable outcomes in the recommendations. Additionally, Ms. Bell stated that elementary school years are a critical time in a child's life in addition to their middle school years.

Tim Collins announced that there is a play at his church, "Murder, What's Next," which would be a great production for anyone in the mental health field to go and watch. He continued to relate the work that the Task Force is doing to his childhood and stated that working on improving a child's home and upbringing would improve their overall wellbeing.

Senator Hall-Long asked members and the public if they had additional questions or comments. As there were none, the Task Force meeting was brought to a close at 3:58 p.m.