Continuity of Care Across Settings

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Disclosure

No relationships or conflicts of interest related to the subject matter of this presentation.

Judicial Facts in Brief Acknowledgements:

Special thanks to Doris Fuller, MFA

Case Example

- 35 y.o. female
- Armed robbery (10th arraignment)
- Jail course
  - opioid withdrawal, depression, anxiety and “hearing voices” likely related to PTSD, suicide watch
- Inpatient Competence to Stand Trial Evaluation

- Trauma history
- Malingering per the SIRS
- Found competent, released on bail
- Defaulted two days later at a mental health court appearance on a different case

- Was competence the real issue?
- Who will treat Maria in the community?
- Will she get treatment as usual?
- Who is paying for her treatment?

The mental health system is “fragmented and in disarray… lead[ing] to unnecessary and costly disability, homelessness, school failure, and incarceration…” (2002)

The “Cross Over” Population

- Care delivered across settings:
  - Correctional
  - Forensic Hospitals
  - Community
- High utilizers
- Poor outcomes

How did we get here?

A Few Theories

Increased Incarceration of Persons with Mental Illness and Substance Use Disorders: 1970s Trends (Hoge et al; APA 2008)

- Drug Policies
- Determinate Sentencing Policies
- Truth in Sentencing (fewer early releases)
- Drug Culture
- Little crime tolerance
- Economic Factors (disability laws not yet emerged)
- Civil Commitment Reform
- Changing policies on community vs. institutional care
- Deinstitutionalization/ insufficient community supports

Driving Forces Toward Community Based Mental Health Care and Community Corrections

Forces Pointing Toward Community Services

- Laws/Legal Decisions
- Finances
- Policies and Principles

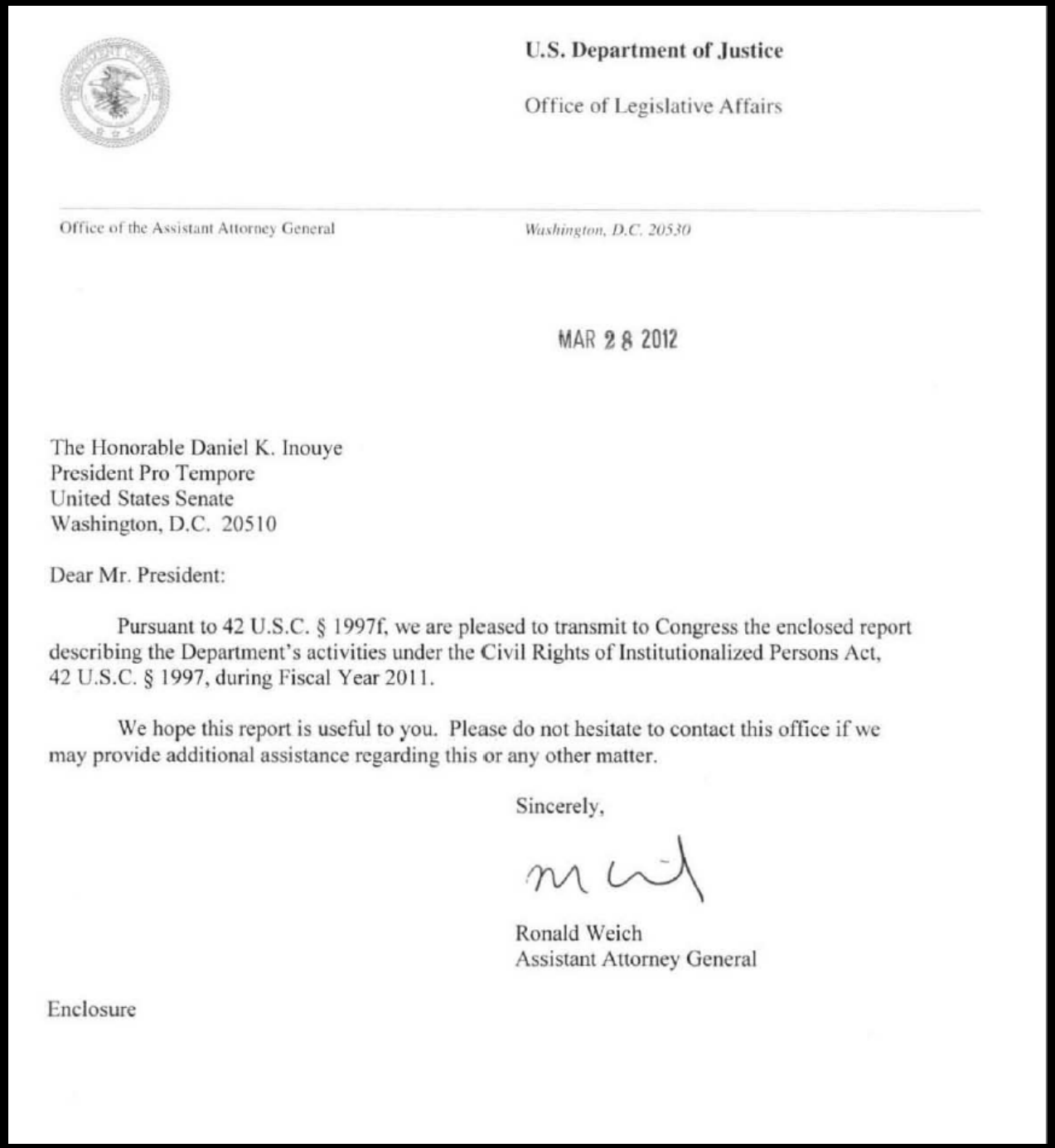
Legal Decisions

- Olmstead v. L.C. (USSC 1999)
  - In accordance with the Americans with Disabilities Act, individuals with mental disabilities have the right to live in the community rather than in institutions…if community placement is appropriate…taking into account the resources available to the State and the needs of others with mental disabilities”

Laws

- Civil Rights of Institutionalized Persons Act of 1980
  - Protects rights of institutionalized persons (MH and DD facilities, jails, prisons, nursing homes, juvenile justice facilities)
  - Administered by the Department of Justice Civil Rights Special Litigation Section

CRIPA in Action



U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

MAR 28 2012

The Honorable Daniel K. Inouye
President Pro Tempore
United States Senate
Washington, D.C. 20510

Dear Mr. President:

Pursuant to 42 U.S.C. § 1997f, we are pleased to transmit to Congress the enclosed report describing the Department's activities under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, during Fiscal Year 2011.

We hope this report is useful to you. Please do not hesitate to contact this office if we may provide additional assistance regarding this or any other matter.

Sincerely,

Ronald Weich
Assistant Attorney General

Enclosure

Excerpts: 2011 DOJ CRIPA Report

- July 2011- agreement with Delaware Mental health to transform services “from an institution-based system to a community-based system” in accordance with the ADA
- November 2010- ADA settlement with MH and DD system to provide “relief to more than 9000 individuals with mental illness in Georgia by increasing community based services”

Are Forensic Services Immune?

- Discharge efforts will be examined EVEN WITH POPULATIONS WITH HIGH FORENSIC MIX

(J Bloom JAAPL 2012)

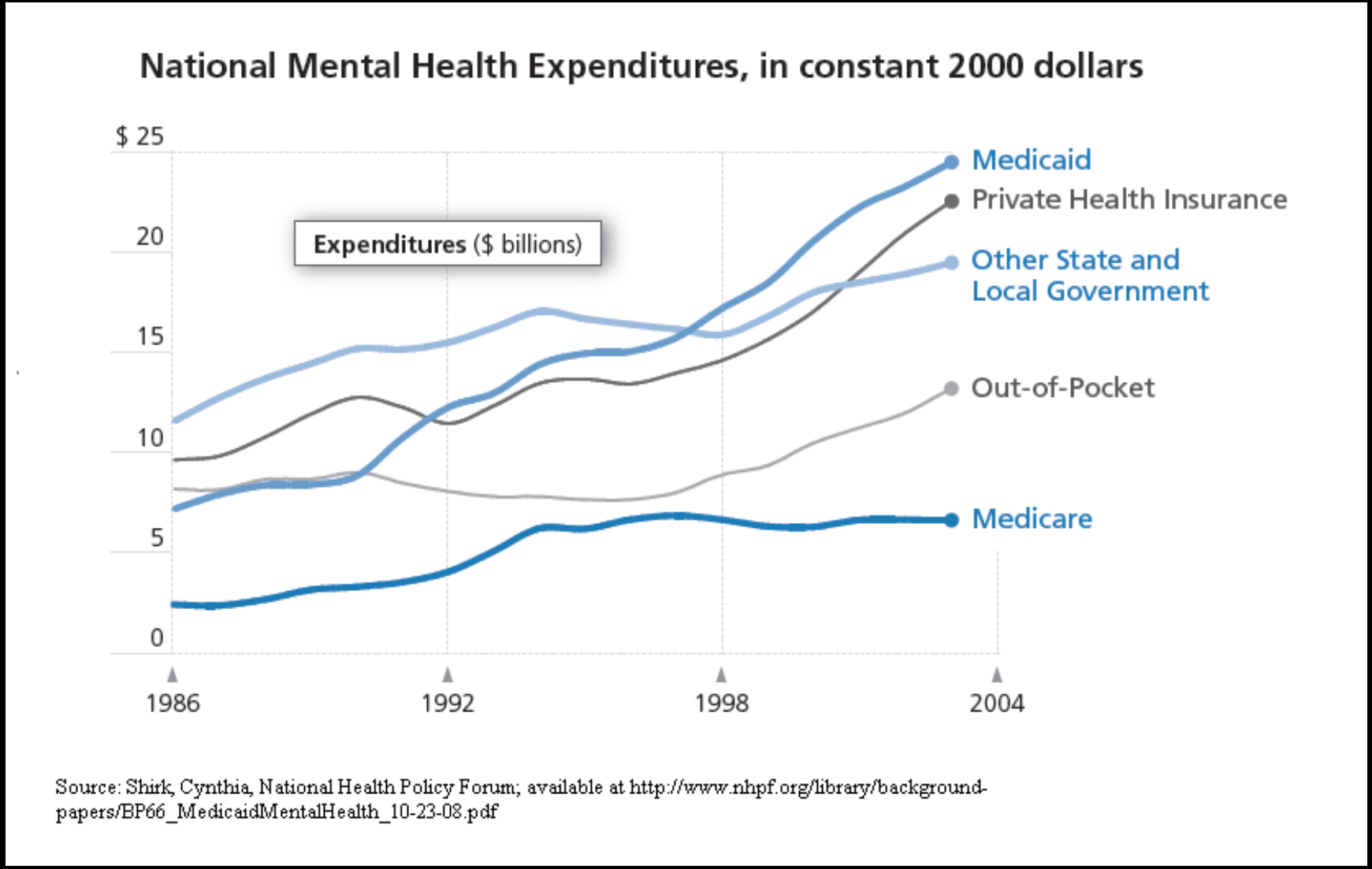
Are Prisons immune from thinking about the community?

- Discharge/”Re-entry” planning a key element in Prison Reviews
- Brown v. Plata (USSC 2011)
  - Prison over-crowding violates 8th amendment rights related to inadequate healthcare
  - Court-ordered release of 40,000 inmates

Forces Pointing Toward Community Services

- Laws/Legal Decisions
- Finances
- Policies and Principles

Coordinating services over the next generation



Source: Shirk, Cynthia, National Health Policy Forum; available at http://www.nhpf.org/library/background-papers/BP66_MedicaidMentalHealth_10-23-08.pdf

Financial Considerations: The IMD Exclusion

- Institutions of Mental Disease
  - Any institution that primarily serves patients with mental illness and has over 16 beds
- If more mental health beds than medical beds: “Tipping” prohibits federal Medicaid reimbursement
- Disproportionate burden on states, driving fiscal decisions of hospital closures

Finances

- Medical Necessity vs. Legal Mandates
- Hospitalization as Incompetent for Restoration may not meet medical necessity criteria for inpatient care
  - May not be eligible for Medicare or Medicaid reimbursement
- Court ordered cases sent for inpatient evaluation and treatment may fall to the state to cover costs

Federal Funds and the Incarcerated Population

- Traditional Medicaid does not cover services provided to “inmates of a public institution”
- Benefits are often terminated upon incarceration/detention
- Costs fall to counties and states to pay
- Terminated Medicaid benefits can take months to re-enroll and restore

Forces Pointing Toward Community Services

- Laws/Legal Decisions
- Finances
- Policies and Principles

Policies and Principles

- Community First
- Recovery
- Person-Centered Care
- Nothing about us without us

Post Release Outcomes

- Individuals with serious mental illness convicted of felonies show poor follow up with treatment services and up to 40% re-arrest within three years

(Lovell et al., 2002; McGuire and Rosenheck 2004)

Post Release Outcomes

- Risk of death of released prison inmates is 12.7 times higher within 2 weeks of release than for state population residents
  - Leading causes include Drug Overdose, Suicide, Homicide, and Cardiovascular

(Binswanger et al. 2007)

Management of High Risk Individuals in the Community

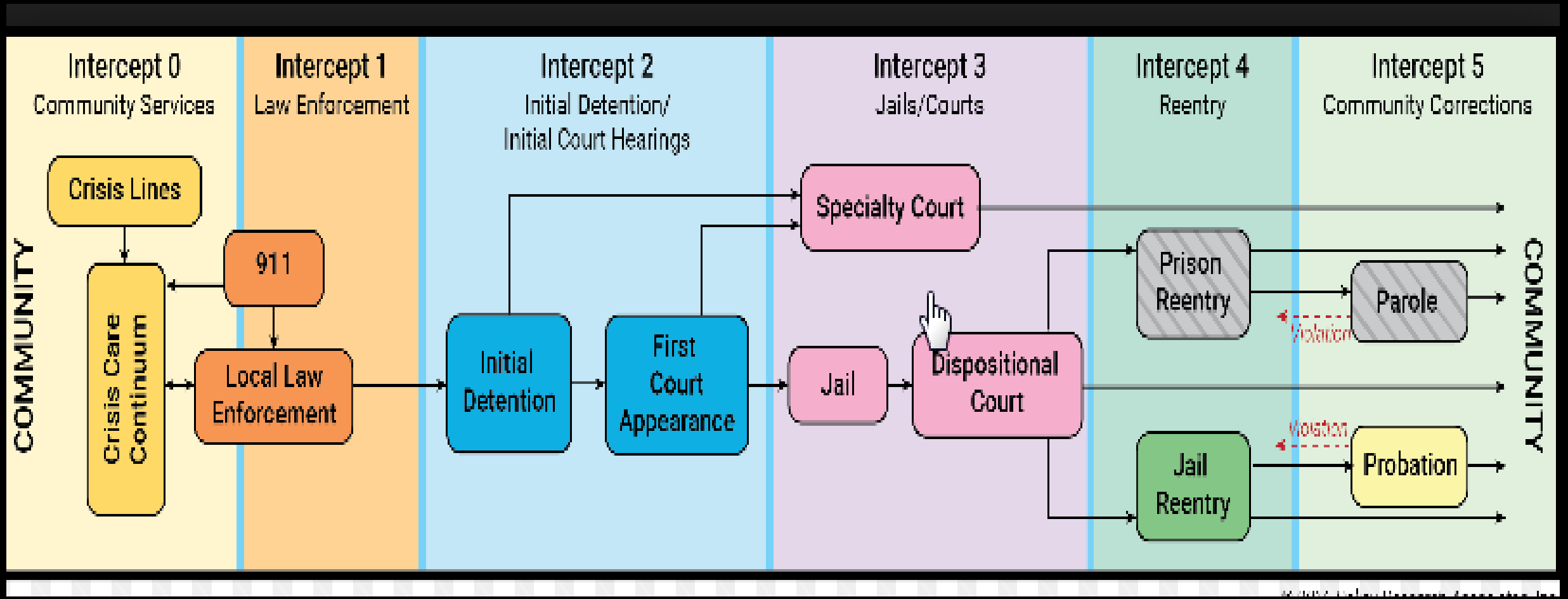
- Definition of High Risk: High fiscal risk may parallels high recidivism risk for crossover populations
  - Screening assessments
  - Specialized models of services integrated with probation and parole
  - Attention to criminogenic needs

Hope for the Future

Hopeful Fixes

- More individuals able to access insurance
- Federal Parity Enforcements
- More prevention

Diversion


Intercept 0
Community Services
Intercept 1
Law Enforcement
Intercept 2
Initial Detention/
Initial Court Hearings
Intercept 3
Jails/Courts
Intercept 4
Reentry
Intercept 5
Community Corrections
COMMUNITY
Crisis Lines
911
Crisis Care Continuum
Local Law Enforcement
Initial Detention
First Court Appearance
Specialty Court
Jail
Dispositional Court
Prison Reentry
Parole
Violation
Jail Reentry
Violation
Probation
COMMUNITY

Creative Ways to Address Cross Over Challenges

Examples of Policy Reforms

- Reclassifying drug offenses
- Revise sentencing practices
- Improve pre-trial systems
- Enhance parole practices (e.g. medical parole, earned good time)
- Enhanced efficiencies
- EBPs in community corrections

Community Policies and Practices

Community Policies and Practices

- **Financial:** Spreading funding for an individual's care across systems supporting the person (e.g., from behavioral health, where the person is seen as a patient, to the correctional system, if they become incarcerated)
- **Clinical:** Assuring that treatments provided in one setting are maintained when the person is treated within other service systems (e.g., medication assisted treatment for addiction being supported in both the substance use and homelessness systems, or the psychiatric medications prescribed in the community also being supplied in the jails)
- **Psychosocial:** Incorporating re-entry specialists and professional peer support in jail/prison discharge planning

Community Policies and Practices

- **Operational:** Combining professionals from different systems to collaborate and respond to situations where combined expertise may produce a better result (e.g., adding mental health professionals to law enforcement crisis response)
- **Navigational:** Convening stakeholders from multiple systems to map pathways that reduce or eliminate roadblocks to the continuity of care between providers
- **Educational:** Developing programs that raise awareness of the importance of continuity of care and promote strategies for achieving it, this *Facts in Brief* among them
- **Legal:** Developing memoranda of agreement that create a foundation for different systems to work together by addressing privacy and other legal barriers to collaboration (e.g., authorizing emergency medical departments to share medical information with homelessness programs)

Continuity and Continuum

- **Continuity**

“the unbroken and consistent existence or operation of something over a period of time.” (google dictionary)

- **Continuum:**

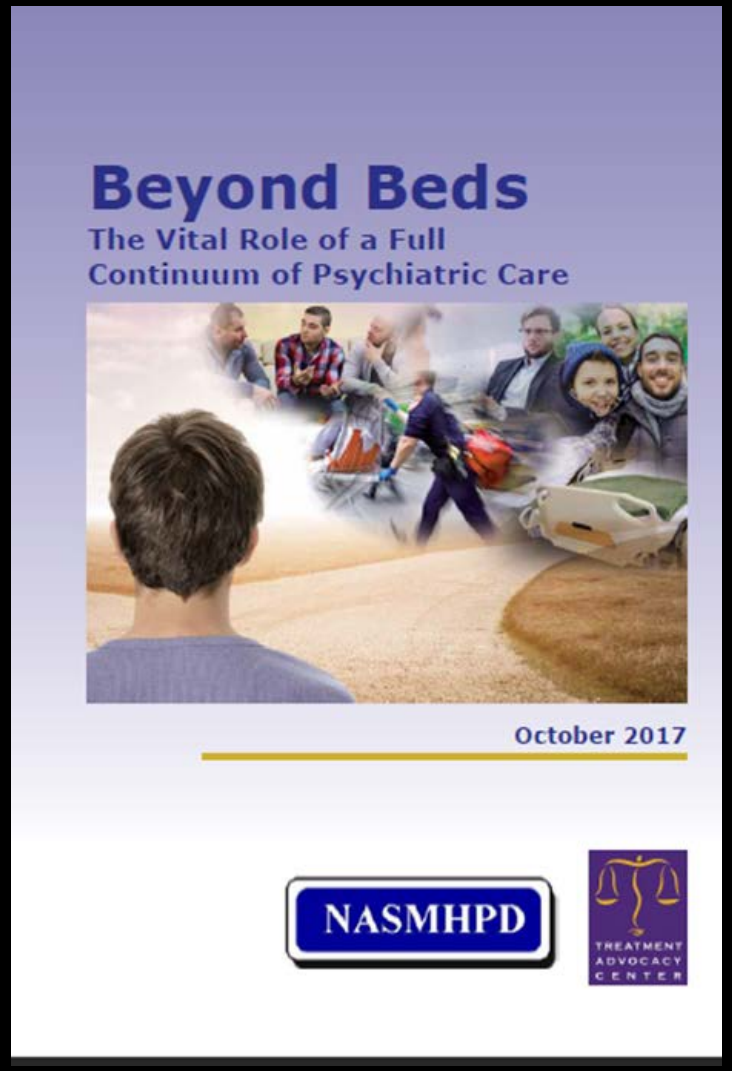
“a continuous sequence in which adjacent elements are not perceptibly different from each other, although the extremes are quite distinct.” (google dictionary)

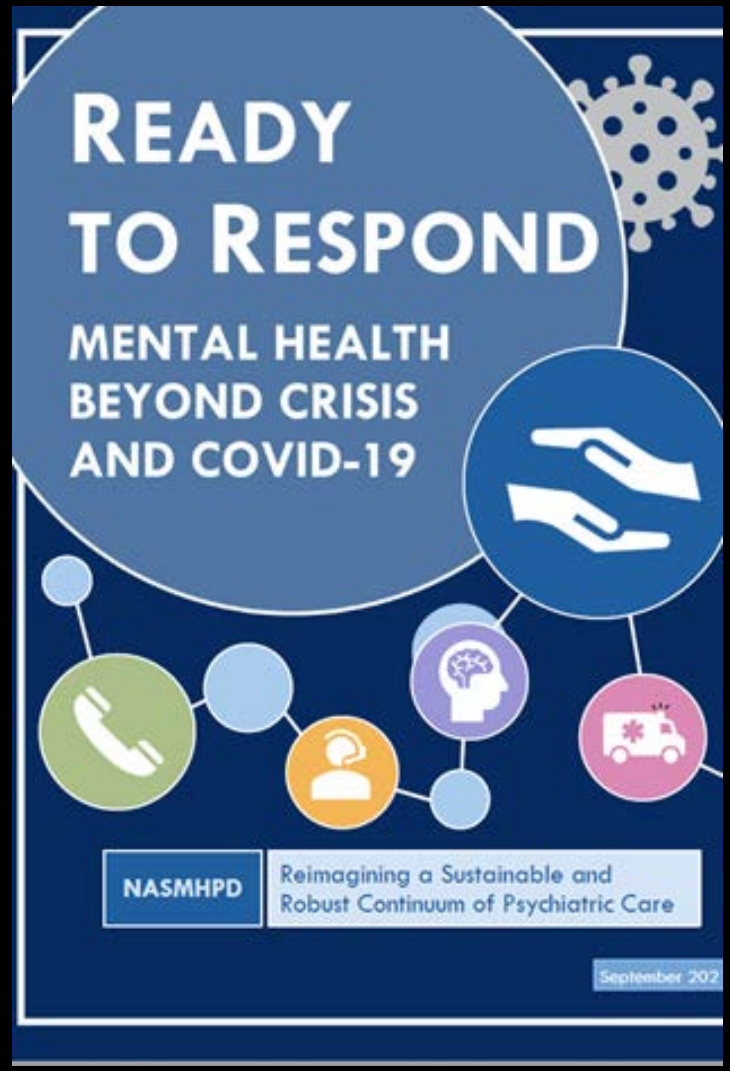
For Maria…

- Continuity
- Information about symptoms and treatment is passed along to next treaters
- Medications started in one site are continued
- Patient feels their illness is seen wholly across sites and do not need to "retell" or "restart" care
- Navigator or peer helps shepherd individual across systems

- Continuum
- From an inpatient level of care a stepdown to a residential treatment program
- From residential supports she could move to intensive outpatient with supported housing
- From intensive outpatient she can move to routine outpatient
- If relapses, she can move up or down a level of care as needed

The Vital Role of the Continuum of Care and the Importance of Continuity





Healthcare Reform and Redesign

- Care coordination
  - Will need attention to population that shifts between institutions
- “Health homes”
- Retail clinics

Improving outcomes of Justice-Involved Individuals with Mental Illness like Maria

- Screening→ Early pre-trial screening and referral
- Innovative Coverage→ Transportation
- Minimize disruption in entitlements → Has Medicaid been suspended or re-activated
- Integrate care with Criminal Justice partners→ Integrated services with probation
- Risk Management→ Consult with care coordinator

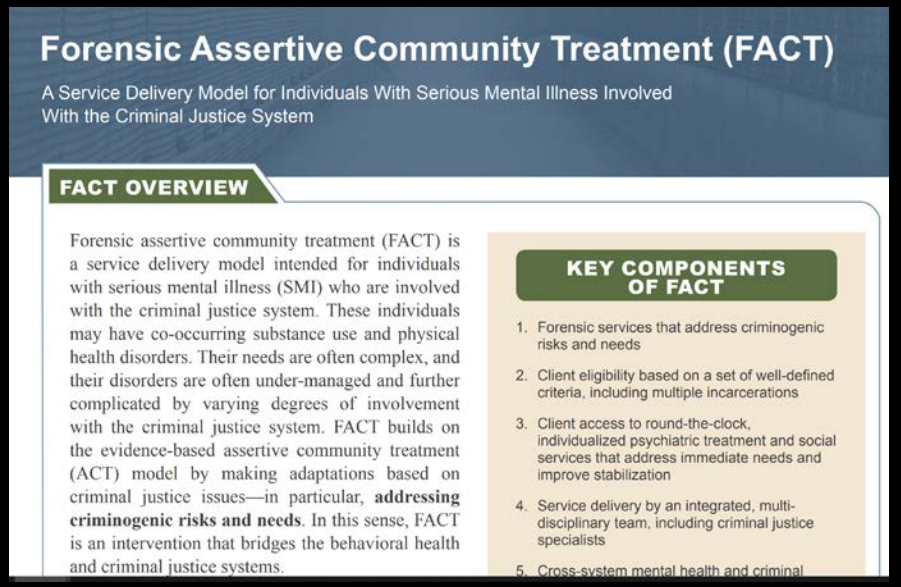
Training Behavioral Health and Justice Professionals of the Future

- Co-occurring Disorders
- Trauma
- Criminogenic risks and recidivism factors
- Behavioral and Physical healthcare integration
- Specialized justice and mental health collaborative services (e.g., MHCs, CIT, Re-entry)

Examples of Emerging Evidence Supported Approaches

Forensic Assertive Community Treatment

- Designed to support individuals with serious mental illness who are criminal justice involved.
- Utilizes the model of ACT with a multidisciplinary team, and add a criminal justice component



Forensic Assertive Community Treatment (FACT)

A Service Delivery Model for Individuals With Serious Mental Illness Involved With the Criminal Justice System

FACT OVERVIEW

Forensic assertive community treatment (FACT) is a service delivery model intended for individuals with serious mental illness (SMI) who are involved with the criminal justice system. These individuals may have co-occurring substance use and physical health disorders. Their needs are often complex, and their disorders are often under-managed and further complicated by varying degrees of involvement with the criminal justice system. FACT builds on the evidence-based assertive community treatment (ACT) model by making adaptations based on criminal justice issues—in particular, **addressing criminogenic risks and needs**. In this sense, FACT is an intervention that bridges the behavioral health and criminal justice systems.

KEY COMPONENTS OF FACT

1. Forensic services that address criminogenic risks and needs
2. Client eligibility based on a set of well-defined criteria, including multiple incarcerations
3. Client access to round-the-clock, individualized psychiatric treatment and social services that address immediate needs and improve stabilization
4. Service delivery by an integrated, multi-disciplinary team, including criminal justice specialists
5. Cross-system mental health and criminal

https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf

Forensic Assertive Community Treatment

SAMHSA's Key Components:

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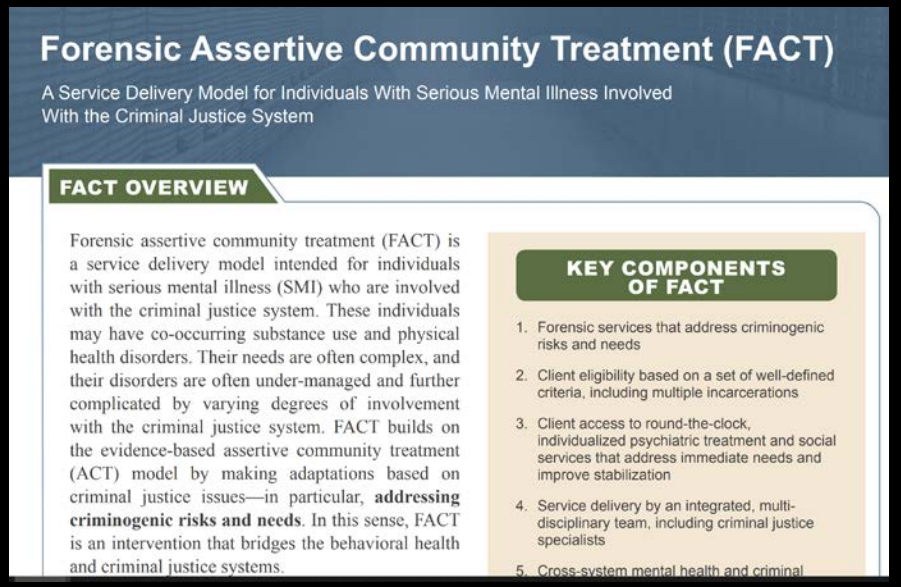
4. Service delivery by an integrated, multidisciplinary team, including criminal justice specialists
5. Cross-system mental health and criminal justice team member training
6. Implementation fidelity to ACT and quality control
7. Flexible funding and implementation support



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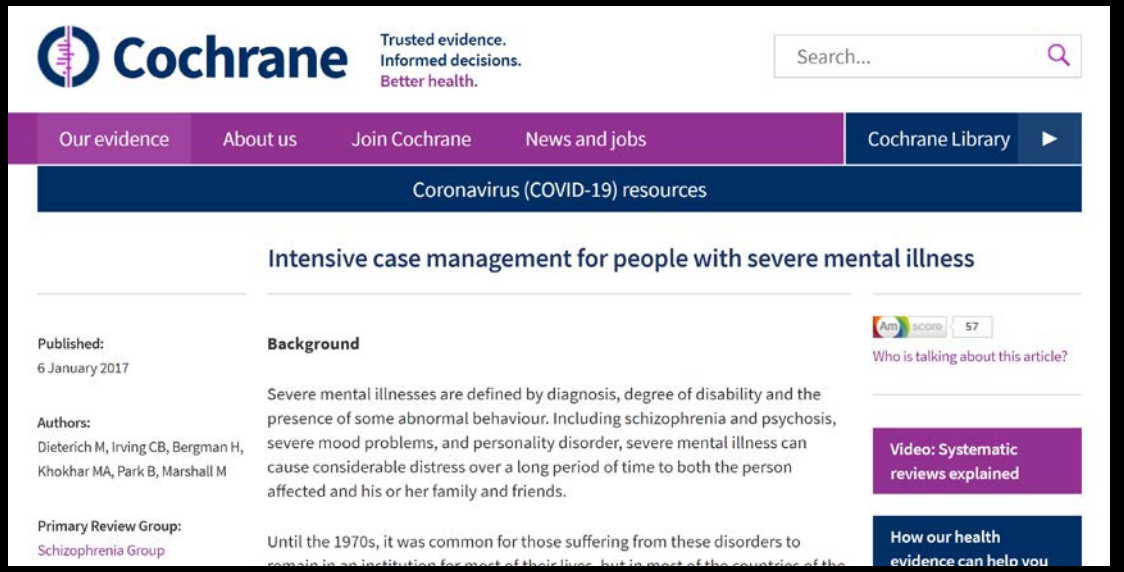
Intensive Case Management

- Provides for management of mental health challenges along with rehabilitation and social support needs
- Provided by a small team with small caseloads
- Offers 24/7/365 supports
- Offers community-based outreach

ICM Cochrane Review (2017)

- Multiple trials from around the world
- Overall data quality was low to moderate
- Cautious conclusion that compared to standard care, ICM recipients were more likely to
  - Remain in services
  - Have improved functioning
  - Get a job
  - Not remain homeless
  - Have fewer hospital days



Housing Supports

- Housing and support from a mental health team resulted in decreased inpatient days, higher housing stability and cost savings in homeless persons with SCZ or BP disorders. (Tinland et al., 2020)
- Numerous studies point to supported housing as a means to help maximize community tenure for individuals with mental illness

Supported Housing Tenets

- Permanence and affordability
- Services that are housing-oriented
- Multi-disciplinary team involvement
- Voluntary services, but assertive approaches
- Integrated in communities
- Emphasis on choice
- Low entry barriers

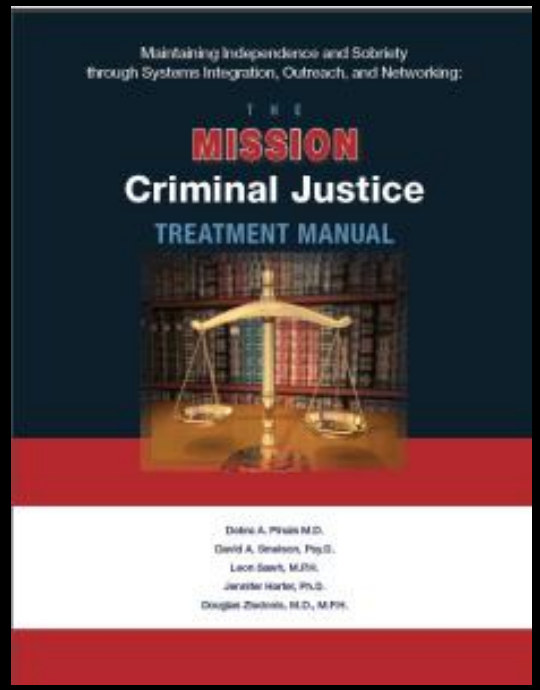
https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community

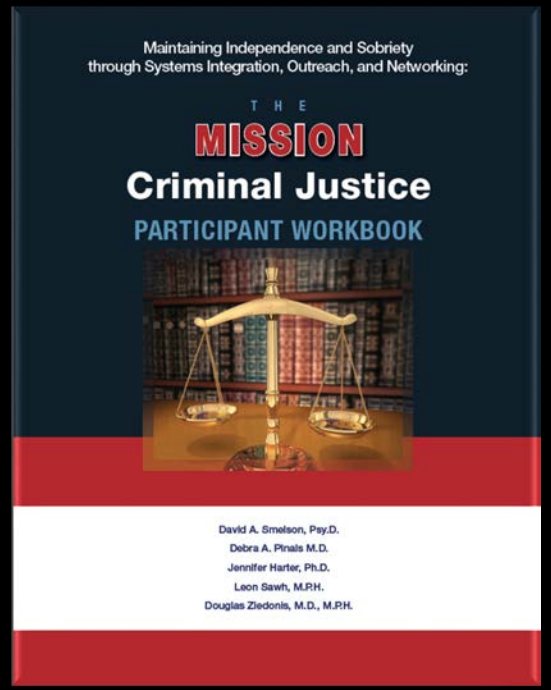
Co-Occurring Treatments

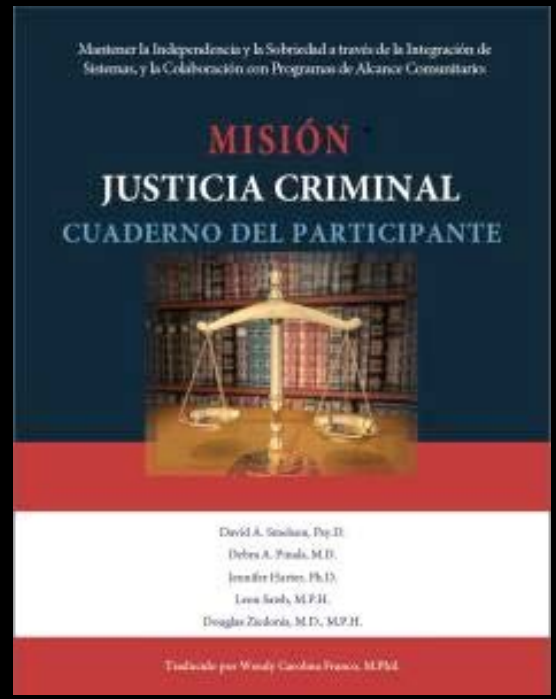
- Frequent co-occurrence
  - Mental illness
  - Substance use disorders
  - Physical illnesses

MISSION-CJ Model

MISSION-CJ
- Emphasis on CJ involved populations
- Addition of Risk Needs Responsivity (RNR) Framework
- Increased focus on readjustment to community
- More resources for case managers, peers, and clients
- Removal of veteran-specific language

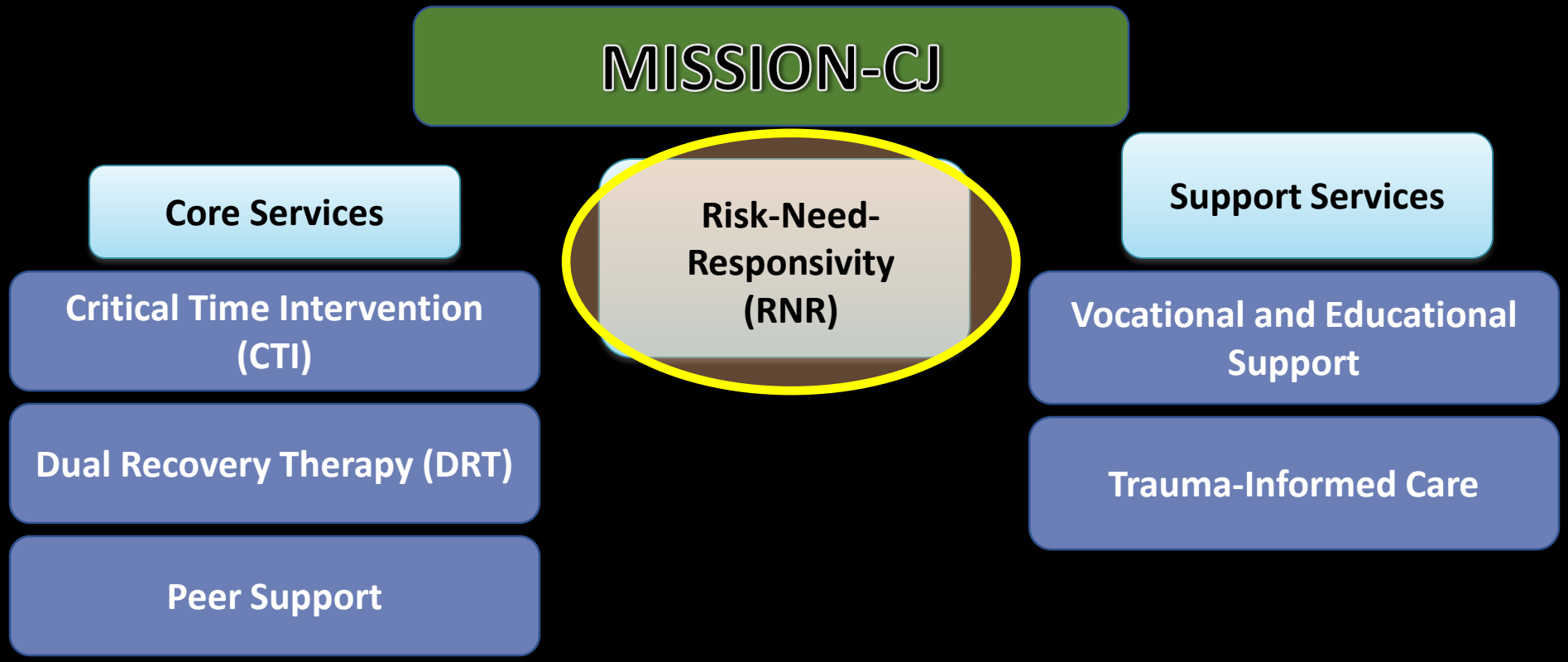






MISSION-CJ Model

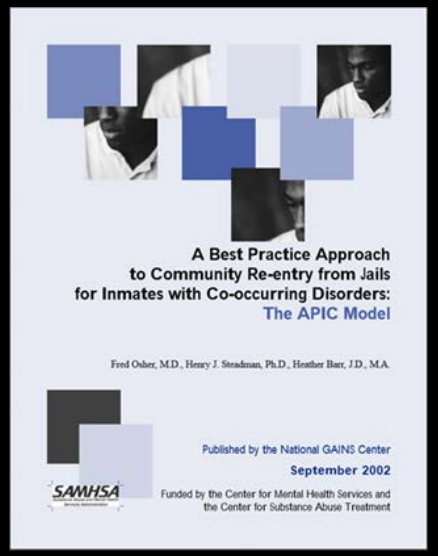
Combining evidence-based services into a comprehensive system of care

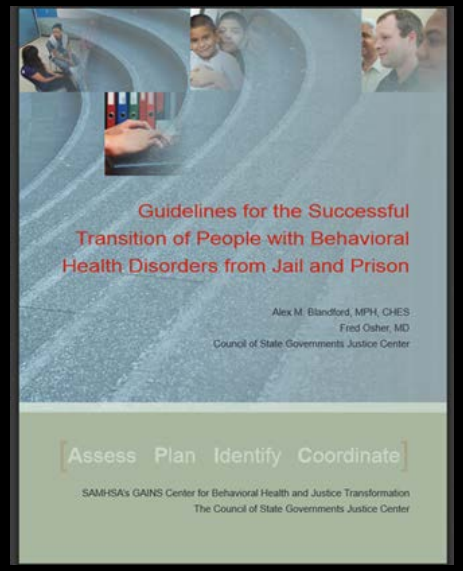


-Critical Time Intervention (Susser et al, 2007)
-Dual Recovery Therapy (Ziedonis et al, 1997)
-Peer Support (Chinman et al, 2010)
-Vocational/Educational Support (Ellison et al, 2012)
-Trauma Informed Care (Najavits et al, 2011)
-Risk-Need-Responsivity (Blanchette & Brown, 2006; Ward, Mesler & Yates, 2007)

Building Consensus

- MOU Example
  - County Authority
  - Court
  - Probation
  - Mental Health Authority
  - District Attorney
  - Public Defenders
  - Local Clinic
  - Local Service Providers





10 Guidelines following the APIC framework including:

Assess
- Screening for behavioral health needs and risk
- Assessments after positive screenings

Plan
- Individualized treatment planning with appropriate treatment levels and dosing to match risk in collaborative programs
- Collaborative responses between behavioral health and justice systems

Identify
- Anticipate critical periods especially time surrounding release
- Policies and practices that enhance continuity of care

Coordinate
- Support “firm but fair” adherence to treatment and supervision conditions
- Develop Information sharing mechanisms
- Support cross training
- Support data analysis

Judicial Considerations

- *Are alternatives to incarceration available that would address public safety? Was the individual previously connected with community-based treatment?*
- *• Is the individual coming from a mental health or substance use treatment program where medications have been prescribed for a mental illness or substance use disorder? If so, what mechanisms can be put in place to assure the medication therapy will not be interrupted?*
- *• Is there a clinical treatment plan in place for this individual, and how can the court support the clinical recommendations? If no treatment plan exists, what is the appropriate course of action to mobilize mental health professionals to develop one?*
- *• What is the mechanism for the individual's service providers to share information across systems, and is there something the court can do to promote its use? For example, is there a need for a court order authorizing or ordering such information-sharing?*
- *• Are there other circumstances that may dissuade the individual from remaining in care, such as distrust of treatment providers, lack of awareness of treatment recommendations, unwanted side effects from treatment interventions, transportation obstacles? Identifying barriers to continuity can shed light on strategies to overcome them.*

Conclusions

- Innovations include enhancing continuity of care
- Often correctional systems are left out, but that may be changing
- Courts can play a role in understanding the importance of continuity for positive outcomes

Selected References

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