A SUCCESSFUL LIFE IN THE COMMUNITY AFTER LONG-TERM INSTITUTIONALIZATION

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This newsletter will describe some of the strategies that have been used by states—particularly as part of settlements resolving claims under the Americans with Disabilities Act's integration mandate and the *Olmstead* decision—to expand the core community services needed to ensure the successful transition of many people with serious mental illness to their own homes and communities after long-term institutionalization.

Strategies to Expand Core Community Services

In virtually every state, the core community services needed to help many people with serious mental illness live successfully in their own homes and communities are in short supply. However, some states have undertaken significant expansions of core community services—most often as part of a settlement agreement requiring such expansions to resolve claims under the Americans with Disabilities Act (ADA) "integration mandate" and the Supreme Court's decision in *Olmstead v. L.C.*

The integration mandate requires states to administer services to people with disabilities in the most integrated setting appropriate to their needs. In some cases, the states effectuating these expansions of community services have a long way to go to address remaining unmet community service needs. Nonetheless, these expansions demonstrate that it is feasible to transition large numbers of individuals with serious mental illness from long-term institutionalization to their own homes. They are also instructive in highlighting strategies that have enabled states to accomplish significant expansions over a relatively short period of time. We focus here on three examples: Delaware, New Jersey, and Illinois.

Delaware, New Jersey, and Illinois all entered into settlement agreements resolving claims that individuals with serious mental illness were unnecessarily segregated in state psychiatric hospitals and private mental health institutions. These settlement agreements included benchmarks to establish a pace for significant expansions of community services to facilitate the transition of people from institutions to community living and divert others from admission to institutions. The Delaware and New Jersey settlements ended in 2016. Illinois' settlement period continues.

The Delaware agreement required expansion of a set of community services statewide, including mobile crisis and other crisis services; assertive community treatment; targeted case management and intensive case management; family and peer support services; supported housing; rehabilitative services including education and substance use disorder services; and supported employment, to serve specific numbers of individuals each year. The settlements in New Jersey and Illinois provided for individuals served in institutional settings (in New Jersey, state psychiatric hospitals, and in Illinois, intermediate-care nursing homes for people with psychiatric disabilities) to be offered the opportunity to transition to supported housing or other community settings with the services they need to succeed. The services developed to comply with those settlements included a similar set of intensive community-based mental health services: supported housing, ACT, peer support services, crisis services, and employment services.

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Delaware

Delaware's settlement agreement, entered with the U.S. Department of Justice, ran from July 15, 2011 to October, 2016. The settlement agreement required the state to expand core community services for people who have received psychiatric inpatient care or emergency room care through public programs, who are homeless, or have a history of arrests or incarcerations. While the settlement did not require closure of hospital beds, the development of this community capacity resulted in a decrease in the average census of the state psychiatric hospital by more than 55%—from 136 in Fiscal Year 2010, when implementation of the settlement started, to 76 when the settlement ended.[i]

In 2015, Delaware regularly diverted over 70 percent of individuals in crisis from acute psychiatric beds into less expensive community crisis services. [ii] Individuals served by Delaware's ACT teams had practically no interaction with the criminal justice system—in State Fiscal Years 2014 and 2015, an average of less than 1 percent of clients of ACT teams were arrested.[iii]

Delaware also achieved a significant expansion in the number of people with serious mental illness receiving employment supports and working, quadrupling the percentage of individuals in the target population who were employed.[iv] Delaware's accomplishment of these things was facilitated by a number of strategies, including among other things, (1) the adoption of a Medicaid demonstration waiver allowing it to maximize federal reimbursement for supported employment services and for services related to securing housing, (2) changes to the state involuntary commitment statute designed to ensure that individuals are first offered an opportunity to be served on a voluntary basis, to improve the timeliness of commitment hearings, and to reduce inappropriate hospitalizations, (3) the adoption of policies to ensure that scattered site supported housing is the default setting offered to individuals and that congregate settings were offered only in rare circumstances, and (4) the hiring of a dedicated state official with the sole responsibility of developing and supporting employment services for people with serious mental illness. Many thousands of individuals with serious mental illness have received needed community services and avoided institutionalization because of the service expansions and policy changes undertaken.

New Jersey

In New Jersey, an agreement between the state and the state protection and advocacy system, Disability Rights New Jersey, was reached in 2009 to develop community services for hundreds of people who remained institutionalized in state psychiatric hospitals even though they had been determined to no longer need hospital care, due to the lack of community alternatives—as well as hundreds more who were at risk of admission to state psychiatric hospitals. New Jersey agreed to provide these individuals with the services they need to live independent, integrated lives in the community.

A primary focus of the New Jersey settlement was access to supported housing. During the settlement period, the state developed 1436 new supported housing units for individuals waiting to be discharged from the state hospitals and for those at risk of admission to these facilities. It successfully discharged 294 of the 297 individuals who had been awaiting discharge for more than one year. In addition, New Jersey significantly reduced the length of time for which individuals remained hospitalized due to the lack of community services, ensuring more prompt discharges.

Among the key steps taken by New Jersey to accomplish these were:

(1) the adoption of a Medicaid state plan amendment that enabled the state to draw down federal reimbursement for services provided in supported housing settings, which were previously paid for in large part by state dollars,

(2) the use of the bidding process for service provider contracts to ensure that community providers committed to serve individuals with particular challenges and explain their plans for doing so, enabling the state to exert more control over the delivery of services it paid for,

(3) the adoption of a new policy and regulation requiring community service providers to accept

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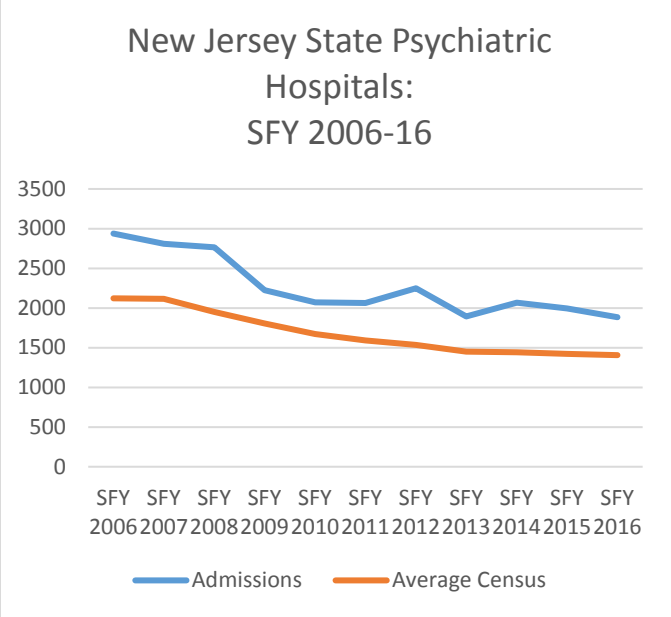
individuals referred by the state, with very limited exceptions,

(4) the imposition of requirements that community service providers begin engaging individuals in the state psychiatric hospitals within a week of admission and coordinate more frequently and effectively with hospital discharge planners, and

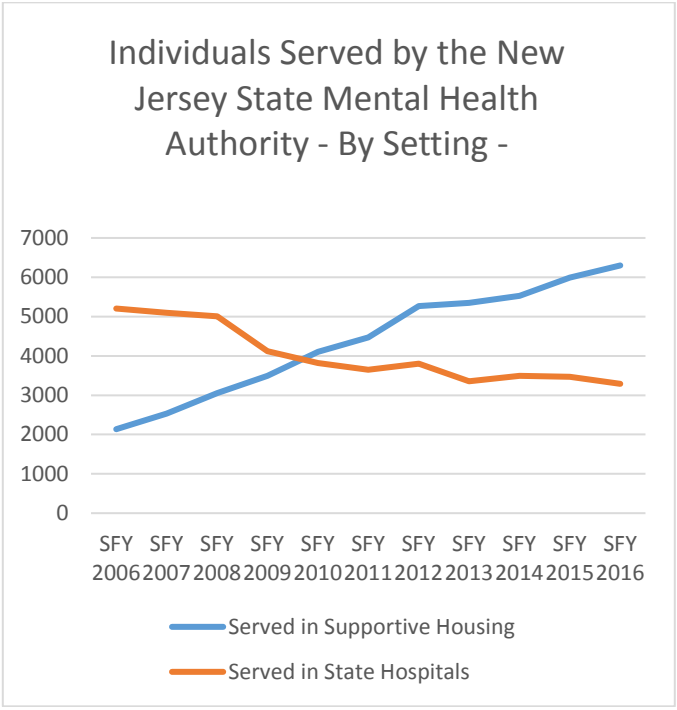
(5) the adoption of new regulations setting clear expectations for the provision of community support services. These policy and practice changes had a significant impact on the state's ability to expand supported housing and other community services at a rapid pace and to facilitate prompt discharges of individuals from state psychiatric hospitals to their own apartments and other community settings.

As a result of the increased access to supported housing and other services, New Jersey reduced admissions to psychiatric hospitals by one third between 2006 (shortly after the litigation was filed) and 2010 (one year after the settlement was entered), a rate that has remained steady over subsequent years. In 2016, admissions had declined 36% from 2006 and the average daily census within state hospitals declined by 33.7%. The average daily census of the state psychiatric hospitals also shrunk by 34%, from 2,122 in 2006 to 1,406 in 2016.[v]



In addition, the number of individuals remaining in state psychiatric hospitals due to the lack of community options has shrunk by more than two-thirds since 2006. In 2006, these individuals comprised nearly half of all state hospital residents, whereas in 2016, they comprised only 22% of state hospital residents.[vi] The reduction in hospital beds has enabled the state to achieve a very significant expansion of community services. Over roughly the same period, the number of individuals served in the community has grown by almost 60,000 people:[vii]

Supported housing is now the most common setting for individuals discharged from New Jersey's state psychiatric hospitals who need a place to live upon discharge. The chart below shows the dramatic increase in individuals served in supported housing and concomitant decrease in individuals served in the state psychiatric hospitals between 2006 and 2016:



Illinois

Illinois entered an Olmstead consent decree in 2010 settling a class action brought on behalf of thousands of residents of intermediate-care nursing homes serving primarily people with psychiatric disabilities. The decree requires the state to develop supportive housing and offer opportunities to receive services in the most integrated setting appropriate for more than 4,000 people consigned—sometimes for decades—to these institutions. As a result of the decree, the state

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has now facilitated the transitions of nearly 2000 residents of these nursing homes to community settings—in almost all cases, to scattered-site supported housing.

The state also made changes to its ACT services to enable them to better meet the needs of individuals transitioning out of these facilities —for example, by adding additional nursing staff capacity. In addition, to accommodate the large numbers of individuals newly enrolled in ACT as a result of the decree, the state allowed lower client-to-staff ratios. The state also used funding through the Balancing Incentives Program to cover 24/7 in-home peer support services and skill-building services to help individuals who are transitioning from institutional settings, although the availability of these services was apparently not widely known and consequently they were not widely used.

Finally, the state developed a supported employment plan targeted at class members under the consent decree, including training in IPS for ACT staff as well as outreach to class members at drop-in centers and at community events. This plan has enabled more of these individuals to access supported employment (particularly individuals receiving ACT, who had not previously been able to access IPS supported employment) and to work. Since the beginning of the plan nearly 2 years ago, the number of class members who have received IPS supported employment increased from a handful to 314, and 94 of those have worked.

Conclusion

These state examples suggest several important steps that others states can take to expand access to the core services for people with psychiatric disabilities, including: adopting a Medicaid demonstration waiver or home and community-based state plan amendment that includes services not reimburseable through other Medicaid options; offering services that include the additional intensity needed by some individuals early in the transition process; ensuring that arrangements with community providers are structured to incentivize serving individuals with the most challenging needs and to prohibit the exclusion of individuals with particular needs; adopting rules that provide clear guidance to community providers about how services should be delivered; ensuring that integrated settings such as supported housing are the default service option and that individuals are not placed in congregate settings unless there are specific reasons why their needs cannot be met in supported housing; creating specific targets to establish a pace for the expansion and specific plans to expand services dramatically; and ensuring sufficient provider staff capacity for planned service expansions. The examples highlighted above demonstrate the successes that can be accomplished through such measures.

[i] Tenth Report of the Court Monitor on Progress Towards Compliance with the Agreement: U.S. v. State of Delaware, U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS (Sept. 19, 2016), https://www.ada.gov/olmstead/documents/de_10th_report.pdf.
[ii] *Id.*
[iii] *Id.*
[iv] *Id.*
[v] New Jersey Dep't of Human Services, Division of Mental Health & Addiction Services, *Home to Recovery 2, 2017-2020, A Vision for the Next Three Years* (Jan. 2017),at 12, 13, http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/Home%20to%20Recovery%202%20Plan%20-%20January%202017.pdf.
[vi] *Id.*
[vii] New Jersey Dep't of Human Services, Division of Mental Health & Addiction Services, Realignment of the NJ Mental Health System (powerpoint, July 1, 2015).

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