

I AM OLMSTEAD

SERVICES AND STRATEGIES

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The Substance Abuse and Mental Health Services Administration
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TABLE OF CONTENTS

| | | |
|----|-------|--|
| 1 | | Mental Health Services: What Works |
| 11 | | Some Strategies to Expand Core Community Services |

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MENTAL HEALTH SERVICES: WHAT WORKS

Helping people with psychiatric disabilities move from institutions and live in their own homes and communities has been a goal of most mental health service systems for decades. Despite progress, however, our mental health service systems do not offer community-based services to many who need them, leading to needless confinement and lost opportunities. As the Supreme Court said in the *Olmstead* decision (affirming that states and localities must normally serve individuals with disabilities in communities rather than institutions), needlessly institutionalizing people with disabilities severely diminishes their everyday activities and perpetuates unwarranted assumptions that they are “incapable or unworthy of participating in community life.”

States’ efforts to comply with the Supreme Court’s 1999 *Olmstead* decision have led to the expansion of innovative community services effective in meeting the needs of individuals with even the most challenging disabilities.

These services afford people with serious mental illness the opportunity to live the same kind of lives as people without disabilities—lives with neighbors and co-workers, gardens and pets, and the ability to choose what to eat and what to do during the day. They include intensive community-based services such as supported housing, assertive community treatment, supported employment, peer support services, and mobile crisis services. They have enabled many individuals with serious mental illness to leave institutions.

These evidence-based services should be sufficiently available to ensure that people with serious mental illness can live and thrive in their own homes and communities. Below, we describe these core services and discuss the evidence supporting them.

Supportive Housing

The Basics: Many people with serious mental illness rely on supported housing to live in their own homes within their community. Housing subsidies are supplemented with a flexible and comprehensive package of voluntary services designed to address each person's individual needs. These services may include, for example, case management, independent living skills training, substance use disorder services, help securing and maintaining employment, help maintaining housing, and home health aide services. To promote community integration, housing is typically scattered throughout the community ("scattered site supported housing"). Individuals with the greatest needs can receive assertive community treatment (ACT).

The Evidence: Supported housing is a cost-effective alternative to institutions and other traditional mental health residential settings. [1] Studies have consistently demonstrated that people with mental illness prefer supported housing over congregate alternatives, and the retention rates of individuals in supported housing are higher than those in congregate settings. [2] Supported housing improves housing stability and increases employment, while also improving symptoms and reducing hospitalizations, even for people with the most significant impairments. [3]

The Implementation: The use of supported housing nationwide is tracked by SAMHSA’s Uniform Reporting System, which identified 35 U.S. states and territories that provided supported housing in 2017 but indicated that only 3% of public mental health services consumers received supported housing services that year. [4]

Assertive Community Treatment (ACT)

The Basics: ACT is a highly individualized package of services and supports devised to meet the day-to-day needs of individuals with serious mental illnesses who have the most significant needs. Services are provided by a multi-disciplinary team that is on call 24 hours a day to address the individual’s needs and may include case managers, housing specialists, employment specialists, physical therapists, occupational therapists, psychiatrists, psychologists, social workers, peer support professionals, and nurses, among others.

The Evidence: ACT has a high return on investment. It saves money and has repeatedly been determined to be a highly effective community-based service for people with serious mental illnesses. [5] Individuals receiving ACT services report improved outcomes and high levels of satisfaction with the service, which promotes housing stability and results in lower costs due to decreases in hospitalizations. [6]

The Implementation: Unfortunately, ACT is not as widely available as it should be. The SAMHSA Uniform Reporting System tracks usage of ACT and reported that in 2017, 41 U.S. states and territories provided ACT services but only 2.1% of public mental health services consumers received ACT services. [7] Far more people need ACT services than have received them. ACT is designed to serve people with severe impairments, and most people with mental illness don't require such intensive services. However, among people with serious mental illness, it is estimated that approximately 20-40% need ACT services. [8]

Supported Employment

The Basics: Supported employment refers to a set of services aimed at helping people with serious mental illness get and keep a job, integrating them into the mainstream workforce. Supported employment is not time-limited and is focused on the individual's own employment goals and preferences. Individual Placement and Support Supported Employment (IPS SE) is the most successful model of supported employment.

The Evidence: IPS SE has consistently produced impressive outcomes, [9] with some studies showing 60% or more of individuals receiving IPS becoming employed (compared to 23% for traditional vocational services). It has demonstrated long-term success, with high employment rates for people receiving IPS SE services 10 years later. [10] IPS SE is a cost-effective alternative to traditional services. IPS SE reduces hospitalization as well as the utilization of mental health services, which saves states money. [11] Estimates of the annual savings if IPS SE were more broadly adopted (though still short of what is needed) have ranged from \$368-550 million. [12]

The Implementation: In 2017, the SAMHSA Uniform Reporting System found that 41 U.S. states and territories provided supported employment services. Despite a great need, only 2% of public mental health services consumers across the U.S. received supported employment services. [13]

Peer Support Services

The Basics: The term “peer support services” covers a wide variety of services designed to support people with mental illness.

Peer support services are provided by trained specialists with “lived experience” in the mental health service system, who are able to use their shared experiences to build trust with people with serious mental illness and help them navigate service systems. Peer specialists may perform a variety of tasks, including assisting individuals through the process of transitioning from an institutional setting to the community, helping individuals build their confidence and understand their options and opportunities, and helping individuals develop relationships and participate meaningfully in their communities. Peer specialists may also staff crisis respite centers or serve on supported employment teams, among other tasks.

The Evidence: Multiple studies have found that participants in peer support services have fewer hospitalizations and improved psychiatric symptoms, which lowers state mental health costs. [14] A 2003 study in Georgia also found that not only did peer support lead to better outcomes for people with schizophrenia, bipolar disorder, and major depression, but it did so at a much lower cost than traditional services. [15]

Other studies have similarly found peer support services to be a cost-effective initiative. [16]

The Implementation: As of January 2017, 42 states and the District of Columbia have peer specialist training and certification programs, and Nevada and Colorado are developing programs. [17] Peer support is a Medicaid billable service in 42 states and the District of Columbia. [18] These are not necessarily the same states which have peer specialist training and certification programs. Alabama, Maryland, Nebraska, North Dakota, and West Virginia all have certification programs but do not cover peer support services under Medicaid. Alaska, California, Colorado, Nevada, and Vermont, meanwhile, cover peer support services under Medicaid but do not currently have peer specialist training and certification programs. [19]

Mobile Crisis Services

The Basics: Mobile crisis teams are made up of mental health professionals trained to de-escalate individuals in the midst of mental health crises. Teams of psychiatric nurses, social workers, and/or paraprofessionals respond to individuals in crisis, assess them, and utilize a variety of techniques to de-escalate the situation. Mobile crisis teams divert individuals from hospitalization or interaction with law enforcement.

The Evidence: A national survey found that both consumers and law enforcement prefer mobile crisis teams to police involvement and find them to be more effective. [20]

Mobile crisis services reduce costs to both law enforcement and the mental health system and were found in one study to “reduce costs associated with inpatient hospitalization by approximately 79 percent” in the six months following a mental health crisis. [21] Other studies also indicate that they reduce hospital admissions and are more effective than hospitalization in connecting individuals to outpatient services. [22]

The Implementation: While all 50 states and the District of Columbia have some form of crisis services that are financed through Medicaid, it is difficult to determine how many states specifically finance mobile crisis services through the program, and a 2014 report identified only twelve states that it could say with certainty funded mobile crisis services through Medicaid at that time. [23] Some states or localities may use their own funds to finance mobile crisis teams, but state-funded or locally funded programs typically operate on a very small scale. Regardless, it is clear that mobile crisis services continue to be underutilized in states. While the statistics are not readily available for programs geared toward adults, in 2015, a survey of mental health services provided to children and young adults found that of 49 states, the District of Columbia, and Guam, only 60% provided mobile crisis and/or crisis stabilization services. [24]

[1] Bazelon Center, *Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities 1* (2010), <http://www.bazelon.org/wp-content/uploads/2017/04/supportive-housing-fact-sheet.pdf>; *see, e.g.*, The Heartland Alliance, *Supportive Housing in Illinois: A Wise Investment* (Apr. 2009), https://shnny.org/uploads/Supportive_Housing_in_Illinois.pdf.

[2] *Id.*

[3] *Id.*

[4] SAMHSA Uniform Reporting System 2016, <https://wwwdasis.samhsa.gov/dasis2/urs.htm>.

[5] Susan D. Phillips et al., *Moving Assertive Community Treatment into Standard Practice* (2001); Alan Rosen et al., *Assertive Community Treatment—Issues From Scientific And Clinical Literature With Implications For Practice*, 44 *J. of Rehabilitation Res. & Dev.* 813, 815-816 (2007).

[6] *Id.*; *see also* Geoffrey Nelson et al., *A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons With Mental Illness Who Have Been Homeless*, 77 *Am. J. of Orthopsychiatry* 350 (2007).

[7] SAMHSA Uniform Reporting System 2016, <https://wwwdasis.samhsa.gov/dasis2/urs.htm>.

[8] United States Department of Justice, *Interim Report to the State of Oregon- Integration of Community Mental Health and Compliance with Title II of the Americans with Disabilities Act* (2014), https://www.justice.gov/sites/default/files/crt/legacy/2014/01/28/oregonmh_interimrpt_1-2-14.pdf. Estimates of the need for ACT services may vary based on how robust other parts of a mental health service system are.

- [9] David Salkever, Westat, *Toward a Social Cost-Effectiveness Analysis of Programs to Expand Supported Employment Services: An Interpretive Review of the Literature* (Dec. 2010), at 27-28, https://www.ssa.gov/disabilityresearch/documents/MHTS_Final_Report_508.pdf.
- [10] Bazelon Center, *Getting to Work: Promoting Employment of People with Mental Illness* (Sept. 2014), at 5-6, <http://www.bazelon.org/wp-content/uploads/2017/01/Getting-to-Work.pdf> (citing Gary R. Bond et al., *An Update on Randomized Controlled Trials of Evidence-Based Supported Employment*, 31 *Psychiatric Rehabilitation Journal* 280, 284 (2008), and Michelle P. Salyers et al., *A Ten-Year Follow-Up of a Supported Employment Program*, 55 *Psychiatric Services* 302, 305 (2004)).
- [11] *Id.* at 8-9.
- [12] See Robert E. Drake et al., *Social Security And Mental Illness: Reducing Disability With Supported Employment*, 28 *Health Affairs* 761, 768 (May/ June 2009); see also William D. Frey et al., Westat, *Mental Health Treatment Study, Final Report* (July 2011), at EX-11, https://www.ssa.gov/disabilityresearch/documents/MHTS_Final_Report_508.pdf.
- [13] SAMHSA Uniform Reporting System 2016, <https://www.dasis.samhsa.gov/dasis2/urs.htm>.
- [14] SAMHSA, *Consumer Operated Services Evidence-Based Practices (EBP) KIT, The Evidence* (2011), <https://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/TheEvidence-COSP.pdf>.
- [15] Christine Vestal, Pew Charitable Trusts, Stateline, *'Peers' Seen Easing Mental Health Worker Shortage* (Sept. 11, 2013), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage>.

[16] See, e.g., Sharon Lawn, et al., *Mental Health Peer Support for Hospital Avoidance and Early Discharge: An Australian Example of Consumer Driven and Operated Service*, 17 J. of Mental Health 498, 503 (2008).

[17] Laura Kaufman et al., Texas Institute for Excellence in Mental Health, *Peer Specialist Training and Certification Programs: National Overview 2016* (last revised Jan. 2017), <http://sites.utexas.edu/mental-health-institute/files/2017/01/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2016-Update-1.5.17.pdf>.

[18] *Id.*

[19] *Id.*

[20] Roger L. Scott, *Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction*, Psychiatric Services, Volume 51, Issue 9 (Sept. 2000), at 1153-1156,
<http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.51.9.1153>.

[21] SAMHSA, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (2014), <https://store.samhsa.gov/system/files/sma14-4848.pdf>.

[22] *Id.*

[23] *Id.* at 16.

[24] Beth A. Stroul, et al., *Implementation and Financing of Home- and Community-Based Services for Children's Mental Health* (2015),
https://gucchd.georgetown.edu/products/FinanceBrief_HCBServices.pdf.

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SOME 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.*

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 also highlight strategies that states can use to significantly expand services in a relatively short period of time. We focus here on two examples: Delaware and New Jersey.

Delaware and New Jersey entered into settlement agreements resolving claims that individuals with serious mental illness were unnecessarily segregated in state psychiatric hospitals. 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.

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 New Jersey settlement provided for individuals served in state psychiatric hospitals 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 this settlement included a similar set of intensive community-based mental health services: supported housing, ACT, peer support services, crisis services, and employment services.

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. [1]

In 2015, Delaware regularly diverted over 70 percent of individuals in crisis from acute psychiatric beds into less expensive community crisis services. [2] 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. [3]

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. [4] 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 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. [5]

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. [6] 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: [7]

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 Takeaway

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 reimbursable through other Medicaid opt
- 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
- Ensuring sufficient provider staff capacity for planned service expansions

The examples highlighted above demonstrate the successes that can be accomplished through such measures.

[1] 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.

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] 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>.

[6] *Id.*

[7] 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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