The DOJ Effect

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Mental Health Program

September 22, 2014
I. GA Olmstead Settlement Agreement
II. TCC Mental Health Program Visioning Report
III. Evidence-Based Practices
IV. State Models
V. 
Case Study:
Georgia Mental Health Crisis
Georgia’s Mental Health Crisis

Mark Miller pleaded for help. What he got at the hospital: neglect

Lax security, easy escape, tragic ending

Sarah Crider was among 115 patients in the state’s care who might have lived

Atlanta Journal-Constitution: www.ajc.com/hiddenshame
A Hidden Shame: Death in Georgia’s Mental Health Hospitals

LESS MONEY, MORE PATIENTS
Georgia’s state psychiatric hospitals have lost millions of dollars from their operating budgets in recent years. At the same time, the average number of adult patients has gone up. A look at the numbers, by fiscal year, since 2002:

PSYCHIATRIC HOSPITAL BUDGETS
(In millions; totals include federal dollars)

AVERAGE NUMBER OF PATIENTS
(Daily census in hospital wards housing adult mental health patients)

*Projected

Source: Georgia Department of Human Resources  Note: Beds, occupancy rates as of February 2006. Suspicious deaths 2002-late 2006 based on AJC analysis.

Photos by KEITH HADLEY, BRANT SÄNDERLIN and RICH ADDICKS / Staff and by Associated Press  JEROME THOMPSON / Staff
Increase in Admission: A National Trend Illustrated in Georgia

- Increase in number of forensic admissions and residents
  - 50% of beds in GA for forensics
- Increase in the number of consumers diagnosed with schizophrenia or affective disorders
- Shortages of community housing and community care staff
- "Never far from the surface in these analyses are concerns about the effects of deinstitutionalization in the absence of parallel efforts to build strong community services."

Manderscheid et al., 2009
Number of Admissions to State Psychiatric Hospitals

The number of admissions to state psychiatric hospitals in 11 states in 2002 and 2005
GA Mental Health System Under Scrutiny

- **January 2007** - Atlanta *Journal-Constiution* series reveals over 100 suspicious deaths in GA state psychiatric hospitals and attracts attention of DOJ

- **Fall 2007** — DOJ investigation into conditions in state psychiatric hospitals begins

- **May 2008**: CRIPA suit filed

- *Civil Rights of Institutionalized Persons Act* (CRIPA, 1980)
  - Institutions, including hospitals
  - Department of Justice, Office of Civil Rights

  - Americans with Disabilities Act
  - Promotes community integration
  - Dept. of Health and Human Services
    - Office of Civil Rights
GA Mental Health System Under Scrutiny

- August 2008—Carter Center Mental Health Program gets involved in case against the state of Georgia
- January 2009—Conditional settlement reached between Department of Justice and Georgia re: CRIPA
- February 2009—MHP and other state and national stakeholders entered as amicus curiae
- July 2009—Department of Behavioral Health and Developmental Disabilities created (DBHDD)
- January 2010—Second suit filed addressing community services/Olmstead
- October 2010—Final settlement addressing both suits finalized
United States District Court for the Northern District of Georgia

United States of America

v.

State of Georgia, et al.

Settlement Agreement
Overview of Details

Signed October 19, 2010
by the Department of Justice Civil Rights Division representing the USA &
by the Governor of Georgia and the Commissioners of the Departments of Behavioral
Health and Developmental Disabilities and Community Health representing the State of
Georgia
Georgia Settlement Objective

To ensure that Georgians with severe mental illnesses (SMI) and developmental disabilities who would otherwise need institutional care have the services they need to live full lives in the community and achieve their goals.
The Carter Center Mental Health Program
Visioning Report

Building a Vision for Community Services
for
Children, Adolescents, and Adults with Behavioral Health Disorders in Georgia

Georgia Mental Health and Addictive Diseases Urgent Model Project

Carter Center Mental Health Program
Document Components

- I. EXECUTIVE SUMMARY
- II. A GEORGIA VISION FOR BEHAVIORAL HEALTH
- III. INTRODUCTION
- IV. OVERVIEW: DEMOGRAPHICS AND BASICS
- V. INTEGRATED WHOLE PERSON HEALTH CARE
- VI. INFRASTRUCTURE
- VII. CHILDREN AND ADOLESCENTS WITH BEHAVIORAL HEALTH DISORDERS
- VIII. TRANSITION—ADOLESCENTS AND YOUNG ADULTS (17-25 YEARS OLD) WITH BEHAVIORAL HEALTH CHALLENGES
- IX. GEORGIA ADULTS WITH BEHAVIORAL HEALTH DISORDERS
- X. OLDER ADULTS: PREVENTING & TREATING BEHAVIORAL HEALTH DISORDERS
- XI. SUPPORTIVE HOUSING AND EMPLOYMENT FOR ADULTS WITH SERIOUS BEHAVIORAL HEALTH DISORDERS
- Appendix 1 Evidence Based and Promising Practices
- Appendix 2 Indicators
- Appendix 3 County Data
### Target Populations

#### Serious & Persistent Mental Illness (SPMI)
- In State Hospitals,
- Frequently readmitted,
- In Emergency Rooms, Chronically Homeless,
- Being released from Jails or prisons,
- Forensic if Court finds community appropriate,
- Co-occurring condition (addiction, brain injury)

#### Developmentally Disabled (DD)
- Severe, chronic disability
- Significant intellectual disability &/or combined with physical impairments manifested before age 22;
- Likely to continue indefinitely;
- Limitations in three or more areas of major life activity;
- Lifelong service needs;
- Also any individual served in a State Hospital 10/10/2010
Settlement Addresses Highest Need Population (Mainly Adults)

SPMI &/or co-occurring disorders in Institutions

Adults with SPMI &/or co-occurring disorders

- Child/Adolescent with SPMI
- Forensics
- All With Mental Illness &/or Co-Occurring Disorder not SPMI

High Risk of Mental Illness &/or Co-Ocurring Disorder
Settlement Outline for SPMI State Hospital: Cessation of Admission & Target for Community Service

October 19, 2010

Children under age 18

July 1, 2011

Mental Health Olmstead list moved to Community

July 1, 2015

9,000 in State hospitals plus persons with SPMI (including those with a co-occurring condition) who are
- Frequently readmitted
- Frequent emergency rooms
- Chronically homeless
- Being released from jails or prisons
- Forensic (if court finds community appropriate)
Community-Based Care

“The goal of community-based services is to serve people as close to home as possible in the least restrictive setting. Doing so allows them to draw on natural supports, such as family, neighbors, churches, schools, and community activities. It gives them a better chance to maintain the kind of quality of life that all of us want with self-determination and independence.”

-DBHDD Fact Sheet

Community Based Services Include

- Community Service Boards
- Mobile Crisis services
- Assertive Community Treatment (ACT) teams that can visit those with persistent mental illness on a daily basis if needed
- Group homes
- Crisis Stabilization Programs
- Peer Wellness Programs
Continuum of Community Behavioral Health Services to Prevent, Identify, Treat, and Support Wellness & Recovery Across The Lifespan

**Promotion**
*Goal:* Information on symptoms & treatments to educate & improve care

**Prevention**
*Goal:* Develop resiliency & protective factors to reduce risk universally or for selective & indicated populations

**Crisis Care & Stabilization**
*Goal:* Early Intervention for relapse & return to recovery

**Screening & Identification**
*Goal:* Early identification & treatment

**Maintenance / Rehabilitation**
*Goal:* Continuing recovery

**Treatment (Including Supports)**
*Goal:* Recovery & wellness

**The Carter Center**
Supportive Housing

- Community Supportive Housing & Employment supports
  - Settlement Population & Other adults with Serious BH
    - Domestic violence victims
    - Older adults
  - Transitioning Adults - Emancipated from Foster Care, Runaway Youth

- Data / Studies
  - Housing need, housing needs met, costs and benefits
  - Employment need, needs met, costs and benefits
Criminal Justice Diversion

- Accountability Courts
- CIT – Crisis Intervention Team Training of 1st Responders
- Peer Support and Wellness Centers
- Crisis Care Beds and Mobile Centers
Community Services for Individuals with SPMI

- Case Management Services
  - Assertive Community Treatment Team
  - Community Support Team
  - Intensive Case Management Team

- Consumer with SPMI

- Toll Free 24/7 Crisis Call Center

- Crisis Service Centers

- Crisis Apartments

- Crisis Stabilization Programs

- Supported Employment

- Peer Support Services

- Mobile Crisis Services

- Supported Housing

- 35 Non-state Hospital Beds

- Bridge Funding

- Supported Employment
Community Services (2)
Timeline in Settlement for Individuals with SPMI

Case Management Services

- **22 Assertive Community Treatment Teams (ACT) by July 2013**
  - 18 ACT by July 2011, 20 ACT by July 2012

- **8 - Community Support Teams (CST) by July 2014**
  - (1-20 rural, 1-30 Urban), 2 CSTs by July 2012, 4 CSTs by July 2013

- **14 Intensive Case Management Teams (ICMs) by July 2015**
  - (1-20 rural, 1-30 Urban), 1 ICM by July 2011, 2 ICMs by July 2012
  - 3 ICMs by July 2013, 8 ICMs by July 2014

- **45 Case Management Services Providers (CMSP) (1 to 50) by July 2015**
  - 5 CMSPs by July 2012, 15 CMSPs by July 2013, 25 CMSPs by July 2014
Community Services (3)
Timeline in Settlement for Individuals with SPMI

- **6 Crisis Service Centers (CSC) by July 2015**
  - 1 CSC by July 2013, 3 CSCs by July 2014

- **3 Additional Crisis Stabilization Programs (CSP) (16 beds each) by July 2014** (1 additional CSP each year beginning July 2012)

- **35 non-State Community Hospital Beds by July 2011**

- **Toll Free 24-7 Statewide Crisis Call Center**

- **159 - Mobile Crisis Services (MCS) 24/7 by July 2015**
  - 91 MCS by July 2013, 126 MCS by July 2014

- **18 Crisis Apartments each with 2 individuals with SPMI**
  - 6 Crisis Apts. By July 2013, 12 Crisis Apts. By July 2014
Community Services (4)
Timeline in Settlement for Individuals with SPMI

**Supported Housing - 9,000 by July 2015**

Integrated permanent housing with tenancy rights, linked with flexible community-based services; not mandated as a condition of tenancy. Funding from Federal, State, or Private Sources

- State DBHDD commits to housing funds for 2,000 not eligible for any other benefit by July 2015, 100 by July 2011, 500 by July 2012, 800 by July 2013, 1,400 by July 2014

- Supported Housing includes apartments clustered in a single building and scattered-site housing
  - Scattered Site - <20% of the units in 1 building or no more than 2 units in 1 building (whichever is greater). Personal care homes not qualified as scattered-site housing
  - By July 1, 2015, 50% of Supported Housing units shall be provided in scattered-site housing; 60% in a 2 bedroom apartment, and approximately 40% in a 1 bedroom apartment.
Community Services (5)
Timeline in Settlement for Individuals with SPMI

**Bridge Funding** for up to 1,800 by July 2015

Deposits, household necessities, living expenses, and other supports prior to becoming a recipient of federal disability or other supplemental income.

**Supported Employment** for 550 SPMI Individuals - by July 2015

Evidence-based supported employment model, assessed by an established fidelity scale (e.g. SAMHSA Tool Kit), Enrollment in congregate programs shall not constitute Supported Employment.
- 70 by July 2011; 1700 by July 2012; 440 by; July 2013; 500 by July 2014; 550 by July 2015
Community Services (6)
Timeline in Settlement for Individuals with SPMI

835 Peer Support Services (in addition to ACT & CST Teams) by July 2015

- Improve an individual's community living skills, ability to cope with and manage symptoms, to develop and utilize existing community supports. provided by face-to-face or telephone contact, outreach, wellness training, and training in self-advocacy.

- 235 by July 2012; 535 by July 2013; 835 by July 2014
Community Service Boards & Provider Oversight

By January 1, 2012

- **Establish responsibilities of community service boards** and/or community providers through contract, letter of agreement, or other agreement, including responsibilities for transition plans.

- **Identify qualified providers** - consistent with DBHDD policy or State law (e.g., RFP Cert. Vendor process)

- **Cost rate study** of provider reimbursement rates

- **Written descriptions of services CSBs & community providers can provide** developed by CSBs / community providers in consultation with community stakeholders

- **Require/provide training** to CSBs/community providers

- **Contract management & corrective action plans** to achieve the goals of this Agreement and of State agencies
Transfers

- No transfers from one institutional setting to another
  - From a state hospital to a skilled nursing facility,
  - Intermediate care facility, or
  - Assisted living facility
- Unless = individual's informed choice or warranted by the individual's medical condition and no more than once.
- Exempted - closing units in institution, dd forensic status but must be appropriate, to needs
Transition Planning

By July 1, 2011

- State shall have at least one case manager

By July 1, 2012

- At least one transition specialist per State Hospital
  - To review transition planning for individuals who have challenging behaviors or medical conditions that impede their transition to the community,
  - Individuals who have been in a State Hospital for more than 45 days.
- Transition Specialist to coordinate w/Hospital staff, regional office, & individual’s choice of community provider(s) in development of transition plan & in moving to community.
Quality Management (1)

By January 1, 2012 State institute Quality Management System

- Community Services, publicly available reports on the DBHDD website
- Annual quality service reviews of samples of community providers
- Face-to-face meetings with individuals, residents, and staff and reviews of treatment records, incident/injury data, and key-indicator performance data.
System's review to include analysis and reporting on:

- Cessation of admissions for DD
- Service requirements of Settlement Agreement
- Contractual compliance - CSBs and/or community providers
- Network analysis
- Analyze key indicator data relevant to the target population and services specified

- Report at least once every six months
  - Summarizing quality assurance activities,
  - Findings, and
  - Recommendations.
Vision for Services in Georgia

- Starting in late 2011, The Carter Center and DBHDD have partnered to hold Town Hall meetings in each of GA’s 6 regions to garner input on a vision for the State’s Community Behavioral Health System.

- Using a collaborative approach that represents the voices of various service providers, consumers, families, and policy makers.

- Emphasis on recovery and best practices.

- Aim to inform and influence state policy from the ground up.

Oversight of the Settlement Agreement in Georgia

- State Appointment of a Settlement Agreement Coordinator by November 19, 2010

- Independent Reviewer - Elizabeth Jones
  - ACT consultant
  - Housing – Marti Knisley
  - Employment – David Lynde
Update 2012

- July 1, 2012 – end of year 2 of the 5 year plan to implement the settlement
- Reviewers report assessed progress:
  - State has exceeded targets in areas of supported housing and employment for people with mental illness.
  - Surpassed required number of placements of individuals with developmental disabilities from state hospitals into residential settings
  - Community supports are lacking – particularly ACT teams

Update 2013

- Majority of obligations for the third year have been met or exceeded
  - 22 ACT teams, 4 Community Support Teams, 3 Intensive Case Management teams, 24-hour Crisis Service Center opened, mobile crisis services in 100 counties, 1,002 housing vouchers awarded, Bridge Funding for 383, Supported Employment to 682 individuals

- Flexibility granted by the courts in August 2012 for restructuring of eight ACT teams and the Quality Management System have led to very productive results

- Serious systemic issues to be resolved regarding transition of individuals with developmental disabilities to community

- Strong network of peer supports and engaged advocacy community is a large advantage to settlement implementation
Update 2014

- Conscious efforts being made to address noted issues.

- Serious systemic issues to be resolved regarding transition of individuals with developmental disabilities to community
  - Absence of timely support coordination
    - No documentation of implementation of Primary Care Physicians’ recommendations to 85% of individuals.

- “Gaps in communication and information sharing” (Columbus Community Services consultant)

- “Duplicative monitoring strategies that failed to effectively resolve identified concerns” (Columbus Community Services consultant)
Georgia is one of few states whose Mental Health Budget substantially increased between FY 2009 and FY 2012 (increase of 21.9%)

NAMI State Mental Health Cuts: The Continuing Crisis
Evidence-Based Practices (EBP)

New Evidence-Based (EBP) Practice
Forensic Adaptation to ACT

- Assertive Community Treatment (ACT)
  - Has been studied for the past 4 decades
  - *Consistent findings across studies are that ACT is effective in reducing the use and number of days of psychiatric hospitalization and in promoting housing stability.*

- FACT Adaptations to ACT *(Forensic Assertive Community Treatment)*
  - Purpose of addition: (1) to interface with criminal justice processes at key sequential intercept points (Munetz & Griffin 2006) and (2) to help people avoid future criminal justice involvement.

www.samhsa.gov
Examples of additions to FACT:

- creating teams that enroll only individuals with prior arrests and jail detentions
- making re-arrest prevention an explicit goal for the team
- accepting referrals from criminal justice agencies
- recruiting criminal justice agency partners
- engaging probation and law enforcement officers as members of the treatment team
- adding substance abuse residential treatment units for consumers with dual diagnoses (Lamberti et al., 2004; Morrissey et al., 2007)

- Project Link (Rochester, NY)
- Thresholds State-County Collaborative Jail Linkage Project in Chicago
- California’s Mentally Ill Offender Crime Reduction (MIOCR)
Evidence-Based Practice Fact Sheets

- Supported Employment for Justice Involved People with Mental Illness, Dr. Gary Bond
- Illness Management and Recovery, Dr. Kim Mueser
- Integrating Mental Health and Substance Abuse Services for Justice-Involved Persons with Co-Occurring Disorders, Dr. Fred Osher

Illinois Center of Excellence for Behavioral Health

“A statewide entity working to equip communities to appropriately respond to the needs of persons with behavioral health disorders that are involved in the criminal justice system. Based in Rockford and serving all Illinois counties, the Center promotes, coordinates, and provides training to communities looking to implement jail diversion programs and problem-solving courts for mentally ill and/or substance abusing offenders.”

http://www.illinoiscenterofexcellence.org/
Illinois Treatment Alternatives for Safer Communities (TASC)

“Not-for-profit organization that provides behavioral health recovery management services for individuals with substance abuse and mental health disorders. Through a specialized system of clinical case management, TASC initiates and motivates positive behavior change and long-term recovery for individuals in Illinois' criminal justice, corrections, juvenile justice, child welfare, and other public systems.”

http://www2.tasc.org/
Behavioral Health/Criminal Justice Technical Assistance Centers

- **Ohio Criminal Justice Coordinating Center of Excellence**
  - "Established in May 2001 to promote jail diversion alternatives for people with mental illness throughout Ohio. The Center is funded by a grant from the Ohio Department of Mental Health to the County of Summit Alcohol, Drug Addiction and Mental Health Services Board. The ADM Board contracts with the Northeast Ohio Medical University to operate the Center."
Behavioral Health/Criminal Justice Technical Assistance Centers

- **Florida Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center**
  - “The Florida legislature designated the Louis de la Parte Florida Mental Health Institute (FMHI), as a site for the Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center. The Florida Mental Health Institute is a research and training center within the University of South Florida with a long history of collaborative relationships with state and local government. Funding for the CJMHSA Technical Assistance Centers has been provided by Florida Department of Children and Families and the JEHT Foundation.”
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