GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS (GACEC)
GENERAL MEMBERSHIP MEETING
7:00PM JUNE 17, 2025
VIRTUAL MEETING

MEMBERS PRESENT: Al Cavalier, Nancy Cordrey, Bill Doolittle, Ann Fisher, Tika Hartsock, Kristina Horton, Thomas Keeton, Molly Merrill, Beth Mineo, Maria Olivere, Trenee Parker, Erika Powell, Jennifer Pulcinella, Marissa Band attended on behalf of Stefanie Ramirez, and Brenné Shepperson.

OTHERS PRESENT: Craig Clizbe, Matthew Clizbe, Harley Doolittle, Mindi Failing, Susan Goekler, Laura Hattier, Lillian McCuen, Bradford Melvin, Ozetta Posey, Krista Register, Kathi Stephan/DDOE, Peg Stewart (ASL interpreter), Jeri Turner, and Mary Whitfield/DDOE.

STAFF PRESENT: Kathie Cherry/Office Manager, Lacie Spence/Administrative Coordinator and Theresa Moore/Administrative Support Specialist.

MEMBERS ABSENT: Matt Denn and Erik Warner (Resignations pending), Cory Gilden (requested leave of absence), Karen Eller, Jessica Mensack, and Meedra Surratte

ADMINISTRATIVE MOTIONS: Ann Fisher called the meeting to order at 7:01 pm. There was a quorum of members present. The motion to approve the May agenda was made by Bill Doolittle and Molly Merrill seconded the motion. The motion passed unanimously. Molly Merrill made a motion to accept the May minutes with changes suggested by Al Cavalier. Erika Powell seconded the motion. The motion to accept the amended minutes passed. Al Cavalier made a motion to send a letter renewing the endorsement of the funding for Delaware State Parks. Council would also like to see a feedback mechanism that includes people with disabilities. The motion passed with Trenee Parker abstaining. Bill Doolittle made a motion to approve the May Financial report. The motion was seconded by Maria Olivere. The motion passed.

PUBLIC COMMENTS: There were no public comments tonight.

COMMITTEE REPORTS:

POLICY AND LAW COMMITTEE: The Committee met tonight and reviewed the Legal Memo dated June 6th. The Legal Memo can be found at the end of the minutes. The Policy and Law Committee made a motion to endorse all of the recommendations in the Disability Rights Delaware (DRD) Legal Memo and to endorse an additional recommendation by DRD to include

SB161 the provision of reasonable accommodations to clients with sensory impairments, clients with communication impairments, and clients who primarily speak a language other than English. The Council unanimously approved the motion, with one abstention by Trenee Parker.

You can find a copy of Council's letters in reference to this legal memo at the following links on the GACEC website:

- Regulatory letters, visit https://gacec.delaware.gov/regulatory-letters/.
- Legislative letters, visit https://gacec.delaware.gov/legislative-letters/.

INFANT AND EARLY CHILDHOOD COMMITTEE: The Committee discussed the following items. The development of the Committee's *Dear Colleague* letter to address the issue of suspension and expulsion in early childhood care and education settings has been completed. The Committee plans to fine tune the letter at a future date. The Interagency Resource Management Committee (IRMC) bill is still in committee and no meetings are set for the upcoming year. Quarterly meetings are expected. The new Director of the Office of Early Childhood Intervention (OECI), Amber Shelton, is settling in and moving in a positive direction. She is also on the Interagency Coordinating Council (ICC). The ICC is working on increasing membership like most councils.

CHILDREN AND YOUTH COMMITTEE: The Children and Youth Committee requested Council to send a letter to the sponsors of Senate Joint Resolution 11 for consideration to have a member of the GACEC and or a representative from Community Legal Aid Society, Inc (CLASI) be added to the task force. The motion passed with Trenee Parker abstaining. The Committee discussed a couple of the due process cases they had selected from the website to review. They discussed things that were lacking within the cases. Specifically, around follow up with the families and recommendations needed to better support families. They would like staff to set up a meeting with Children and Youth and Maria Locuniak to discuss the due process review process.

ADULT AND TRANSITION SERVICES COMMITTEE: The Committee discussed their goals and making sure they were measurable, attainable, etc. One of the things that they talked about looking at this year's goals was breaking up their goals a little bit differently and trying to narrow the focus. They appreciated having Kathi Stephan in their meeting and she will also get information for the Committee. They plan to put together some things and share them out among their committee as to how they can narrow the focus even more, but still include the things that they want to focus on. When they get to the retreat, they want to have a good starting point for next year.

CHAIR REPORT: Ann announced the guests and those Council members who were absent. Ann reminded Council members of the new retreat format for this year. The first session will be in person on August 19th from 6 to 9pm. The second session will be virtual on September 16th from 6 to 9pm.

ADJOURNMENT: Bill Doolittle made a motion that was seconded by Jen Pulcinella to adjourn the meeting. The motion passed and Ann adjourned the meeting at 7:40 pm.

POLICY AND LAW MEMO

Date: 6/6/2025

Re: June 2025 Policy and Law Memo

I. Proposed regulations

- **Proposed DHSS, DVI Regulation on 16 DE Admin. Code 9101, 28 DE Reg. 854 (6/01/25).**

The Department of Health and Social Services ("DHSS"), Division for the Visually Impaired ("DVI") is proposing revisions to the rules and regulations of statewide contracts to support employment for individuals with disabilities (16 **DE Admin. Code** 9101). The proposed amendments are technical changes to bring the regulation into compliance with the *Delaware Administrative Code Style Manual*.

Recommendation: **this rulemaking requires no action by Council.**

- **Proposed DDOE Regulation on 14 DE Admin. Code 1519, 28 DE Reg. 837 (6/01/25).**

DDOE's Proposed changes to 14 Del. Admin. C. 1519 do not apply to any of the standard certificates required for educators of students with disabilities (1570-75), those involved in evaluating suspected students with disabilities, or those providing direct special education and related services to students with disabilities. Therefore, Council may wish to refrain from providing public comment.

Recommendation: **this rulemaking requires no action by Council.**

- **PROPOSED Department of Safety and Homeland Security (DSHS) POLICE OFFICER STANDARDS AND TRAINING COMMISSION, 1 DE Admin. Code 801, 29 DE Reg. 861 (06/01/25)**

The Police Officer Standards and Training Commission (POST), formerly the Council on Police Training (COPT), pursuant to 11 Del. C. 8404 (a)(14), proposes to amend 801 Regulations of the Delaware Council on Police Training. The proposed amendments, which were voted on during a public meeting of the COPT on April 6, 2025, seek to modify requirements regarding the number of qualification shoots for less lethal weapons and the number of rounds to be used for shotgun qualifications. The amendments also replace references to COPT with POST.

While the proposed changes in these amendments do not necessarily negatively impact Delawareans with disabilities, Councils may wish to consider using this opportunity to suggest DSHS revisit disability related trainings.

Despite making up only 20% of the population, it is estimated that people with disabilities make up between 30 to 50% of individuals subject to police use of force.[1] Additionally, people with

[1] https://www.ohchr.org/sites/default/files/Documents/Issues/Racism/RES_43_1/NGOsAndOthers/disability-rights-ohio.pdf

psychiatric disabilities are sixteen (16) times more likely to be killed by law enforcement during a police encounter.[2] Currently, section 15.17 mandates an eight (8) hour training on Interactions with Persons with Disabilities. According to the regulation, the purpose of this course is to identify behavioral factors which the officer may encounter, to discuss the influence of group behavior or individual behavior, and to emphasize the importance of understanding unusual behaviors in order to handle that behavior most effectively. It also includes a review of the 24-hour commitment procedures.[3]

It is commendable that DSHS have adopted this crucial training to enable police officers to identify the signs that indicate a person may have a behavioral health disability, or be in a mental health crisis, but it is worrying that this training focuses entirely on the ***behavior*** of persons with disabilities. Not every disability affects behavior. Additionally, not every disability is readily visible. This is particularly true of hearing and visual disabilities, many medical disabilities, as well as cognitive disabilities.

Upon review of the regulation, there is no training on compliance with the Americans with Disabilities Act of 1990 ("ADA"), Section 504 of the Rehabilitation Act ("504"), or the Delaware Equal Accommodations Law ("DEAL. These are fundamental laws that protect people with disabilities from discrimination when attempting to access public accommodations, employment, education, and housing, and require state and local governments to provide effective communication to people with disabilities. These statutes require individuals with disabilities to be offered reasonable accommodations or modifications to promote equitable treatment. The ADA applies to nearly every action a police officer may take, including receiving citizen complaints; interrogating witnesses; arresting, booking, and holding suspects; operating telephone (9-1-1) emergency centers; providing emergency medical services; and enforcing laws.[4]

Even when a police officer can identify a person with a disability, this regulation does not address training to prevent discrimination based on that disability. For instance, a police officer might be able to identify that a person is deaf from their speech, but that police officer should also know how to utilize interpretation services to communicate with that person effectively. Or that an individual with an intellectual disability may need additional time to process and comprehend an officer's instructions. Council should consider recommending DSHS add training that informs police officers on when and how to offer effective communications, as well as reasonable accommodations and modifications when interacting with the public.

Additional training is necessary to prevent future incidents of police misconduct against people with disabilities. Police misconduct creates distrust in law enforcement and makes it much harder

[2] https://www.delawareonline.com/videos/news/local/2022/08/03/advocates-disabled-people-more-prone-police-violence/10227558002/
[3] https://regulations.delaware.gov/register/june2025/proposed/28%20DE%20Reg%20861%2006-01-25.htm
[4] https://archive.ada.gov/q&a_law.htm

for police to do their jobs effectively. It is difficult to quantify the frequency of police force or discrimination used against civilians because there is no legal requirement for local, state or federal law enforcement agencies to aggregate or collect the number, type, and result of violent incidents that occur between police officers and disabled people.[5] However, there have been several high-profile instances of this conduct in Delaware in recent years.

One such example occurred in 2022, New Castle County Police responded to a 9-1-1 call made by a thirty-seven (37) year old man with an intellectual disability. When police discovered that the man was in violation of a protective order, they approached him on the street and ordered immediate compliance. When the man hesitated to comply with the officer's orders, an officer leg-swept him to the ground, pinned him down, and broke the man's arm.[6] Had de-escalation tactics been used – or even just slower, calmer communication to facilitate comprehension - prior to resorting immediately to use of force, this incident, and the negative press attention associated with it, could have been avoided.

In January of 2025, a 24-year-old man called 9-1-1 and told operators he had a knife and was suicidal. The University of Delaware police responded to the scene. When the first officer arrived at the scene, she directed the man to remain in his vehicle. When he did not immediately comply and began to attempt to exit the vehicle, the officer drew her pistol and pointed it at the man, giving commands to put the knife down as she walked backwards. The officer then fired several shots at the man, hitting him several times.[7] The man survived.[8] This incident is particularly worrying because the officer immediately used deadly force on a man going through a mental health crisis. No de-escalation tactics were used prior to the officer's shooting of the man nor did the officer attempt to use less-lethal weapons to gain compliance. The only threats that the man had made to 9-1-1 operators were against himself. This case highlights the need for ongoing and refresher training for skills like de-escalation.

Or consider the Oklahoma case of Pearl Pearson, a 64 year-old deaf man, who was attempting to show police a placard saying "I am deaf" when they pulled him from his car, assaulted him, dislocating his shoulder and swelling his eyes. Immediately following Pearson's assault, the

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[5] https://rudermanfoundation.org/wp-content/uploads/2017/08/MediaStudy-PoliceDisability_final-final.pdf

[6] https://www.delawareonline.com/story/news/2022/08/16/delaware-arrest-of-man-with-disability-prompts-questions-over-training/9961627002/

[7] https://www.delawareonline.com/story/news/crime/2025/01/10/university-of-delaware-police-involved-shooting-what-we-know/77542946007/

[8] Brandon Roberts was a similar case which resulted in the death of Mr. Roberts, a man diagnosed with bipolar disorder, depression, and post-traumatic stress disorder ("PTSD") called 9-1-1 while he was experiencing a psychotic episode. Milford police responded to the call, and banged on the door, demanding Roberts come to the door. Roberts approached the door, holding a knife at his side. When Roberts opened the door, police demanded he put his hands up, and then immediately opened fire on him, fatally wounding him in front of his pregnant fiancée.[8] Police officers made no attempt to deescalate the situation, even though Roberts' fiancée had told 9-1-1 operators that Roberts hadn't taken his medication and was experiencing a psychotic episode. Had Milford police not immediately resorted to the use of deadly force; Roberts would still be alive today. See https://www.delawareonline.com/story/news/2020/02/11/lawyer-milford-man-killed-officers-say-police-need-more-training-deal-disabled/4722042002/

officers' dashboard camera reveals officers cursing after they run a quick check of his license and find out that he is deaf. [9]

While there are many accounts of people with disabilities who have negative experiences with Delaware police, the procedures to request accommodations / modifications, or to file a 504/ADA grievance are difficult to find. Anecdotally, officers responding to calls may be unaware of the process based on a recent experience DRD staff had after viewing the Delaware State Police (DSP) force's website we could not identify the ADA/504 officer; DRD called DSP and were told to call the Attorney General's office or the county police (which would not be appropriate as it was not a county police case). It took DRD contacting the Statewide ADA Coordinator to identify the appropriate DSP ADA coordinator's contact information. This is absolutely not acceptable and highlights the lack of training in general disability anti-discrimination requirements. Delaware's police forces have an important job to do but part of keeping all Delawareans safe is ensuring that they do so in a way that does not place people with disabilities in jeopardy of harm or discrimination.

Recommendation: **Council may wish to recommend DSHS:**

1) **add requirements around ADA and 504 compliance training to prevent police discrimination and unnecessary force against people with disabilities; and**
2) **add additional recurring "refresher" training focused on accessibility and de-escalation.**

II. Bills

- **SB 161 – Oversight of Behavioral Health Providers**

SB 161 was introduced on May 21, 2025 and assigned to the Senate Health & Human Services Committee. As of June 15, 2025 it remains in committee. SB 161 seeks to create a licensing scheme for behavioral health providers. The bill also contains additional provisions relating to client rights, provider duties, and the role of the Division of Substance Abuse & Mental Health (DSAMH). The provisions of the bill would replace existing statutes at 16 Del. C. §§ 2201-2232 (Substance Abuse Treatment Act) and 16 Del. C. §§ 5181-5186 (Community Mental Health Treatment Act) and strike those statutes from the Code.

The bill appears intended to target entities providing mental health or substance abuse treatment services through contracts with DSAMH. Currently many of these providers are not required to be licensed by the State, though many have private accreditation from entities such as the Commission of Accredited Rehabilitation Facilities (CARF) or the Joint Commission. **The exceptions are mental health group homes, which are considered long-term care facilities under Delaware law (see 16 Del. C. § 1102(5)) and are already licensed by the Division of Health Care Quality (DCHQ), as well as some substance abuse providers, which are currently governed by the Substance Abuse Treatment Act and accompanying regulations.**

[9] https://www.huffpost.com/entry/pearl-pearson-police-brutality_n_4603445

The bill would require behavioral health providers serving adults to be licensed and would give DSAMH the authority to issue such licenses (although this authority is already contemplated under existing law at 29 Del. C. § 7908(c)). The bill also states DSAMH can issue regulations to further implement these requirements. The licensing requirements would not apply to providers only serving children. Providers in private practice or "a licensed professional providing treatment services incidental to the professional's regular practice" would also be exempt from licensing requirements. DSAMH would also have the discretion to waive the requirements in other circumstances, including but not limited to when a provider organization is otherwise licensed by the State or when an entity is providing support services but not clinical services such as peer support or recovery housing. **The bill would impose criminal penalties for providing services covered by these provisions without appropriate licensure. The bill contemplates a fee structure being imposed for license issuance and renewal.**

The bill would also give DSAMH the authority to conduct audits. DSAMH would also have the authority to impose various penalties in response to noncompliance, including civil money penalties, monitoring to be conducted at the expense of the provider agency, suspension of admission of new clients, or suspension or revocation of a license. These penalties are comparable to those that may be imposed by DCHQ on entities licensed by that agency. Additionally, the Department of Health & Social Services would have the authority to issue an emergency order to transfer management of a program to another entity in circumstances where "the Department reasonably believes that a provider organization is acting in a manner that creates an imminent risk of substantial harm to the organization's clients." **The bill also requires providers to notify DSAMH about any anticipated disruptions in services or if the organization anticipates becoming insolvent. The bill establishes procedures for the imposition of disciplinary actions including the right of a provider agency to receive written notice and a process through which providers can request a hearing to appeal disciplinary action.**

SB 161 also enumerates specific rights of clients receiving behavioral health services and contemplates that clients would be informed of these rights in writing when services are initiated. It is not entirely clear whether or how these provisions apply to providers that would not be required to be licensed by DSAMH (i.e. those providing "support" services but not clinical services). Notably the enumerated rights specifically include the right to participate in elections if eligible, which does not appear in the existing statutes this bill seeks to replace, and is only obliquely referenced in the resident rights provisions of the long-term care statute. **As people with disabilities frequently encounter obstacles in accessing the electoral process the Council may specifically wish to state their support for this language.**

However, there are some omissions in this list of enumerated rights. First, **there is no mention or acknowledgement of a client having a choice in which level of care they receive and which provider they receive services from; although this may be implied from some of the other language about treatment decisions, it is not explicitly stated.** While in some circumstances choice may be limited from a practical standpoint due to the small number of

State-contracted providers, choice is an important element of client autonomy. Additionally, **there is no discussion about circumstances in which services can be terminated or transferred to a different provider against a client's wishes or what rights a client has in the discharge process** (although there are references to discharge plans as part of treatment planning). While to some extent these rights would be governed by applicable federal Medicaid law and regulations, or by other provisions in the Code for residents of mental health group homes, **it would be beneficial for clients to be informed about these rights and procedures on the front end.**

SB 161 clearly acknowledges the right of clients to present complaints or grievances and states that grievances or complaints should be responded to in a "fair, timely, and impartial manner," but it does not provide a lot of specificity about the type of response the individual is entitled to receive. While some of this could be further detailed in regulation or DSAMH policy, it is important that clients receive a substantive response to a grievance, preferably in writing, that clearly details whether the entity reviewing the grievance was able to substantiate the concern or agrees that an established right has been violated, as well as any corrective action that will be instituted to address an identified violation. Ideally there would also be the opportunity to request further review if the client does not agree with the initial outcome of the grievance. **DSAMH may wish to look at the Rights Complaint process utilized by the Division of Developmental Disability Services (DDDS) as one example of a more formalized process for addressing complaints raised by clients or their representatives at the Division level.**

Additionally, the bill contains broad provisions about the circumstances in which the enumerated rights can be subject to limitation so long as the reasons are documented; these include but are not limited to "during an emergency" and "whenever a client is in the custody of a peace officer and the officer determines the limitation is necessary to protect the client's or another person's health, well-being, or safety." Given the array of rights contemplated here, including communication-related rights, the right to assert grievances, assistance in understanding rights, and access to appropriate physical health care, **these provisions seem overly broad and potentially problematic.** It is also worth noting that a peace officer may not have any clinical training or specific knowledge of the client's behavioral or other health conditions that may be necessary to assess whether such a limitation is necessary or safe.

The bill also enumerates specific duties of providers, though most of the listed duties appear to be essentially restatements of the enumerated client rights. **The listed provider duties include but are communicating in a client's preferred language, providing written information about client rights to individuals upon admission, establishing a procedure for clients to assert grievances, and providing clients with assistance in exercising their right to vote. The bill contains additional provisions related to the maintenance and disclosure of records by licensed providers,** including under what circumstances disclosure of records could be limited to prevent anticipated harm that may be caused by disclosure. Additionally, the bill states that the Attorney General or protection and advocacy (P&A) system can seek to enforce

the client rights, provider duties and records disclosure provisions in Chancery Court. **The bill does not give a client or any other interested individual the right to seek enforcement by legal action; they would only have the option to report these concerns to one of the entities given standing to enforce the statute in Court. The Council may wish to suggest that this section be expanded so that impacted individuals have more options to enforce their rights.**

The bill would also codify procedures for incident reporting by providers and investigations conducted by DSAMH. DSAMH would have the authority to promulgate regulations to implement these requirements. DSAMH would also be required to develop an online system for "submitting, collecting, and retaining" incident reports. While creation of such a system would likely require significant resources, it would greatly assist DSAMH in monitoring reports and analyzing trends in data and would be in line with systems already used by some other similarly situated State agencies such as DDDS. The bill would also create penalties for failure to report certain kinds of incidents and protections for individuals reporting concerns to DSAMH in good faith. It would also require DSAMH to report substantiated reports of abuse or neglect to outside entities as applicable, potentially including law enforcement, other professional licensing bodies or agencies, and the Adult Abuse Registry.

The bill also would modify the descriptions of DSAMH's role that are currently found at 29 Del. C. § 7908. While the new language for the most part appears substantially similar to the existing statutory language, although the new language would include specific references to issuing licenses as well as receiving and investigating complaints, grievances and incident reports. The bill would also add language to 16 Del. C. § 1212 making clear that providers may be required to disclose otherwise protected health information to DSAMH without individual consent when DSAMH is conducting certain oversight activities.

Meaningful oversight and accountability for providers are essential to protecting the rights and safety of individuals with mental illness and substance use disorders receiving state-funded services. The quality of services provided to people with behavioral health conditions in Delaware has been an ongoing concern for many years. The crisis created by the myriad legal troubles confronting Connections CSP a few years ago is perhaps the most notable example highlighting why increased oversight of these providers by the State is necessary. The Councils should support the broader effort to ensure the safety and quality of these services, **however there are a few more general areas of concern about the bill as written in addition to the specific concerns noted above.**

First, this bill does not acknowledge that mental health group homes are separately licensed as long-term care facilities by the Division of Health Care Quality (DHCQ) and subject to both statutory provisions under Title 16, Chapter 11 of the Delaware Code as well as regulations issued by DHCQ. The bill does not provide any further guidance as to how these licensing schemes differ or potentially overlap, although it contemplates existing State licensure as one circumstance in which DSAMH would have the discretion to waive its licensing requirements. The Code also already contains a list of enumerated rights of residents of long-term care facilities, including mental health group homes, found at 16 Del. C. § 1121. Compared with the rights that would be established by SB 161, there are more

specific provisions in the long-term care statute related to individual privacy and a client's rights with respect to their assigned room (including notice of room or roommate changes) as well as limitations on transfer and discharge. The long-term statute also explicitly states that a resident has the right to request an organizational chart that contains includes the chain of command for the purpose of asserting grievances (SB 161 says people have the right to know the names of individuals involved in treatment but doesn't go beyond that). On the flip side, SB 161 has stronger language than what is contained in 16 Del. C. § 1121 about providers potentially helping clients with accessing the electoral process. **While SB 161 would not change the rights already codified at 16 Del C. § 1121, it may create confusion for clients residing in mental health group homes as well as provider agencies serving clients in these group homes to have two separate lists of enumerated rights with different schemes for enforcement.**

Another concern is that the bill specifies in numerous places that records relating to many of the proposed statutory requirements, including provider audits, incident reports, and investigations, would not be considered "public records" under the Delaware Freedom of Information Act (29 Del. C. § 100, et seq). Notably there is no indication that written notice of disciplinary actions or records from disciplinary hearings would not be considered public records, meaning more information might be available to the public about these actions, especially if a provider chooses to appeal the imposition of discipline (although that could perhaps discourage a provider from appealing). While internal investigations of abuse or neglect would likely be considered peer review processes and therefore privileged, it is concerning that the public, including clients receiving services in this system or their representatives, might be prevented from accessing other information about known problems with provider agencies, especially given the potential vulnerability of the client population served by these agencies.

By contrast, many records pertaining to the oversight of healthcare facilities licensed by DCHQ, including survey reports and corrective action plans, are available to the public and are in some cases even published on DCHQ's website (references to specific resident medical records are de-identified by DHCQ and sensitive or non-public information may redacted). Along these lines, the long-term care statute specifically states that records maintained of investigations conducted by the DHCQ of reported abuse, neglect, mistreatment, financial exploitation or medication diversion are not public records, however there is no clear indication that records of incidents or possible abuse or neglect reported to DCHQ would not be considered public records. The concerns about these provisions in SB 161 might be mitigated if DSAMH were to make clearer how transparency to clients and the general public about provider performance would be assured. It is reasonable to expect that to the extent clients or their representatives are given a choice as to which provider the client receives services from, information about the assessed quality of services or noted safety concerns might influence that choice. Additionally, it is important to note that there are provisions in the Code that create an Adult Mental Health Peer Review Commission (see 16 Del. C. § 5194) to review this type of quality assurance data and make recommendations, however that Commission was never actually formed and has never been active, so **additional external oversight has been lacking since the conclusion of the State's settlement U.S. Department of Justice related to the State's mental health system in 2016.**

While it clear that the impetus for this bill was DSAMH's desire to impose more oversight on the services it has the authority to provide and contract for, the fact that **this bill only applies to providers of adult services also creates some questions about the oversight of child mental health services and why children receiving state-funded services and their parents or guardians should not have the same or comparable rights and options for enforcement of those rights.** There could also be unintended consequences to this legislation in that provider organizations may be encouraged to start providing services solely to children if DSAMH's licensing requirements are perceived by the provider community to be too onerous.

Finally, **the bill acknowledges the role of the protection and advocacy (P&A) system (Community Legal Aid Society, Inc. as presently designated by the Governor), however at § 5667 of the proposed statutory language, it only explicitly acknowledge the P&A's access authority under the Protection and Advocacy for Individuals with Mental Illness (PAIMI) statute (codified at 42 U.S.C. 10801, et seq). References to the other P&A statutes should also be included in this section to address circumstances in which an individual with a substance abuse disorder diagnosis might otherwise be eligible for assistance from the P&A but does not have a diagnosis that meets eligibility requirements under the PAIMI statute. Additionally, the Councils may wish to suggest that the bill incorporate additional provisions related to the P&A to provide more consistency with other chapters of the Delaware Code. For example, 16 Del. C. § 1134(g) establishes certain protections for individuals making a report to the P&A or otherwise cooperating with the P&A's investigation of a report in the long-term care facility context. It would be beneficial for such protections to be in place across settings to encourage anyone who is aware of potential abuse or neglect of a person with a disability to report this information. Additionally, inpatient mental health facilities are required to report certain types of critical incidents to the P&A in addition to DHSS. See 16 Del. C. § 5162, et seq. A similar requirement for community services would encourage more oversight, particularly as external review of these services has been lacking (see discussion above about the Adult Mental Health Peer Review Commission).**

Recommendations: **Council may wish to generally support the goal of the bill to create better oversight and make patient rights clearer, such as access to the electoral process, but recommend the bill sponsor amend the bill, or introduce a companion bill to address the below concerns.**

1) **Clarify if the bill of rights provisions apply to providers that would not be required to be licensed by DSAMH (i.e. those providing "support" services but not clinical services).**
2) **Recommend an explicit acknowledgement of a client having a choice in which level of care they receive and which provider they receive services from.**
3) **The bill should address circumstances in which services can be terminated or transferred to a different provider against a client's wishes or what rights a client has in the discharge process, it would be beneficial for clients to be informed about these rights and procedures on the front end.**

4) **The bill should provide more specificity about the type of response the individual is entitled to receive when they file complaints and grievances. DSAMH may wish to look at the Rights Complaint process utilized by the Division of Developmental Disability Services (DDDS) as one example of a more formalized process for addressing complaints raised by clients or their representatives at the Division level.**
5) **The bill contains broad provisions about the circumstances in which the enumerated rights can be subject to limitation so long as the reasons are documented; these include but are not limited to "during an emergency" and "whenever a client is in the custody of a peace officer and the officer determines the limitation is necessary to protect the client's or another person's health, well-being, or safety." Given the array of rights contemplated here, including communication-related rights, the right to assert grievances, assistance in understanding rights, and access to appropriate physical health care, these provisions seem overly broad and potentially problematic and Councils may wish to recommend they be more narrowly tailored.**
6) **The bill does not give a client or any other interested individual the right to seek enforcement by legal action; they would only have the option to report these concerns to one of the entities given standing to enforce the statute in Court. The Councils may wish to suggest that this section be expanded so that impacted individuals have more options to enforce their rights.**
7) **This bill does not acknowledge that mental health group homes are separately licensed as long-term care facilities by the Division of Health Care Quality (DHCQ) and subject to both statutory provisions under Title 16, Chapter 11 of the Delaware Code as well as regulations issued by DHCQ. The bill does not provide any further guidance as to how these licensing schemes differ or potentially overlap, although it contemplates existing State licensure as one circumstance in which DSAMH would have the discretion to waive its licensing requirements. The Code also already contains a list of enumerated rights of residents of long-term care facilities, including mental health group homes, found at 16 Del. C. § 1121. While SB 161 would not change the rights already codified at 16 Del C. § 1121, it may create confusion for clients residing in mental health group homes as well as provider agencies serving clients in these group homes to have two separate lists of enumerated rights with different schemes for enforcement.**
8) **Another concern is that the bill specifies in numerous places that records relating to many of the proposed statutory requirements, including provider audits, incident reports, and investigations, would not be considered "public records" under the Delaware Freedom of Information Act (29 Del. C. § 100, et seq). By contrast, many records pertaining to the oversight of healthcare facilities licensed by DCHQ, including survey reports and corrective action plans, are available to the public and are in some cases even published on DCHQ's website (references to specific resident medical records are de-identified by DHCQ and sensitive or non-public information may redacted). Councils may wish to recommend that the bill be amended to be consistent with DHCQ's practice, and allow such survey reports and corrective plans to be public.**

9) **This bill only applies to providers of adult services also creates some questions about the oversight of child mental health services and why children receiving state-funded services and their parents or guardians should not have the same or comparable rights and options for enforcement of those rights. Councils may wish to recommend a similar bill of rights be developed for children.**
10) **The bill acknowledges the role of the protection and advocacy (P&A) system (Community Legal Aid Society, Inc. as presently designated by the Governor), however, it only explicitly acknowledge the P&A's access authority under the Protection and Advocacy for Individuals with Mental Illness (PAIMI) statute (codified at 42 U.S.C. 10801, et seq). References to the other P&A statutes should also be included in this section to address circumstances in which an individual with a substance abuse disorder diagnosis might otherwise be eligible for assistance from the P&A but does not have a diagnosis that meets eligibility requirements under the PAIMI statute.**
11) **Council may wish to suggest that the bill incorporate additional provisions related to the P&A to provide more consistency with other chapters of the Delaware Code. For example, 16 Del. C. § 1134(g) establishes certain protections for individuals making a report to the P&A or otherwise cooperating with the P&A's investigation of a report in the long-term care facility context. It would be beneficial for such protections to be in place across settings to encourage anyone who is aware of potential abuse or neglect of a person with a disability to report this information.**
12) **Additionally, inpatient mental health facilities are required to report certain types of critical incidents to the P&A in addition to DHSS. See 16 Del. C. § 5162, et seq. A similar requirement for community services would encourage more oversight, particularly as external review of these services has been lacking (see discussion above about the Adult Mental Health Peer Review Commission).**