Vulnerable Populations with Serious Mental Illnesses

Presentation to HHS Advisory Committee on Minority Health
Monday, March 26th 2018

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Overview

• Background
• Homelessness
• Criminal justice involvement
• Veterans
• Q&A
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Background

• Significant improvements in circumstances for most Americans with SMI in last several decades:
  – Advances in science/medicine (psychopharmacology)
  – Increases in health care coverage and parity in mental health coverage and payments
  – Increased social inclusion, greater integration, and protection of disability rights
  – Reduced stigma
Better, but not good enough?

“Access to care […] has improved. However, not all people with mental health problems have shared in these improvements. Access to care appears to have declined, and we estimate that because of continued incarceration, at least 7 percent of the population with serious and persistent mental illnesses are incarcerated in jail or prison each year…

Finally, despite pressures on the availability of low-income housing, homelessness has remained steady in recent years, and the relative incomes of people with mental illnesses show marginal improvement.”

(Sherry Glied & Richard Frank, 28, no.3, 2009)
Key challenges driving the problem

Complex, multi-dimensional needs:
- High rates of co-occurring disorders, chronic medical conditions, and trauma.

Social factors:
- Heavily impacted by factors and conditions that compromise health (e.g., safe and affordable housing, access to health care, and public safety)

Historical lack of insurance & access to care:
- Historically high uninsured rates (but has improved, especially since ACA and other policies)

Lack of ownership:
- No one system “owns” the problem. Accountability for outcomes is diffused. Incentives still drive a focus on units of services rather than outcomes/people.
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An estimated 169,000 people experiencing homelessness have a serious mental illness.

<table>
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<th>General Population</th>
<th>Homeless Population</th>
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<tr>
<td>5% Serious Mental Illness</td>
<td>25% Serious Mental Illness</td>
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Relationship between homelessness and SMI

• Research indicates that the relationship between homelessness and SMI is indirect
  – Increases in homelessness among people with SMI comparable to that experienced by non-SMI population, and are attributable to changes in low-income housing market that affect all (O’Flaherty, 1996)
  – SMI increases one’s vulnerability to homelessness to the extent that it impacts income and earnings relative to cost of housing. Average cost of private market apartment in 2016 was 99% of total monthly SSI. (TAC, 2017).
Relationship between SMI and Homelessness

- SMI may also increase duration and severity of homelessness

- Kuhn and Culhane (1998) identified three distinct patterns of homelessness:
  - Transitional: Experience homelessness as a single, transitory episode; exit from homelessness with minimal assistance
  - Episodic: Experience homelessness as repeated, short-term episodes, punctuated by stays in other institutions or unstable settings; **have moderate-to-high substance use disorders and mental health conditions**
  - Chronic: Experience homelessness as a persistent or continuous condition; **have higher rates of substance use and mental illnesses**
Solution: Permanent Supportive Housing

• Intervention that couples non-time-limited affordable housing or rental assistance with wrap-around services

• Designed to immediately increase housing stability while using stable housing as platform to address health and social challenges.
The Housing First Paradigm

Old paradigm:
• People with mental health or substance use disorders cannot be successful renters/tenants with leases
• Housing should be a reward for sobriety or compliance with treatment
• We can’t afford to give homeless and jail-involved people supportive housing.

What science and policy has proven:
• Nearly every individual, regardless of health status, can be successful tenants with the right supports
• Housing is a foundation and precursor to recovery and treatment adherence
• Homelessness—and the cycle of public services use—is costly. We can’t afford not to provide people with supportive housing.
Evidence Regarding Supportive Housing Using a Housing First Approach

• 85-90% of participants achieve housing stability and avoid returns to homelessness
• Improved mental health outcomes, addiction recovery, less use of opioids and other hard drugs
• Improvements in chronic health conditions, higher survival rates for people with HIV/AIDS
• Fewer emergency department visits and inpatient hospitalizations
• Cost offsets in Medicaid and other publicly funded services
• Reductions in recidivism to jail and prison
Policy Context

- Efforts to address homelessness among people with SMI equated with effort to end chronic homelessness

- Bi-partisan, interagency, and intergovernmental support for ending chronic homelessness dates back nearly two decades:
  - In 2000, national organizations formed a Compact to End Long-Term Homelessness, calling for the creation of 150,000 units of supportive housing
  - In 2002, federal government endorsed the goal of ending chronic homelessness, encouraged communities to develop 10-year plans to end chronic homelessness
  - In 2010, federal plan to end homelessness included goal to end chronic homelessness
Increased Focus on Engagement and Delivery Systems

• Recent years have added emphasis on:
  – Use of real-time data to track homelessness and manage towards outcomes
  – Homeless outreach and engagement
  – Targeting of interventions to highest need
  – Increasing efficiency in resource allocation and supportive housing delivery system
  – “Mainstreaming” supportive housing
The cycle of chronic homelessness

Outreach and engagement

Assess and prioritize

Permanent Supportive Housing

Invest State, local, and CoC Program funds

Lower barriers to entry (Housing First)

Leverage mainstream housing and Medicaid

Hospital

Alcohol/Drug Treatment

Psychiatric Hospital

Shelter

Jail/Prison

Streets

The cycle of chronic homelessness
Financing Supportive Housing

- Requires aligning 2-3 types of funding:
  - Rental assistance
  - Supportive services
  - Capital, optional

- Often involves a patchwork of multiple funding sources from multiple agencies/systems

- HUD’s targeted homelessness funding (Continuum of Care program) has been largest source to date
Mainstreaming Supportive Housing

2015 CMS Info Bulletin:
- Medicaid increasingly covering behavioral health services
- Medicaid can also cover a comprehensive range of flexible, housing-related services:
  - Pre-Tenancy Services
  - Move-In Services
  - Tenancy Services
- Services can be provided in collaboration with agencies that administer affordable and subsidized housing programs
Mainstreaming Supportive Housing

• Public housing authorities increasingly using mainstream affordable housing programs (not specific to homelessness) to fund rental assistance in supportive housing or develop supportive housing

• This includes:
  – Housing Choice Vouchers (Section 8)
  – Public housing
U.S. has achieved reductions in chronic homelessness

Beds

Supportive Housing

Chronically Homeless Individuals
Some communities have effectively ended chronic homelessness

- In March 2017, Bergen County, NJ announced that it has effectively ended chronic homelessness

- All chronically homeless individuals were identified, engaged, placed into stable housing with supports and community has capacity to house any individual that becomes chronically homeless
Current Challenges

- High concentrations in certain jurisdictions (e.g. Los Angeles County)
- Rising rates of unsheltered homelessness and encampments, leading to stronger law enforcement response ("criminalization" of homelessness)
- Limitations of federal chronic homelessness definition
- Growing indications of medical vulnerability and mortality risk
Policy Opportunities

• Continue creating federal incentives to encourage communities to **efficiently allocate existing resources** to create and target supportive housing

• Provide technical assistance to help communities **maximize use of mainstream resources** like Medicaid and Housing Choice Vouchers to increase supportive housing

• Provide technical assistance and resources to help communities’ enhance and coordinate their **outreach and engagement** capacity
Policy Opportunities

• Improve **access to medical care** through Health Care for the Homeless programs, community health centers, and medical respite programs

• Identify best practices and provide technical assistance on **law enforcement and homeless services partnerships**
Overview

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• Veterans
• Q&A
Mental illness in jails remains a national tragedy

The inmate, who suffered from schizophrenia, was left in his own filth, eating and drinking almost nothing…

When he was finally unbound, guards dumped him to the floor of a nearby cell. Within 40 minutes, he had stopped breathing.”
A Top Concern of Criminal Justice Leaders

“You will not find a sheriff in this state or in this nation who is not struggling with the growing number of people with mental illnesses in our jails.”

- Orange County, CA Sheriff Sandra Hutchens
Prevalence of mental illness in jails 3X higher than in U.S.

Jails are where the volume is

Annual admissions to Jails vs. Prisons

626,644
6.9 million

Prison admissions
Jail admissions

Factors Driving the Crisis

- Disproportionately higher rates of arrest
- Longer stays in jail and prison
- Limited access to health care
- Higher recidivism rates
- Low utilization of EBPs
- More criminogenic risk factors
A Multi-System Failure

**Law enforcement**
Officers lack training on mental health and de-escalation and crisis services

**Courts**
Lack capacity to recognize mental illness, take clinical needs into account, and process cases quickly

**Local behavioral health**
Services are lacking or not equipped to service individuals with complex needs

**Programs and Probation**
Not using evidence-based practices
Incarceration Is Not Always Directly Related to the Individuals’ Mental Illness

Source: Peterson, Skeem, Kennealy, Bray, and Zvonkovic (2014)
Assessments for people with behavioral health conditions in the criminal justice system must attend to public safety dynamics as well as the individual’s health concerns

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<th>Objective</th>
<th>Public Safety</th>
<th>Health</th>
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<tr>
<td>Risk</td>
<td>Recidivism, Violence</td>
<td>Relapse, Decompensation, Overdose</td>
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<tr>
<td>Needs</td>
<td>Criminal Thinking, Associates, Drugs &amp; Alcohol, Family &amp; Relationships, Work/School, Lifestyle</td>
<td>Substance Abuse, Mental Illness, Co-occurring, Physical health, Supportive housing</td>
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Evidence-based framework for targeting interventions

Low Criminogenic Risk (low)

- Low Severity of Substance Abuse (low)
  - Group 1: I-L
    - CR: low
    - SA: low
    - MI: low
  - Group 2: II-L
    - CR: low
    - SA: low
    - MI: med/high

- Substance Dependence (med/high)
  - Group 3: III-L
    - CR: low
    - SA: med/high
    - MI: low
  - Group 4: IV-L
    - CR: low
    - SA: med/high
    - MI: med/high

Medium to High Criminogenic Risk (med/high)

- Low Severity of Substance Abuse (low)
  - Group 5: I-H
    - CR: med/high
    - SA: low
    - MI: med/high
  - Group 6: II-H
    - CR: med/high
    - SA: low
    - MI: med/high

- Substance Dependence (med/high)
  - Group 7: III-H
    - CR: med/high
    - SA: med/high
    - MI: low
  - Group 8: IV-H
    - CR: med/high
    - SA: med/high
    - MI: med/high

Low Severity of Mental Illness (low)

Serious Mental Illness (med/high)

Medium to High Severity of Mental Illness (med/high)

Substance Dependence (med/high)
Framework informs system and collaborative case planning

Subgrouping A
Low criminogenic risk/ significant BH treatment needs

- Group 2: II-L
  - CR: low
  - SA: low
  - MI: med/high

- Group 3: III-L
  - CR: low
  - SA: med/high
  - MI: low

- Group 4: IV-L
  - CR: low
  - SA: med/high
  - MI: med/high

Divert from criminal justice system without intensive community supervision if connected to appropriate treatment and supports

Subgrouping B
High criminogenic risk/ significant BH treatment needs

- Group 6: II-H
  - CR: med/high
  - SA: low
  - MI: med/high

- Group 7: III-H
  - CR: med/high
  - SA: med/high
  - MI: low

- Group 8: IV-H
  - CR: med/high
  - SA: med/high
  - MI: med/high

Prioritize for intensive supervision (in lieu of incarceration or as condition of release) coordinated with appropriate treatment and supports
Range of Diversion and Reentry to Continuum of Services and Supports

Flowchart:
- Law Enforcement:
  - Initial Contact with Law Enforcement
- Law Enforcement:
  - Arrest
- Jail-based:
  - Initial Detention
- Court-based:
  - First Court Appearance
- Pretrial:
  - Jail - Pretrial
- Court-based:
  - Dispositional Court
  - Specialty Court
- Jail-based:
  - Jail/Reentry
  - Prison/Reentry
  - Probation
  - Parole

Diagram:
- Services and Supports:
  - Mental Illness Treatment
  - Substance Use Treatment
  - Integrated Mental Illness and Substance Use Disorder Treatment
  - Primary Care
  - Integrated Behavioral Health and Primary Care
  - Short-term residential stabilization services
  - Mobile crisis services
  - Crisis hotlines
  - Outreach
  - Housing
  - Employment Services
  - Peer Support
  - Case Management
  - Trauma-Specific Treatment and Services
  - Income Supports
  - Transportation
- Clinical Treatment
- Crisis Response and Community Engagement
National Momentum Building to Address Crisis

The Vision
There will be fewer people with mental illnesses in jails than there are today.

420+ counties in 43 states, representing 40% of the U.S. population, have pledged to reduce the number of people with mental illnesses in jails.
Applying a “Collective Impact” Approach to Local Systems Change

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<tr>
<th>Six Questions</th>
<th>Four Key Measures</th>
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<tbody>
<tr>
<td>• Is your <strong>leadership</strong> committed?</td>
<td>1. Reduce the number of people with mental illnesses <em>booked</em> into jails</td>
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<tr>
<td>• Do you have <strong>timely screening and assessment</strong>?</td>
<td>2. Shorten the <strong>length of stay</strong> in jails for people with mental illnesses</td>
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<td>• Do you have <strong>baseline data</strong>?</td>
<td>3. Increase the percentage of people <strong>connected to treatment</strong></td>
</tr>
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<td>• Have you conducted a <strong>comprehensive process analysis</strong> and service inventory?</td>
<td>4. Reduce rates of <strong>recidivism</strong></td>
</tr>
<tr>
<td>• Have you prioritized <strong>policy, practice, and funding</strong>?</td>
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<tr>
<td>• Do you track <strong>progress</strong>?</td>
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Current Challenges

• Many counties lack collaborative governance structures to align decision-making across agencies
• Many counties do not systematically screen/assess for mental illnesses in jails and lack accurate data (and capacity to match data) on the prevalence of mental illnesses in jails
• Communities lack crisis response systems, coordinated entry and triage systems
• Misconception, fear, and stigma limit solutions
Medicaid and Managed Care

• Significant numbers of people in the criminal justice system are eligible for (and many, enrolled) in Medicaid

• Shifting rapidly to different payment and delivery systems with the goals of improving outcomes and controlling costs
  – Whole person care
  – People with complex care needs

• Managed care
  – Greater accountability for outcomes
  – Opportunities to improve care coordination and management
  – More states have moved to carve-in arrangements for BH in recent years
Policy Opportunities

• Use federal policy levers to encourage and reinforce collaborative planning and decision-making at the local level
• Support accurate mental health screening and assessment by jails
• Improve data collection and accuracy on criminal justice-involved population and capacity to match data across sectors
• Provide funding and technical assistance to help communities address gaps in diversion and community-based services (crisis stabilization and recovery supports)
• Support state innovation in Medicaid and managed care to incentivize improved recovery and recidivism outcomes
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Veterans

- 50% of military veterans report needing mental health care
- 4.6% of veterans in VHA identified as having SMI
- High rates of justice-involvement and homelessness among veterans, but prevalence of SMI not clear

All Veterans

Justice-Involved Veterans (20%)

Veterans with SMI (5%)

Homeless Veterans (8%)
Significant Progress in Addressing Homelessness and Justice-Involvement among Veterans

- 45% decrease in homelessness among veterans since 2009, coinciding with investments of HUD-VASH and other programs
- Greater identification of veterans in jails and prisons and connection to services through Veterans Justice Outreach and Health Care for Reentry Veterans
- Serves as “proof point” of effectiveness of services interventions, system accountability, and collective impact
Policy Opportunities

• Sustain level of investment and resource deployment for HUD-VA Supportive Housing program, both at HUD and VA
• Continue encouraging communities to systematically identify, engage, and track data on veterans experiencing homelessness
• Encourage coordination between VA Medical Centers and counties to identify, engage, and track data on veterans with SMI in jails
• Improve coordination between 9-1-1 dispatch, law enforcement, and VA’s bed programs (domiciliary care, HCHV, and Grant and Per Diem) to provide crisis stabilization for veterans with SMI
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The presentation was developed by members of The Council of State Governments Justice Center staff. The statements made reflect the views of the authors, and should not be considered the official position of The Council of State Governments Justice Center, the members of The Council of State Governments, or the funding agency supporting the work.

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