

Oregon Department of Human Services/Oregon Health Authority

Addictions and Mental Health Division

Olmstead Plan draft

May 13, 2010

To achieve the intent of the Olmstead decision (*Appendix A*) Oregon intends to move healthy people to independent housing that promotes recovery, resiliency, independence and wellness in a system that is consumer driven and assists people in obtaining “a key to their own door.” Oregon will achieve this goal by reducing the length of stay (LOS) at the Oregon State Hospital (OSH), establishing independent living environments statewide and preventing hospitalization at OSH.

This Olmstead plan will provide the reader with a brief history of the current barriers, Oregon’s solution to those barriers as well as future plans and projects to prevent these and other barriers from recurring. The plan consists of three sections and thirteen strategies to assure that people transition to the community expeditiously as they work towards self-sufficiency.

Section I

OSH Length of Stay (LOS)

The emphasis on community-based treatment for mental health services grew in the 1980s, based on recommendations by a series of commissions, task forces appointed by the Governor and DHS, and Executive Orders. The closure of Dammasch State Hospital in 1995 was a landmark step to moving from state hospital care to community mental health services. The “deinstitutionalization” movement in Oregon paralleled a national movement. Oregon has been intentional in its goal of keeping people as independent as possible, as demonstrated by the closure of the Dammasch State Hospital, moving approximately 375 people to Oregon communities primarily in smaller, structured, state licensed residential facilities.

To reduce the LOS at the OSH, the Addictions and Mental Health Division (AMH) is working closely with consumers of mental health services and supports, OSH staff, community mental health programs, providers of mental health services and supports, stakeholders and advocates to identify past practice, current barriers and future solutions to more timely discharges that would contribute to a reduced LOS at OSH. Currently the average LOS across the state hospital system is 338 days. This work was done in concert with the Transformation efforts that are being utilized throughout the Oregon Department of Human Services. In 2007, DHS embarked on a Transformation which is a systematic approach to fundamentally changing the way business is done. At AMH, these structures and tools are being used to provide more and effective client services and to improve accountability. The goal is to build a foundation for continuous improvement by repeatedly measuring performance, quickly resolving problems and efficiently using resources. OSH, AMH and community mental health partners currently have several initiatives underway which will address the barriers to diversion, de-institutionalization and community integration previously outlined in this plan.

I. Transitioning People to the Community

Staff from OSH and AMH, consumers of mental health services and supports, community mental health program representatives, providers of mental health services and supports worked together and identified several barriers that resulted in people staying too long at OSH. These barriers and accompanying solutions are the basis for AMH’s transformation initiative for transitioning people to the community. The main goal is to assure that people are discharged from OSH more quickly using both a standardized set

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of readiness discharge criteria and a standardized level of care tool. (*Appendix B*) The tool selected is the Level of Care Utilization of Services 10th edition. (*Appendix C*) AMH is implementing training of the LOCUS using a “train the trainer methodology” to train a core group of individuals from OSH, AMH, the community mental health programs, providers of mental health services and supports as well as consumers of mental health services and supports how to apply the tool as part of both the OSH discharge process and to determine the level of care, supports and services an individual needs to be successful in the community. These representatives can then provide training to their peers so that a large number of people will be trained to the same assessment tool across the state. Oregon believes that this current transformation initiative will be successful in decreasing the LOS at OSH by providing standardization to both the discharge criteria and standardization in the use of an assessment tool used statewide. Those standardization components, increased statewide training capacity to those who administer and provide the services and supports, plus improving the entire discharge process from OSH to the community will prove successful for Oregonians in obtaining “a key to their own door.” Both the standardized ready to place criteria and the LOCUS were adopted April 2010 and are scheduled for implementation May 2010.

II. Psychiatric Security Review Board (PSRB)

In 2009, the Governor directed the Department of Human Services (DHS) and Addictions and Mental Health (AMH) to research and make recommendations to improve the process for moving people under the jurisdiction of the Psychiatric Security Review Board (PSRB) into the community when they were deemed ready. The research included reviewing current process, policies, procedures, Oregon Administrative Rules and Statutes, and interviewing OSH staff, patients, patient families, advocates, community providers, AMH staff, PSRB staff and board members. After gathering data, recommendations were created and a Coalition group was formed in 2010 to review and approve them. The Coalition group includes the Executive Director of PSRB, OSH Superintendent, and Assistant Director of AMH with assistance from the Governor’s Office, the AMH researchers, and Oregon Department of Justice (ODOJ). The Coalition’s charge is to determine goals, create implementation strategies, and implement approved recommendations.

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At this time, work is being done on several approved short term goals to ensure the conditional release readiness determinations and community placements of patients under PSRB jurisdiction by OSH and PSRB occur more smoothly by decreasing delays caused by inconsistencies, lack of information, lack of training, and backlogs.

In addition, OSH in conjunction with both AMH and the PSRB needs to provide a standardized assessment of need in order to identify appropriate treatment resources both in the community and the forensic hospital.

III. Community Residential Capacity Utilization Review

To determine “patient flow” within the community residential system, AMH conducted a utilization review of 10 residential care providers. These providers were selected for interview because their residents typically experience unusually long lengths of stay. The 10 providers represented 5 residential treatment facilities, 2 secure residential treatment facilities, and 3 residential treatment homes. This study yielded some interesting information and allowed AMH staff to refine its tools and methodology. Subsequently, AMH contracted with Acumentra Health, a nonprofit organization whose focus is improving the quality and effectiveness of healthcare by providing external quality reviews of services and supports, to conduct a more comprehensive system-wide utilization review. The basic goals for the utilization review work of Acumentra is to assess the appropriateness of current placements and determine the appropriateness of placements. The Acumentra Health utilization study is anticipated to be completed September 2010 with results to be posted on the AMH website.¹ AMH believes that this study will yield data that will further efforts to provide people the right amount of treatment in the most appropriate settings for the right amount time.

IV. Peer Bridger Program (OSH)

The fourth strategy that will help address the LOS concerns at OSH will build on the current Peer Bridgers Program that OSH adopted in 2008. The program uses peers who have received inpatient public mental health services to formally support and mentor patients ready to be discharged. A

¹ [AMH \[web link\]](#)

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Peer Bridgers' representative will work closely with the person once s/he has been discharged into the community. This program is modeled on a New York state program. A multi-year evaluation of the New York Peer Bridgers program demonstrated that state hospital patients participating in the program were re-hospitalized an average of 19%, while a control group of patients averaged a 60% re-hospitalization rate. OSH has four Peer Bridgers/Recovery Specialists. In addition Oregon is expanding its work with peer delivered services in the community as well with the belief that increased peer services and supports with people receiving mental health treatment will enhance and provide the necessary bridge, when combined with community based treatment for both successful community living and decreased re-hospitalizations. This initiative will be more fully addressed later in this plan. (*Appendix E*)

V. New Treatment Model at OSH

Oregon believes that providing at least 20 hours of active treatment in a treatment setting that more closely mirrors treatment in the community will promote recovery, resiliency, independence and wellness for those people receiving services. In anticipation of the new Oregon State Hospital physical facility and in keeping with Oregon's Olmstead goals, OSH has adopted and is currently implementing an innovative "treatment mall" approach to treatment and service delivery for people needing state hospital level of care. The purpose of this strategy is to better prepare people for a more independent living setting after leaving the hospital.

The new treatment mall is based on a treatment philosophy utilized by new and renovated psychiatric hospitals. It employs a community design of centralized care in which the patients' living areas are connected to a "neighborhood" mall that connects to a larger "downtown" mall so that patients can access at least 20 hours of active treatment services per week provided on the treatment mall and have more opportunities for healthy socialization and wellness activities. While patients will live on a unit, they will receive treatment, eat meals, attend classes and participate in activities in the mall areas. There is growing evidence that this centralized model can provide lasting benefits, including a decrease in hospital readmission rates, increased skills in symptom management and improved quality of life. This also prepares the person for a treatment experience that more closely mirrors how community members receive treatment, services and supports; that is to

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say we leave our homes to seek treatment, employment, services and supports in the communities in which we live. Current new treatment malls operating are the Gero Psychiatric Mall which opened June 1st, 2008, the 40 Treatment Mall which opened March 3rd, 2009, Portland Mall which opened February 2007 and the 50 Treatment Mall which opened January 19th, 2010. For the new facility, the treatment malls and scheduled opening dates are: ABC Harbors. Scheduled to open December 3rd, 2010 with the remaining malls Trails (PSR), Bridger's transition, Neuro and New Generation to open based on the facility construction schedule.

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Section II

Establishment of Independent Living Environments

VI. Supported Housing

Prior to the 1999 Olmstead decision, Oregon closed the Dammasch State Hospital, (Dammasch) located in Wilsonville in July 1995. To accomplish this Oregon focused on providing less restrictive community based services for those people living in Dammasch. Dammasch opened in 1961 and was successfully closed 1995, moving approximately 375 people to Oregon communities primarily in smaller, structured, state licensed residential facilities. The former Dammasch site is now home to Villebois, a planned community.² Currently at Villebois, there are 10 beds available in two residential treatment homes (Hearthstone and Fieldstone) and 64 supported housing opportunities in three settings (The Charleston, Renaissance Court and Rain Garden).

The current average length of stay in Oregon's residential treatment programs varies by the type of facility and ranges from just under 400 days in adult foster homes to nearly 600 days in residential treatment facilities. The average length of stay in Oregon state hospitals for the civilly committed population is just over one year with a small group of clients staying more than five years. The time many people are staying in these institutions is far too long. The length of stay can only be reduced with an investment in supportive housing resources.

To meet the growing need for community services for people with mental illness, over the past 15 years Oregon had focused on increasing facility-based care in local communities rather than expanding state hospital services for people who are civilly committed. For the past several biennia, the Oregon legislature has approved funding to increase facility-based care which resulted in an increase in residential treatment facilities throughout the state. This increase has provided community treatment opportunities for

² Inspired by traditional European villages, Villebois, which translates to "village near the woods," is a 500-acre master-planned community in Wilsonville, Ore. At the heart of Villebois will be the Village Center, characterized by elements such as apartments and row homes as well as ground level retail and commercial space. Surrounding the Village Center are three distinct neighborhoods, Villebois features diverse housing types, including apartments, community housing and condominiums, attached row and town homes, as well as single-family detached homes on lots of varying sizes. The entire community is connected by more than 130-acres of trails and open green spaces, including parks and nature preserves that join to trails that lead well beyond Villebois.

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people who are discharged from OSH and Blue Mountain Recovery Center (BMRC).

The current service delivery system is overly reliant on the use of residential facilities, which are less flexible and more costly than a community-based supportive housing system. The residential facility system lacks the supportive housing resources that keep people living in their own homes rather than small or large group settings.

To address these deficiencies, housing opportunities in the community with an array of supportive services is not only more effective treatment for many, but it provides an increase in capacity by reducing the length of stay in residential facilities by providing more permanent housing plus services. Without an investment in supportive housing, intensive outpatient and peer services Oregon will not be able to move individuals from state or community facilities to self-sufficiency.

Central to Oregon's mental health policy direction is the need for an individually driven treatment system that promotes recovery, resiliency, independence and wellness while providing people with "a key to their own door." A foundational component of recovery is safe and affordable housing with access to treatment services and supports when they are needed; in other words the right amount of services at the right time for the right amount of time. To create an effective and efficient array of housing services and supports and in response to the aforementioned utilization study results, Oregon is establishing more independent living environments through increased supportive housing capacity, increased rental subsidies and associated housing supports and services and increased supported employment opportunities. This strategy is captured and documented in AMH's supportive housing initiative. (*Appendix E*) AMH will work with community partners to provide rental assistance for at least 400 people by June 30, 2011, through a combined effort of the supportive housing initiative and the AMHI initiative.

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Oregon is working to provide treatment to people at the earliest point possible within the course of their illness. Understandably, this will occur at different times for every person but the primary goal is to prevent state hospitalization and the associated stigma that accompanies a person when they re-enter the community.

Oregon is focusing investments on several key issues to prevent people from being hospitalized at OSH; those issues are the establishment, promotion and sustainment of a recovery oriented system of care, investment in early psychosis and early assessment screening, peer delivered services and wellness programs.

VII. Improving Service Access Through Local Accountability

The seventh strategy that Oregon is developing is the Adult Mental Health Initiative (AMHI). AMHI is designed to promote more effective utilization of current capacity in facility based treatment settings, increase care coordination and increase accountability at a local and state level. It is also designed to promote the availability and quality of individualized community-based services and supports, so that adults with mental illness are served in the least restrictive environment possible and use of long-term institutional care is minimized.

AMHI is working with local or regional MHOs, Community Mental Health Programs (CMHPs), providers and stakeholders, to design and implement financing, contracting and service delivery strategies that bring together isolated service components to assist individuals in a collaborative clinically appropriate approach to recovery. Services will be community-based with management, decision-making and service delivery occurring at the local level. AMHI will build on and compliment other efforts currently under way such as implementing a standardized assessment tool, utilizing a standardized discharge processes from state institutions and introducing newly approved Medicaid State Plan Amendments. The intent of AMHI is to manage utilization to the get the right level of service to individuals at the right time and place. AMHI will be system-wide care management to move individuals to self sufficiency.

Oregon believes that the AMHI initiative will provide the ongoing

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framework, continued development and support of a statewide initiative to improve the integration and collaboration among providers of mental health, substance abuse treatment and physical health care. In addition, there will be coordinated care for people accessing publicly funded health services and early intervention for mental health and substance abuse issues will be maximized. This intervention will help prevent avoidable illnesses and provide treatment of chronic conditions. Ramifications of these health disparities and chronic conditions will be addressed in the Wellness section of this plan.

VIII. Recovery-oriented System of Care

Recovery is a lifelong process that brings with it many experiences of both success and temporary setbacks. For a successful recovery-oriented system of care to thrive, there needs to be adequate funding for services and supports, adequate access to services and supports at the time a person needs them and for the right amount of time for people to succeed in treatment. In March 2007 the Addictions and Mental Health Division's (AMH) Community Services Workgroup (CSWG) published its final report. The purpose of the report was to inform AMH, the Department of Human Services (DHS), the Governor and the Legislature about the range of community-based services needed to complement the replacement of state hospital facilities and to assure the successful operation of the new hospitals. (*Appendix D*)

The CSWG report indicated that without a fully funded and operational services and supports system, the staff would be frustrated in its efforts to provide treatment to people in the community versus the state hospital. Unless the state invests in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant new investment must also be made to develop and enhance a robust array of community services that support individual recovery goals.

IX. Early Psychosis and Early Assessment Screening

Early intervention in psychosis is a well-researched model. It is based on the observation that identifying and treating someone in the early stages of a psychosis can significantly improve their longer-term outcome. Beginning in 2007, HB 2144 created the Children's Wraparound Initiative in order to build a system of care that collaborates across agencies, families and youth to improve access and expand the array of coordinated community-based,

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culturally and linguistically appropriate services and natural supports for children and youth with serious mental health needs. The Children's Wrap Around initiative is cross-divisional with the Children, Adults and Families (CAF) division of DHS, touching the lives of children from birth to age 18, who have been in the custody of DHS for more than one year and have had at least four placements or who come into custody and immediately need specialized behavioral health services and supports. (*Appendix E*)

The 2007 Oregon legislature funded EASA to bring the most current, evidence-based treatment to individuals in the early stages of illness. This approach advocates the use of an intensive multi-disciplinary approach during what is known as the critical period, where intervention is the most effective, and prevents the long term morbidity associated with chronic psychotic illness. There are currently seven community mental health programs with EASA sites representing nine counties. EASA uses evidence-based practices to do early assessment and intervention for young adults having their first experience with psychosis. Its primary purpose is to reduce the disability associated with psychosis.

X. Peer Delivered Services

Research increasingly demonstrates the effectiveness of peer delivered services, and people receiving mental health services voice the positive effect of services provided by people who have had similar experiences. Mental health disorders are chronic conditions requiring treatment of acute symptoms and on-going management, supports and monitoring to avoid relapse. Individuals with mental health disorders need recovery support services to help them navigate systems, understand the issues related to these chronic diseases and provide them with the tools and skills to begin healing and rebuilding their lives. These support services are often best provided by people who themselves have received mental health services.

Oregon is expanding its work with peer delivered services with the knowledge that increased peer services and supports combined with community based treatment will enhance and provide people the necessary bridge for both successful community living and decreased re-hospitalizations.

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Providing community-based treatment to both young adults in transition and adults needing mental health treatment, services and supports is a cornerstone of recovery. AMH in collaboration with local community mental health programs funded a “warm” line. This warm line is designed and provided by people who have or have had mental health challenges and are able to support their peers telephonically when they are struggling with a variety of mental health concerns. [The warm line was frequently used.](#) For 2009, the average number of calls responded to per month was approximately 350-400, with an average call length of 30 minutes, using 100 trained operators statewide.

AMH is implementing rules, policies and procedures to promote and increase the utilization of peer delivered services (PDS) in Oregon. AMH is streamlining and consolidating service delivery through the March 2010 adoption of the Integrated Services and Supports Administrative Rules (ISSR) that includes defining peer delivered services and identifying service areas for employment and volunteer opportunities. AMH aligns its focus with national and international recovery thinking, person-centered health care planning, client self-determination and a holistic wellness approach in its mental health and addiction services delivery transformation. This focus is demonstrated by a policy and procedure for reviewing and approving peer delivered services training and curricula which meet Center for Medicare and Medicaid Services (CMS) and national consumer operated organization standards.

XI. Wellness

In its report, *Measuring Premature Mortality among Oregonians* (AMH, 2008) AMH reported that clients with mental illness die approximately 16 years younger than the average population. Individuals with dual diagnosis die even earlier. This disparity is due to heart disease, diabetes and problems related to side effects of medications, smoking, obesity and lack of holistic medical care, according to research by a national mental health council. AMH will build on current activities within the Wellness Initiative by working closely with AMH Wellness Task Force, DHS Core Integration Team, the Public Health Division, Oregon State Hospital, mentors, consumers, family members, community stakeholder groups and providers

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with national experts to move from knowing about health inequities to taking immediate action steps to prevent these disparities.

The Community Services Workgroup report states that AMH “. . . should include the establishment and ongoing support of a wellness task force. AMH should also develop a quality improvement process that supports increased access to physical health care and ensures appropriate prevention, screening and treatment services for persons with addictions and/or mental health disorders.” The Oregon study concludes that premature mortality among people receiving mental health services is a health care crisis and recommends AMH (via a Wellness Task Force) work with community agencies to implement changes in care coordination, wellness screening and use of peer-to-peer support services to empower people with serious mental illness and/or substance use disorders in achieving lifestyle changes that will improve their overall health. The AMH Wellness Initiative strengthens integration efforts already underway between physical health and behavioral health care providers. It blends the work of the AMH Wellness Task Force, DHS Core Integration Team, the Oregon Public Health Division, hospitals, mentors, consumers, family members, community stakeholder groups, providers and national experts to move as a united force to end health inequities and take immediate action to eliminate contributing factors to preventable diseases. Here are three current wellness projects:

A Public Health Approach – Health integration is our future and will translate into increased access to appropriate health care services through a public health care approach across the lifespan. Integrated physical health care and behavioral health care experts are joining forces to provide a full range of health promotion and intervention services – collaborating, collocating, cross-training with our health care workforce to reach individuals and families where they live...in their community.

The Oregon Public Health Division (PHD) and Oregon Addictions and Mental Health Division (AMH) are taking a lead role in our statewide AMH Wellness Initiative. Currently, we are working on new policy recommendations to dramatically address the use of tobacco products at all DHS-AMH treatment or residential service sites. In addition to the local projects reflected below, PHD and AMH are teaming up with statewide representatives from the mental health and addictions recovery community

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to build community wellness champions in every county and/or region of the state to build a local peer wellness program.

Tobacco Freedom – An approach to support self-determination, utilizing a person’s motivation to choose to be free from an addictive substance; equipping individuals, residential treatment settings and community consumer run organizations with cessation supports and treatment strategies.

Community Peer Wellness Forums – Quarterly education forums bring together providers, customers, family members, and local complimentary healing vendors to increase awareness of health promotion and wellness options in the community, promote a healing network, and raise community action to increase prevention efforts and health care services to meet the needs of all citizens. The face-to-face interaction between community members from all walks of life breaks down social barriers, dispelling myths about mental illness and eliminate stigma.

Nutrition and Exercise – A multi-pronged approach to increase adoption of healthy food options and appropriate levels of exercise; i.e., dance, yoga, walking for the populations we serve in all therapeutic and independent settings.

The goals for the above initiatives include:

- Decrease access and use of tobacco products by clients and staff.
- Health promotion with appropriate NRT supports in place for AMH clients.
- Expansion of a peer services network in the community providing wellness coaching.
- Increase access to holistic, person-centered healthcare in the public service arena through collaboration and collocation.
- Increase in opportunities for workforce development in health care services; promoting physical health and behavioral health care integration.

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- Increase in complimentary therapeutic interventions available to persons receiving services.
- Increase in client self-empowerment and self-determination in fulfilling their personal wellness plans.
- Statewide agency coordination on health and wellness efforts.
- Shared resources and resource savings through greater state and community partnership.
- Decrease in the number of productive years of life lost to preventable conditions.

XII. Oregon Health Authority

Oregon has a unique opportunity to provide services and supports in a more integrated manner through the Oregon Health Authority (OHA). The OHA was created by legislation in 2009 (House Bill 2009) to be implemented at the beginning of the July 2011 biennium. The mission of the OHA is to help people and communities achieve optimum physical, mental and social well being through partnerships, prevention and access to quality, affordable health care. The ultimate aim of the OHA is to ensure access to health care while making changes that will stem rising costs, improve quality and promote good health. This provides Oregon with an opportunity to have the needs of this population considered in important health care reform. OHA knows what it needs to do to improve health care: focus on health and preventive care, provide care for everyone and reduce waste in the health care system. OHA will be tackling these problems in both the public and private sectors.

XIII. Consumer Participation

Oregon Revised Statute (ORS) 430.075 provides that at least 20 percent membership of task forces, commissions, advisory groups and committees primarily related to mental health or addictions issues must be composed of consumers of services. This important legislation was passed in 2007 with the full support of local and statewide consumer groups, ensuring that the

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voice of people who are currently receiving mental health or addiction services or have received services are included in policy and decision making. In order to encourage statewide participation, individuals receive compensation for their travel expenses. Reimbursement comes from a combination of federal (i.e. Mental Health Block Grant) and General Fund sources. To expand consumer voice statewide, Oregon is promoting consumers as educators of mental health and addiction services. Oregon will continue to actively seek consumer participation in the development of community based programs. Oregon will actively seek and support consumer participation as members of quality improvement site reviews and will provide increased consumer education regarding Olmstead and policy development and implementation. AMH will seek funding to support community based consumer organizations thru an Office of Consumer Activities.

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Summary

Looking to the future, Oregon is embarking on 15 new policy driven initiatives. Many of which are identified in this document. (*Appendix E*) These initiatives will move Oregon to a more recovery focused system and will substantially increase the availability, utilization and quality of individualized, integrated, culturally competent, home and community-based services for children, youth, and adults.

Oregon's goal to achieve the intent of the Olmstead decision is to move healthy people to independent housing that promotes recovery, resiliency, independence and wellness while providing people with "a key to their own door." Oregon will achieve this goal by reducing the length of stay (LOS) at the Oregon State Hospital (OSH), establishing independent living environments statewide and preventing hospitalization at OSH.

Oregon's system is now under stress because the state had relied on creating a facility-based approach to service delivery. The mental health system at present is meeting less than 50 percent of the need for public services for adults and children. As identified in the CSWG report ". . . without the investment in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant investment must also be made to develop and enhance a robust array of community services that support individual recovery goals." These services and supports must be consumer driven not only at the clinical level, but with consumer's providing an active voice through participation in local and state governance bodies.

It is critical that each community or regional system of care in our state have enough resources to fund a set of core services and supports. Oregon will not be successful with the replacement state hospital facilities envisioned by the State Hospital Master Plan. The facilities will be successful in operating with limited beds, shorter lengths of stay and a manageable occupancy rate if every region is not funded comprehensively and comparably, based on objective analysis of the relative need in each geographic area. A robustly funded community-based system of care is not only essential to the operation of the state hospital it is essential in meeting Oregon's Olmstead goals.

Appendix A

Olmstead v. L.C. (98-536) 527 U.S. 581 (1999)

OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* v. L. C.,
by zimiring, guardian ad litem and next
friend, et al.

certiorari to the united states court of appeals for the eleventh circuit

No. 98-536. Argued April 21, 1999--Decided June 22, 1999

In the Americans with Disabilities Act of 1990 (ADA), Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. 42 U. S. C. §§12101(a)(2), (5). Title II of the ADA, which proscribes discrimination in the provision of public services, specifies, *inter alia*, that no qualified individual with a disability shall, "by reason of such disability," be excluded from participation in, or be denied the benefits of, a public entity's services, programs, or activities. §12132. Congress instructed the Attorney General to issue regulations implementing Title II's discrimination proscription. See §12134(a). One such regulation, known as the "integration regulation," requires a "public entity [to] administer ... programs ... in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR §35.130(d). A further prescription, here called the "reasonable-modifications regulation," requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," but does not require measures that would "fundamentally alter" the nature of the entity's programs. §35.130(b)(7).

Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women were voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where they were confined for treatment in a psychiatric unit. Although their treatment professionals eventually concluded that each of the women could be cared for appropriately in a community-based program, the women remained institutionalized at GRH. Seeking placement in community care, L. C. filed this suit against petitioner state officials (collectively, the State) under 42 U. S. C. §1983 and Title II. She alleged that the State violated Title II in failing to place her in a community-based program once her treating professionals determined that such placement was appropriate. E. W. intervened, stating an identical claim. The District Court granted partial summary judgment for the women, ordering their placement in an appropriate community-based treatment program. The court rejected the State's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of [their] disabilit[ies]," accounted for their retention at GRH. Under Title II, the court concluded, unnecessary institutional segregation constitutes discrimination *per se*, which cannot be justified by a lack of funding. The court also rejected the State's defense that requiring immediate transfers in such cases would "fundamentally alter" the State's programs. The Eleventh Circuit affirmed the District Court's judgment, but remanded for reassessment of the State's cost-based defense. The District Court had left virtually no room for such a defense. The appeals court read the statute and regulations to allow the defense, but only in tightly limited circumstances. Accordingly, the Eleventh Circuit instructed the District Court to consider, as a key factor, whether the additional cost for treatment of L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget.

Held: The judgment is affirmed in part and vacated in part, and the case is remanded.

138 F. 3d 893, affirmed in part, vacated in part, and remanded.

Justice Ginsburg delivered the opinion of the Court with respect to Parts I, II, and III-A, concluding that, under Title II of the ADA, States are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Pp. 11-18.

(a) The integration and reasonable-modifications regulations issued by the Attorney General rest on two key determinations: (1) Unjustified placement or retention of persons in institutions severely limits their exposure to the outside community, and therefore constitutes a form of discrimination based on disability prohibited by Title II, and (2) qualifying their obligation to avoid unjustified isolation of individuals with disabilities, States can resist modifications that would fundamentally alter the nature of their services and programs. The Eleventh Circuit essentially upheld the Attorney General's construction of the ADA. This Court affirms the Court of Appeals decision in substantial part. Pp. 11-12.

(b) Undue institutionalization qualifies as discrimination "by reason of ... disability." The Department of Justice has consistently advocated that it does. Because the Department is the agency directed by Congress to issue Title II regulations, its views warrant respect. This Court need not inquire whether the degree of deference described in *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 844, is in order; the well-reasoned views of the agencies implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. *E.g.*, *Bragdon v. Abbott*, 524 U. S. 624, 642. According to the State, L. C. and E. W. encountered no discrimination "by reason of" their disabilities because they were not denied community placement on account of those disabilities, nor were they subjected to "discrimination," for they identified no comparison class of similarly situated individuals given preferential treatment. In rejecting these positions, the Court recognizes that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA. The ADA stepped up earlier efforts in the Developmentally Disabled Assistance and Bill of Rights Act and the Rehabilitation Act of 1973 to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The ADA both requires all public entities to refrain from discrimination, see §12132, and specifically identifies unjustified "segregation" of persons with disabilities as a "for[m] of discrimination," see §§12101(a)(2), 12101(a)(5). The identification of unjustified segregation as discrimination reflects two evident judgments: Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, *cf.*, *e.g.*, *Allen v. Wright*, 468 U. S. 737, 755; and institutional confinement severely diminishes individuals' everyday life activities. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. The State correctly uses the past tense to frame its argument that, despite Congress' ADA findings, the Medicaid statute "reflected" a congressional policy preference for institutional treatment over treatment in the community. Since 1981, Medicaid has in fact provided funding for state-run home and community-based care through a waiver program. This Court emphasizes that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. In this case, however, it is not genuinely disputed that L. C. and E. W. are individuals "qualified" for noninstitutional care: The State's own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. Pp. 12-18.

Justice Ginsburg, joined by *Justice O'Connor*, *Justice Souter*, and *Justice Breyer*, concluded in Part III-B that the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of "reasonable modifications" to avoid discrimination, and allows States to resist modifications that entail a "fundamenta[l] alter[ation]" of the States' services and programs. If, as the Eleventh Circuit indicated, the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities. The ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State

proposed, then retracted, for E. W. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time to stabilize acute psychiatric symptoms. For others, no placement outside the institution may ever be appropriate. To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions. The case is remanded for further consideration of the appropriate relief, given the range of the State's facilities for the care of persons with diverse mental disabilities, and its obligation to administer services with an even hand. Pp. 18-22.

Justice Stevens would affirm the judgment of the Court of Appeals, but because there are not five votes for that disposition, joined *Justice Ginsburg*'s judgment and Parts I, II, and III-A of her opinion. Pp. 1-2.

Justice Kennedy concluded that the case must be remanded for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U. S. C. §12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed. On the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. Thus, respondents could demonstrate discrimination by showing that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities). This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. Thus far, respondents have identified no class of similarly situated individuals, let alone shown them to have been given preferential treatment. Without additional information, the Court cannot address the issue in the way the statute demands. As a consequence, the partial summary judgment granted respondents ought not to be sustained. In addition, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. The lower courts should determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested. Pp. 1-10.

Ginsburg, J., announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III-A, in which *Stevens*, *O'Connor*, *Souter*, and *Breyer*, JJ., joined, and an opinion with respect to Part III-B, in which *O'Connor*, *Souter*, and *Breyer*, JJ., joined. *Stevens*, J., filed an opinion concurring in part and concurring in the judgment. *Kennedy*, J., filed an opinion concurring in the judgment, in which *Breyer*, J., joined as to Part I. *Thomas*, J., filed a dissenting opinion, in which *Rehnquist*, C. J., and *Scalia*, J., joined.

TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* ,
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend* , *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

Justice Ginsburg announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III-A, and an opinion with respect to Part III-B, in which *O'Connor*, *Souter*, and *Breyer, JJ.*, joined.

This case concerns the proper construction of the anti-discrimination provision contained in the public services portion (Title II) of the Americans with Disabilities Act of 1990, 104 Stat. 337, 42 U. S. C. §12132. Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes. Such action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. In so ruling, we affirm the decision of the Eleventh Circuit in substantial part. We remand the case, however, for further consideration of the appropriate relief, given the range of facilities the State maintains for the care and treatment of persons with diverse mental disabilities, and its obligation to administer services with an even hand.

I

This case, as it comes to us, presents no constitutional question. The complaints filed by plaintiffs-respondents L. C. and E. W. did include such an issue; L. C. and E. W. alleged that defendants-petitioners, Georgia health care officials, failed to afford them minimally adequate care and freedom from undue restraint, in violation of their rights under the Due Process Clause of the Fourteenth Amendment. See Complaint ¶ ;¶ ;87-91; Intervenor's Complaint ¶ ;¶ ;30-34. But neither the District Court nor the Court of Appeals reached those Fourteenth Amendment claims. See Civ. No. 1:95-cv-1210-MHS (ND Ga., Mar. 26, 1997), pp. 5-6, 11-13, App. to Pet. for Cert. 34a-35a, 40a-41a; 138 F. 3d 893, 895, and n. 3 (CA11 1998). Instead, the courts below resolved the case solely on statutory grounds. Our review is similarly confined. Cf. *Cleburne v. Cleburne Living Center, Inc.* , 473 U. S. 432, 450 (1985) (Texas city's requirement of special use permit for operation of group home for mentally retarded, when other care and multiple-dwelling facilities were freely permitted, lacked rational basis and therefore violated Equal Protection Clause of Fourteenth Amendment). Mindful that it is a statute we are construing, we set out first the legislative and regulatory prescriptions on which the case turns.

In the opening provisions of the ADA, Congress stated findings applicable to the statute in all its parts. Most relevant to this case, Congress determined that

"(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

"(3) discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization . . . ;

.....

"(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, . . . failure to make modifications to existing facilities and practices, . . . [and] segregation . . ." 42 U. S. C. §§12101(a)(2), (3), (5).¹

Congress then set forth prohibitions against discrimination in employment (Title I, §§12111-12117), public services furnished by governmental entities (Title II, §§12131-12165), and public accommodations provided by private entities (Title III, §§12181-12189). The statute as a whole is intended "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." §12101(b)(1).²

This case concerns Title II, the public services portion of the ADA.³ The provision of Title II centrally at issue reads:

"Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." §12132.

Title II's definition section states that "public entity" includes "any State or local government," and "any department, agency, [or] special purpose district." §§12131(1)(A), (B). The same section defines "qualified individual with a disability" as

"an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." §12131(2).

On redress for violations of §12132's discrimination prohibition, Congress referred to remedies available under §505 of the Rehabilitation Act of 1973, 92 Stat. 2982, 29 U. S. C. §794a. See 42 U. S. C. §12133 ("The remedies, procedures, and rights set forth in [§505 of the Rehabilitation Act] shall be the remedies, procedures, and rights this subchapter provides to any person alleging discrimination on the basis of disability in violation of section 12132 of this title.").⁴

Congress instructed the Attorney General to issue regulations implementing provisions of Title II, including §12132's discrimination proscription. See §12134(a) ("[T]he Attorney General shall promulgate regulations in an accessible format that implement this part.").⁵ The Attorney General's regulations, Congress further directed, "shall be consistent with this chapter and with the coordination regulations . . . applicable to recipients of Federal financial assistance under [§504 of the Rehabilitation Act]." 42 U. S. C. §12134(b). One of the §504 regulations requires recipients of federal funds to "administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 CFR §41.51(d) (1998).

As Congress instructed, the Attorney General issued Title II regulations, see 28 CFR pt. 35 (1998), including one modeled on the §504 regulation just quoted; called the "integration regulation," it reads:

"A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR §35.130(d) (1998).

The preamble to the Attorney General's Title II regulations defines "the most integrated setting appropriate to the needs of qualified individuals with disabilities" to mean "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 CFR

pt. 35, App. A, p. 450 (1998). Another regulation requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," unless those modifications would entail a "fundamenta[l] alter[ation]"; called here the "reasonable-modifications regulation," it provides:

"A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998).

We recite these regulations with the caveat that we do not here determine their validity. While the parties differ on the proper construction and enforcement of the regulations, we do not understand petitioners to challenge the regulatory formulations themselves as outside the congressional authorization. See Brief for Petitioners 16-17, 36, 40-41; Reply Brief 15-16 (challenging the Attorney General's interpretation of the integration regulation).

II

With the key legislative provisions in full view, we summarize the facts underlying this dispute. Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women have a history of treatment in institutional settings. In May 1992, L. C. was voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where she was confined for treatment in a psychiatric unit. By May 1993, her psychiatric condition had stabilized, and L. C.'s treatment team at GRH agreed that her needs could be met appropriately in one of the community-based programs the State supported. Despite this evaluation, L. C. remained institutionalized until February 1996, when the State placed her in a community-based treatment program.

E. W. was voluntarily admitted to GRH in February 1995; like L. C., E. W. was confined for treatment in a psychiatric unit. In March 1995, GRH sought to discharge E. W. to a homeless shelter, but abandoned that plan after her attorney filed an administrative complaint. By 1996, E. W.'s treating psychiatrist concluded that she could be treated appropriately in a community-based setting. She nonetheless remained institutionalized until a few months after the District Court issued its judgment in this case in 1997.

In May 1995, when she was still institutionalized at GRH, L. C. filed suit in the United States District Court for the Northern District of Georgia, challenging her continued confinement in a segregated environment. Her complaint invoked 42 U. S. C. §1983 and provisions of the ADA, §§12131-12134, and named as defendants, now petitioners, the Commissioner of the Georgia Department of Human Resources, the Superintendent of GRH, and the Executive Director of the Fulton County Regional Board (collectively, the State). L. C. alleged that the State's failure to place her in a community-based program, once her treating professionals determined that such placement was appropriate, violated, *inter alia*, Title II of the ADA. L. C.'s pleading requested, among other things, that the State place her in a community care residential program, and that she receive treatment with the ultimate goal of integrating her into the mainstream of society. E. W. intervened in the action, stating an identical claim.⁶

The District Court granted partial summary judgment in favor of L. C. and E. W. See App. to Pet. for Cert. 31a-42a. The court held that the State's failure to place L. C. and E. W. in an appropriate community-based treatment program violated Title II of the ADA. See *id.*, at 39a, 41a. In so ruling, the court rejected the State's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of" their disabilities, accounted for their retention at GRH. Under Title II, the court concluded, "unnecessary institutional segregation of the disabled constitutes discrimination *per se*, which cannot be justified by a lack of funding." *Id.*, at 37a.

In addition to contending that L. C. and E. W. had not shown discrimination "by reason of [their] disabilit[ies]," the State resisted court intervention on the ground that requiring immediate transfers in cases of this order would "fundamentally alter" the State's activity. The State reasserted that it was already using all available funds to provide services to other persons with disabilities. See *id.* , at 38a. Rejecting the State's "fundamental alteration" defense, the court observed that existing state programs provided community-based treatment of the kind for which L. C. and E. W. qualified, and that the State could "provide services to plaintiffs in the community at considerably *less* cost than is required to maintain them in an institution." *Id.* , at 39a.

The Court of Appeals for the Eleventh Circuit affirmed the judgment of the District Court, but remanded for reassessment of the State's cost-based defense. See 138 F. 3d, at 905. As the appeals court read the statute and regulations: When "a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting--the most integrated setting appropriate to that patient's needs"; "[w]here there is no such finding [by the treating professionals], nothing in the ADA requires the deinstitutionalization of th[e] patient." *Id.* , at 902.

The Court of Appeals recognized that the State's duty to provide integrated services "is not absolute"; under the Attorney General's Title II regulation, "reasonable modifications" were required of the State, but fundamental alterations were not demanded. *Id.* , at 904. The appeals court thought it clear, however, that "Congress wanted to permit a cost defense only in the most limited of circumstances." *Id.* , at 902. In conclusion, the court stated that a cost justification would fail "[u]nless the State can prove that requiring it to [expend additional funds in order to provide L. C. and E. W. with integrated services] would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service [the State] provides." *Id.* , at 905. Because it appeared that the District Court had entirely ruled out a "lack of funding" justification, see App. to Pet. for Cert. 37a, the appeals court remanded, repeating that the District Court should consider, among other things, "whether the additional expenditures necessary to treat L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget." 138 F. 3d, at 905.⁷

We granted certiorari in view of the importance of the question presented to the States and affected individuals. See 525 U. S. ____ (1998).⁸

III

Endeavoring to carry out Congress' instruction to issue regulations implementing Title II, the Attorney General, in the integration and reasonable-modifications regulations, see *supra* , at 5-7, made two key determinations. The first concerned the scope of the ADA's discrimination proscription, 42 U. S. C. §12132; the second concerned the obligation of the States to counter discrimination. As to the first, the Attorney General concluded that unjustified placement or retention of persons in institutions, severely limiting their exposure to the outside community, constitutes a form of discrimination based on disability prohibited by Title II. See 28 CFR §35.130(d) (1998) ("A public entity shall administer services . . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities."); Brief for United States as *Amicus Curiae* in *Helen L. v. DiDario* , No. 94-1243 (CA3 1994), pp. 8, 15-16 (unnecessary segregation of persons with disabilities constitutes a form of discrimination prohibited by the ADA and the integration regulation). Regarding the States' obligation to avoid unjustified isolation of individuals with disabilities, the Attorney General provided that States could resist modifications that "would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998).

The Court of Appeals essentially upheld the Attorney General's construction of the ADA. As just recounted, see *supra* , at 9-10, the appeals court ruled that the unjustified institutionalization of persons with mental disabilities violated Title II; the court then remanded with instructions to measure the cost of caring for L. C. and E. W. in a community-based facility against the State's mental health budget.

We affirm the Court of Appeals' decision in substantial part. Unjustified isolation, we hold, is properly regarded as discrimination based on disability. But we recognize, as well, the States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand. Accordingly, we further hold that the Court of Appeals' remand instruction was unduly restrictive. In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.

A

We examine first whether, as the Eleventh Circuit held, undue institutionalization qualifies as discrimination "by reason of . . . disability." The Department of Justice has consistently advocated that it does.⁹ Because the Department is the agency directed by Congress to issue regulations implementing Title II, see *supra*, at 5-6, its views warrant respect. We need not inquire whether the degree of deference described in *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 844 (1984), is in order; "[i]t is enough to observe that the well-reasoned views of the agencies implementing a statute 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'" *Bragdon v. Abbott*, 524 U. S. 624, 642 (1998) (quoting *Skidmore v. Swift & Co.*, 323 U. S. 134, 139-140 (1944)).

The State argues that L. C. and E. W. encountered no discrimination "by reason of" their disabilities because they were not denied community placement on account of those disabilities. See Brief for Petitioners 20. Nor were they subjected to "discrimination," the State contends, because " 'discrimination' necessarily requires uneven treatment of similarly situated individuals," and L. C. and E. W. had identified no comparison class, *i.e.*, no similarly situated individuals given preferential treatment. *Id.*, at 21. We are satisfied that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA.¹⁰

The ADA stepped up earlier measures to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The Developmentally Disabled Assistance and Bill of Rights Act (DDABRA), a 1975 measure, stated in aspirational terms that "[t]he treatment, services, and habilitation for a person with developmental disabilities . . . *should be* provided in the setting that is least restrictive of the person's personal liberty." 89 Stat. 502, 42 U. S. C. §6010(2) (1976 ed.) (emphasis added); see also *Pennhurst State School and Hospital v. Halderman*, 451 U. S. 1, 24 (1981) (concluding that the §6010 provisions of the DDABRA "were intended to be hortatory, not mandatory"). In a related legislative endeavor, the Rehabilitation Act of 1973, Congress used mandatory language to proscribe discrimination against persons with disabilities. See 87 Stat. 394, as amended, 29 U. S. C. §794 (1976 ed.) ("No otherwise qualified individual with a disability in the United States . . . *shall*, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." (Emphasis added)). Ultimately, in the ADA, enacted in 1990, Congress not only required all public entities to refrain from discrimination, see 42 U. S. C. §12132; additionally, in findings applicable to the entire statute, Congress explicitly identified unjustified "segregation" of persons with disabilities as a "for[m] of discrimination." See §12101(a)(2) ("historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"); §12101(a)(5) ("individuals with disabilities continually encounter various forms of discrimination, including . . . segregation").¹¹

Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Cf. *Allen v. Wright*, 468 U. S. 737, 755 (1984) ("There can be no doubt that [stigmatizing injury often caused by racial discrimination] is one of the most serious consequences of discriminatory government action."); *Los Angeles Dept. of Water and Power v.*

Manhart, 435 U. S. 702, 707, n. 13 (1978) (" `In forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.' " (quoting *Sprogis v. United Air Lines, Inc.*, 444 F. 2d 1194, 1198 (CA7 1971)). Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. See Brief for American Psychiatric Association et al. as *Amici Curiae* 20-22. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. See Brief for United States as *Amicus Curiae* 6-7, 17.

The State urges that, whatever Congress may have stated as its findings in the ADA, the Medicaid statute "reflected a congressional policy preference for treatment in the institution over treatment in the community." Brief for Petitioners 31. The State correctly used the past tense. Since 1981, Medicaid has provided funding for state-run home and community-based care through a waiver program. See 95 Stat. 812-813, as amended, 42 U. S. C. §1396n(c); Brief for United States as *Amicus Curiae* 20-21.¹² Indeed, the United States points out that the Department of Health and Human Services (HHS) "has a policy of encouraging States to take advantage of the waiver program, and often approves more waiver slots than a State ultimately uses." *Id.*, at 25-26 (further observing that, by 1996, "HHS approved up to 2109 waiver slots for Georgia, but Georgia used only 700").

We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Title II provides only that "qualified individual[s] with a disability" may not "be subjected to discrimination." 42 U. S. C. §12132. "Qualified individuals," the ADA further explains, are persons with disabilities who, "with or without reasonable modifications to rules, policies, or practices, . . . mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." §12131(2).

Consistent with these provisions, the State generally may rely on the reasonable assessments of its own professionals in determining whether an individual "meets the essential eligibility requirements" for habilitation in a community-based program. Absent such qualification, it would be inappropriate to remove a patient from the more restrictive setting. See 28 CFR §35.130(d) (1998) (public entity shall administer services and programs in "the most integrated setting *appropriate* to the needs of qualified individuals with disabilities" (emphasis added)); cf. *School Bd. of Nassau Cty. v. Arline*, 480 U. S. 273, 288 (1987) ("[C]ourts normally should defer to the reasonable medical judgments of public health officials.").¹³ Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. See 28 CFR §35.130(e)(1) (1998) ("Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . which such individual chooses not to accept."); 28 CFR pt. 35, App. A, p. 450 (1998) ("[P]ersons with disabilities must be provided the option of declining to accept a particular accommodation."). In this case, however, there is no genuine dispute concerning the status of L. C. and E. W. as individuals "qualified" for noninstitutional care: The State's own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. See *supra*, at 7-8.¹⁴

B

The State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of "reasonable modifications" to avoid discrimination, and allows States to resist modifications that entail a "fundamenta[l] alter[ation]" of the States' services and programs. 28 CFR §35.130(b)(7) (1998). The Court of Appeals construed this regulation to permit a cost-based defense "only in the most limited of circumstances," 138 F. 3d, at 902, and remanded to the District Court to consider, among other things,

"whether the additional expenditures necessary to treat L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget," *id.* , at 905.

The Court of Appeals' construction of the reasonable-modifications regulation is unacceptable for it would leave the State virtually defenseless once it is shown that the plaintiff is qualified for the service or program she seeks. If the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. See Tr. of Oral Arg. 27 (State's attorney argues that Court of Appeals' understanding of the fundamental-alteration defense, as expressed in its order to the District Court, "will always preclude the State from a meaningful defense"); cf. Brief for Petitioners 37-38 (Court of Appeals' remand order "mistakenly asks the district court to examine [the fundamental-alteration] defense based on the cost of providing community care to just two individuals, not all Georgia citizens who desire community care"); 1:95-cv-1210-MHS (ND Ga., Oct. 20, 1998), p. 3, App. 177 (District Court, on remand, declares the impact of its decision beyond L. C. and E. W. "irrelevant"). Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.

When it granted summary judgment for plaintiffs in this case, the District Court compared the cost of caring for the plaintiffs in a community-based setting with the cost of caring for them in an institution. That simple comparison showed that community placements cost less than institutional confinements. See App. to Pet. for Cert. 39a. As the United States recognizes, however, a comparison so simple overlooks costs the State cannot avoid; most notably, a "State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions." Brief for United States as *Amicus Curiae* 21. ¹⁵

As already observed, see *supra* , at 17, the ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Cf. *post* , at 2-3 (*Kennedy, J.* , concurring in judgment). Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State proposed, then retracted, for E. W. See *supra* , at 8. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time "to stabilize acute psychiatric symptoms." App. 98 (affidavit of Dr. Richard L. Elliott); see 138 F. 3d, at 903 ("[T]here may be times [when] a patient can be treated in the community, and others whe[n] an institutional placement is necessary."); Reply Brief 19 (placement in a community-based treatment program does not mean the State will no longer need to retain hospital accommodations for the person so placed). For other individuals, no placement outside the institution may ever be appropriate. See Brief for American Psychiatric Association et al. as *Amici Curiae* 22-23 ("Some individuals, whether mentally retarded or mentally ill, are not prepared at particular times--perhaps in the short run, perhaps in the long run--for the risks and exposure of the less protective environment of community settings"; for these persons, "institutional settings are needed and must remain available."); Brief for Voice of the Retarded et al. as *Amici Curiae* 11 ("Each disabled person is entitled to treatment in the most integrated setting possible for that person--recognizing that, on a case-by-case basis, that setting may be in an institution."); *Youngberg v. Romeo*, 457 U. S. 307, 327 (1982) (Blackmun, J., concurring) ("For many mentally retarded people, the difference between the capacity to do things for themselves within an institution and total dependence on the institution for all of their needs is as much liberty as they ever will know.").

To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. See Tr. of Oral Arg. 5 (State's attorney urges that, "by asking [a] person to wait a short time until a community bed is available, Georgia does not exclude [that] person by reason of disability, neither does Georgia discriminate against her by reason of disability"); see

also *id.* , at 25 ("[I]t is reasonable for the State to ask someone to wait until a community placement is available."). In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.¹⁶

* * *

For the reasons stated, we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. The judgment of the Eleventh Circuit is therefore affirmed in part and vacated in part, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* ,
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend* , *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

Justice Stevens , concurring in part and concurring in the judgment.

Unjustified disparate treatment, in this case, "unjustified institutional isolation," constitutes discrimination under the Americans with Disabilities Act of 1990. See *ante* , at 15. If a plaintiff requests relief that requires modification of a State's services or programs, the State may assert, as an affirmative defense, that the requested modification would cause a fundamental alteration of a State's services and programs. In this case, the Court of Appeals appropriately remanded for consideration of the State's affirmative defense. On remand, the District Court rejected the State's "fundamental-alteration defense." See *ante* , at 10, n. 7. If the District Court was wrong in concluding that costs unrelated to the treatment of L. C. and E. W. do not support such a defense in this case, that arguable error should be corrected either by the Court of Appeals or by this Court in review of that decision. In my opinion, therefore, we should simply affirm the judgment of the Court of Appeals. But because there are not five votes for that disposition, I join *Justice Ginsburg* 's judgment and Parts I, II, and III-A of her opinion. Cf. *Bragdon v. Abbott* , 524 U. S. 624, 655-656 (1998) (*Stevens* , J. concurring); *Screws v. United States* , 325 U. S. 91, 134 (1945) (Rutledge, J. concurring in result).

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[June 22, 1999]

Justice Kennedy , with whom *Justice Breyer* joins as to Part I, concurring in the judgment.

I

Despite remarkable advances and achievements by medical science, and agreement among many professionals that even severe mental illness is often treatable, the extent of public resources to devote to this cause remains controversial. Knowledgeable professionals tell us that our society, and the governments which reflect its attitudes and preferences, have yet to grasp the potential for treating mental disorders, especially severe mental illness. As a result, necessary resources for the endeavor often are not forthcoming. During the course of a year, about 5.6 million Americans will suffer from severe mental illness. E. Torrey, *Out of the Shadows* 4 (1997). Some 2.2 million of these persons receive no treatment. *Id.* , at 6. Millions of other Americans suffer from mental disabilities of less serious degree, such as mild depression. These facts are part of the background against which this case arises. In addition, of course, persons with mental disabilities have been subject to historic mistreatment, indifference, and hostility. See, *e.g.* , *Cleburne v. Cleburne Living Center, Inc.* , 473 U. S. 432, 461-464 (1985) (Marshall, J., concurring in judgment in part and dissenting in part) (discussing treatment of the mentally retarded).

Despite these obstacles, the States have acknowledged that the care of the mentally disabled is their special obligation. They operate and support facilities and programs, sometimes elaborate ones, to provide care. It is a continuing challenge, though, to provide the care in an effective and humane way, particularly because societal attitudes and the responses of public authorities have changed from time to time.

Beginning in the 1950's, many victims of severe mental illness were moved out of state-run hospitals, often with benign objectives. According to one estimate, when adjusted for population growth, "the actual decrease in the numbers of people with severe mental illnesses in public psychiatric hospitals between 1955 and 1995 was 92 percent." Brief for American Psychiatric Association *et al.* as *Amici Curiae* 21, n. 5 (citing Torrey, *supra* , at 8-9). This was not without benefit or justification. The so-called "deinstitutionalization" has permitted a substantial number of mentally disabled persons to receive needed treatment with greater freedom and dignity. It may be, moreover, that those who remain institutionalized are indeed the most severe cases. With reference to this case, as the Court points out, *ante* , at 7-8, 17-18, it is undisputed that the State's own treating professionals determined that community-based care was medically appropriate for respondents. Nevertheless, the depopulation of state mental hospitals has its dark side. According to one expert:

"For a substantial minority. . . deinstitutionalization has been a psychiatric *Titanic* . Their lives are virtually devoid of 'dignity' or 'integrity of body, mind, and spirit.' 'Self-determination' often means merely that the person has a choice of soup kitchens. The

'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies." Torrey, *supra* , at 11.

It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe.

It would be unreasonable, it would be a tragic event, then, were the Americans with Disabilities Act of 1990 (ADA) to be interpreted so that States had some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision. The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference. It is a common phenomenon that a patient functions well with medication, yet, because of the mental illness itself, lacks the discipline or capacity to follow the regime the medication requires. This is illustrative of the factors a responsible physician will consider in recommending the appropriate setting or facility for treatment. *Justice Ginsburg's* opinion takes account of this background. It is careful, and quite correct, to say that it is not "the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter . . ." *Ante* , at 20.

In light of these concerns, if the principle of liability announced by the Court is not applied with caution and circumspection, States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition. This danger is in addition to the federalism costs inherent in referring state decisions regarding the administration of treatment programs and the allocation of resources to the reviewing authority of the federal courts. It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers.

II

With these reservations made explicit, in my view we must remand the case for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U. S. C. §12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed.

At the outset it should be noted there is no allegation that Georgia officials acted on the basis of animus or unfair stereotypes regarding the disabled. Underlying much discrimination law is the notion that animus can lead to false and unjustified stereotypes, and vice versa. Of course, the line between animus and stereotype is often indistinct, and it is not always necessary to distinguish between them. Section 12132 can be understood to deem as irrational, and so to prohibit, distinctions by which a class of disabled persons, or some within that class, are, by reason of their disability and without adequate justification, exposed by a state entity to more onerous treatment than a comparison group in the provision of services or the administration of existing programs, or indeed entirely excluded from state programs or facilities. Discrimination under this statute might in principle be shown in the case before us, though further proceedings should be required.

Putting aside issues of animus or unfair stereotype, I agree with *Justice Thomas* that on the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she "received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic." *Post* , at 1-2 (dissenting opinion). In my view, however, discrimination so defined might be shown here. Although the Court seems to reject *Justice Thomas'* definition of discrimination, *ante* , at 13, it asserts that unnecessary institutional care does lead to "[d]issimilar treatment," *ante* , at 16. According to the Court, "[i]n order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable

accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice." *Ibid* .

Although this point is not discussed at length by the Court, it does serve to suggest the theory under which respondents might be subject to discrimination in violation of §12132. If they could show that persons needing psychiatric or other medical services to treat a mental disability are subject to a more onerous condition than are persons eligible for other existing state medical services, and if removal of the condition would not be a fundamental alteration of a program or require the creation of a new one, then the beginnings of a discrimination case would be established. In terms more specific to this case, if respondents could show that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities), I believe it would demonstrate discrimination on the basis of mental disability.

Of course, it is a quite different matter to say that a State without a program in place is required to create one. No State has unlimited resources and each must make hard decisions on how much to allocate to treatment of diseases and disabilities. If, for example, funds for care and treatment of the mentally ill, including the severely mentally ill, are reduced in order to support programs directed to the treatment and care of other disabilities, the decision may be unfortunate. The judgment, however, is a political one and not within the reach of the statute. Grave constitutional concerns are raised when a federal court is given the authority to review the State's choices in basic matters such as establishing or declining to establish new programs. It is not reasonable to read the ADA to permit court intervention in these decisions. In addition, as the Court notes, *ante*, at 6-7, by regulation a public entity is required only to make "reasonable modifications in policies, practices, or procedures" when necessary to avoid discrimination and is not even required to make those if "the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998). It follows that a State may not be forced to create a community-treatment program where none exists. See Brief for United States as *Amicus Curiae* 19-20, and n. 3. Whether a different statutory scheme would exceed constitutional limits need not be addressed.

Discrimination, of course, tends to be an expansive concept and, as legal category, it must be applied with care and prudence. On any reasonable reading of the statute, §12132 cannot cover all types of differential treatment of disabled and nondisabled persons, no matter how minimal or innocuous. To establish discrimination in the context of this case, and absent a showing of policies motivated by improper animus or stereotypes, it would be necessary to show that a comparable or similarly situated group received differential treatment. Regulations are an important tool in identifying the kinds of contexts, policies, and practices that raise concerns under the ADA. The congressional findings in 42 U. S. C. §12101 also serve as a useful aid for courts to discern the sorts of discrimination with which Congress was concerned. Indeed, those findings have clear bearing on the issues raised in this case, and support the conclusion that unnecessary institutionalization may be the evidence or the result of the discrimination the ADA prohibits.

Unlike *Justice Thomas* , I deem it relevant and instructive that Congress in express terms identified the "isolat[ion] and segregat[ion]" of disabled persons by society as a "for[m] of discrimination," §§12101(a)(2), (5), and noted that discrimination against the disabled "persists in such critical areas as . . . institutionalization," §12101(a)(3). These findings do not show that segregation and institutionalization are always discriminatory or that segregation or institutionalization are, by their nature, forms of prohibited discrimination. Nor do they necessitate a regime in which individual treatment plans are required, as distinguished from broad and reasonable classifications for the provision of health care services. Instead, they underscore Congress' concern that discrimination has been a frequent and pervasive problem in institutional settings and policies and its concern that segregating disabled persons from others can be discriminatory. Both of those concerns are consistent with the normal definition of discrimination--differential treatment of similarly situated groups. The findings inform application of that definition in specific cases, but absent guidance to the contrary, there is no reason to think they displace

it. The issue whether respondents have been discriminated against under §12132 by institutionalized treatment cannot be decided in the abstract, divorced from the facts surrounding treatment programs in their State.

The possibility therefore remains that, on the facts of this case, respondents would be able to support a claim under §12132 by showing that they have been subject to discrimination by Georgia officials on the basis of their disability. This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. For example, the evidence might show that, apart from services for the mentally disabled, medical treatment is rarely offered in a community setting but also is rarely offered in facilities comparable to state mental hospitals. Determining the relevance of that type of evidence would require considerable judgment and analysis. However, as petitioners observe, "[i]n this case, no class of similarly situated individuals was even identified, let alone shown to be given preferential treatment." Brief for Petitioners 21. Without additional information regarding the details of state-provided medical services in Georgia, we cannot address the issue in the way the statute demands. As a consequence, the judgment of the courts below, granting partial summary judgment to respondents, ought not to be sustained. In addition, as *Justice Ginsburg's* opinion is careful to note, *ante*, at 19, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. We must be cautious when we seek to infer specific rules limiting States' choices when Congress has used only general language in the controlling statute.

I would remand the case to the Court of Appeals or the District Court for it to determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested above.

For these reasons, I concur in the judgment of the Court.

TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.*,
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend*, *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

Justice Thomas, with whom *The Chief Justice* and *Justice Scalia* join, dissenting.

Title II of the Americans with Disabilities Act of 1990 (ADA), 104 Stat. 337, 42 U. S. C. §12132, provides:

"Subject to the provisions of this subchapter, no qualified individual with a disability shall, *by reason of such disability*, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, *or be subjected to discrimination* by any such entity." (Emphasis added.)

The majority concludes that petitioners "discriminated" against respondents--as a matter of law--by continuing to treat them in an institutional setting after they became eligible for community placement. I

disagree. Temporary exclusion from community placement does not amount to "discrimination" in the traditional sense of the word, nor have respondents shown that petitioners "discriminated" against them "by reason of" their disabilities.

Until today, this Court has never endorsed an interpretation of the term "discrimination" that encompassed disparate treatment among members of the *same* protected class. Discrimination, as typically understood, requires a showing that a claimant received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. This interpretation comports with dictionary definitions of the term discrimination, which means to "distinguish," to "differentiate," or to make a "distinction in favor of or against, a person or thing based on the group, class, or category to which that person or thing belongs rather than on individual merit." Random House Dictionary 564 (2d ed. 1987); see also Webster's Third New International Dictionary 648 (1981) (defining "discrimination" as "the making or perceiving of a distinction or difference" or as "the act, practice, or an instance of discriminating categorically rather than individually").

Our decisions construing various statutory prohibitions against "discrimination" have not wavered from this path. The best place to begin is with Title VII of the Civil Rights Act of 1964, 78 Stat. 253, as amended, the paradigmatic anti-discrimination law.¹ Title VII makes it "an unlawful employment practice for an employer ... to *discriminate* against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." 42 U. S. C. §2000e-2(a)(1) (emphasis added). We have explained that this language is designed "to achieve equality of employment opportunities and remove barriers that have operated in the past to favor an identifiable group of white employees over other employees." *Griggs v. Duke Power Co.*, 401 U. S. 424, 429-430 (1971).²

Under Title VII, a finding of discrimination requires a comparison of otherwise similarly situated persons who are in different groups by reason of certain characteristics provided by statute. See, e.g., *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U. S. 669, 683 (1983) (explaining that Title VII discrimination occurs when an employee is treated "in a manner which but for that person's sex would be different") (quoting *Los Angeles Dept. of Water and Power v. Manhart*, 435 U. S. 702, 711 (1978)). For this reason, we have described as "nonsensical" the comparison of the racial composition of different classes of job categories in determining whether there existed disparate impact discrimination with respect to a particular job category. *Wards Cove Packing Co. v. Atonio*, 490 U. S. 642, 651 (1989).³ Courts interpreting Title VII have held that a plaintiff cannot prove "discrimination" by demonstrating that one member of a particular protected group has been favored over another member of that same group. See, e.g., *Bush v. Commonwealth Edison Co.*, 990 F. 2d 928, 931 (CA7 1993), cert. denied, 511 U. S. 1071 (1994) (explaining that under Title VII, a fired black employee "had to show that although he was not a good employee, equally bad employees were treated more leniently by [his employer] if they happened not to be black").

Our cases interpreting §504 of the Rehabilitation Act of 1973, 87 Stat. 394, as amended, which prohibits "discrimination" against certain individuals with disabilities, have applied this commonly understood meaning of discrimination. Section 504 provides:

"No otherwise qualified handicapped individual ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

In keeping with the traditional paradigm, we have always limited the application of the term "discrimination" in the Rehabilitation Act to a person who is a member of a protected group and faces discrimination "by reason of his handicap." Indeed, we previously rejected the argument that §504 requires the type of "affirmative efforts to overcome the disabilities caused by handicaps," *Southeastern Community College v. Davis*, 442 U. S. 397, 410 (1979), that the majority appears to endorse today. Instead, we found that §504 required merely "the evenhanded treatment of handicapped persons" relative to those persons who do not have disabilities. *Ibid.* Our conclusion was informed by the fact that some

provisions of the Rehabilitation Act envision "affirmative action" on behalf of those individuals with disabilities, but §504 itself "does not refer at all" to such action. *Ibid.* Therefore, "[a] comparison of these provisions demonstrates that Congress understood accommodation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so." *Id.*, at 411.

Similarly, in *Alexander v. Choate*, 469 U. S. 287, 302 (1985), we found no discrimination under §504 with respect to a limit on inpatient hospital care that was "neutral on its face" and did not "distinguish between those whose coverage will be reduced and those whose coverage will not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having," *id.*, at 302. We said that §504 does "not ... guarantee the handicapped equal results from the provision of state Medicaid, even assuming some measure of equality of health could be constructed." *Id.*, at 304.

Likewise, in *Traynor v. Turnage*, 485 U. S. 535, 548 (1988), we reiterated that the purpose of §504 is to guarantee that individuals with disabilities receive "evenhanded treatment" relative to those persons without disabilities. In *Traynor*, the Court upheld a Veterans' Administration regulation that excluded "primary alcoholics" from a benefit that was extended to persons disabled by alcoholism related to a mental disorder. *Id.*, at 551. In so doing, the Court noted that, "[t]his litigation does not involve a program or activity that is alleged to treat handicapped persons less favorably than nonhandicapped persons." *Id.*, at 548. Given the theory of the case, the Court explicitly held: "There is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." *Id.*, at 549.

This same understanding of discrimination also informs this Court's constitutional interpretation of the term. See *General Motors Corp. v. Tracy*, 519 U. S. 278, 298 (1997) (noting with respect to interpreting the Commerce Clause, "[c]onceptually, of course, any notion of discrimination assumes a comparison of substantially similar entities"); *Yick Wo v. Hopkins*, 118 U. S. 356, 374 (1886) (condemning under the Fourteenth Amendment "illegal discriminations between persons in similar circumstances"); see also *Adarand Constructors, Inc. v. Peña*, 515 U. S. 200, 223-224 (1995); *Richmond v. J. A. Croson Co.*, 488 U. S. 469, 493-494 (1989) (plurality opinion).

Despite this traditional understanding, the majority derives a more "capacious" definition of "discrimination," as that term is used in Title II of the ADA, one that includes "institutional isolation of persons with disabilities." *Ante*, at 13-14. It chiefly relies on certain congressional findings contained within the ADA. To be sure, those findings appear to equate institutional isolation with segregation, and thereby discrimination. See *ante*, at 14 (quoting §§12101(a)(2) and 12101(a)(5), both of which explicitly identify "segregation" of persons with disabilities as a form of "discrimination"); see also *ante*, at 2-3. The congressional findings, however, are written in general, hortatory terms and provide little guidance to the interpretation of the specific language of §12132. See *National Organization for Women, Inc. v. Scheidler*, 510 U. S. 249, 260 (1994) ("We also think that the quoted statement of congressional findings is a rather thin reed upon which to base a requirement"). In my view, the vague congressional findings upon which the majority relies simply do not suffice to show that Congress sought to overturn a well-established understanding of a statutory term (here, "discrimination").⁴ Moreover, the majority fails to explain why terms in the findings should be given a medical content, pertaining to the place where a mentally retarded person is treated. When read in context, the findings instead suggest that terms such as "segregation" were used in a more general sense, pertaining to matters such as access to employment, facilities, and transportation. Absent a clear directive to the contrary, we must read "discrimination" in light of the common understanding of the term. We cannot expand the meaning of the term "discrimination" in order to invalidate policies we may find unfortunate. Cf. *NLRB v. Highland Park Mfg. Co.*, 341 U. S. 322, 325 (1951) (explaining that if Congress intended statutory terms "to have other than their ordinarily accepted meaning, it would and should have given them a special meaning by definition").⁵

Elsewhere in the ADA, Congress chose to alter the traditional definition of discrimination. Title I of the ADA, §12112(b)(1), defines discrimination to include "limiting, segregating, or classifying a job applicant

or employee in a way that adversely affects the opportunities or status of such applicant or employee." Notably, however, Congress did not provide that this definition of discrimination, unlike other aspects of the ADA, applies to Title II. Ordinary canons of construction require that we respect the limited applicability of this definition of "discrimination" and not import it into other parts of the law where Congress did not see fit. See, e.g., *Bates v. United States*, 522 U. S. 23, 29-30 (1997) ("Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion'") (quoting *Russello v. United States*, 464 U. S. 16, 23 (1983)). The majority's definition of discrimination--although not specifically delineated--substantially imports the definition of Title I into Title II by necessarily assuming that it is sufficient to focus exclusively on members of one particular group. Under this view, discrimination occurs when some members of a protected group are treated differently from other members of that same group. As the preceding discussion emphasizes, absent a special definition supplied by Congress, this conclusion is a remarkable and novel proposition that finds no support in our decisions in analogous areas. For example, the majority's conclusion that petitioners "discriminated" against respondents is the equivalent to finding discrimination under Title VII where a black employee with deficient management skills is denied in-house training by his employer (allegedly because of lack of funding) because other similarly situated black employees are given the in-house training. Such a claim would fly in the face of our prior case law, which requires more than the assertion that a person belongs to a protected group and did not receive some benefit. See, e.g., *Griggs*, 401 U. S., at 430-431 ("Congress did not intend by Title VII, however, to guarantee a job to every person regardless of qualifications. In short, the Act does not command that any person be hired simply because he was formerly the subject of discrimination, or because he is a member of a minority group").

At bottom, the type of claim approved of by the majority does not concern a prohibition against certain conduct (the traditional understanding of discrimination), but rather imposition of a standard of care.⁶ As such, the majority can offer no principle limiting this new species of "discrimination" claim apart from an affirmative defense because it looks merely to an individual in isolation, without comparing him to otherwise similarly situated persons, and determines that discrimination occurs merely because that individual does not receive the treatment he wishes to receive. By adopting such a broad view of discrimination, the majority drains the term of any meaning other than as a proxy for decisions disapproved of by this Court.

Further, I fear that the majority's approach imposes significant federalism costs, directing States how to make decisions about their delivery of public services. We previously have recognized that constitutional principles of federalism erect limits on the Federal Government's ability to direct state officers or to interfere with the functions of state governments. See, e.g., *Printz v. United States*, 521 U. S. 898 (1997); *New York v. United States*, 505 U. S. 144 (1992). We have suggested that these principles specifically apply to whether States are required to provide a certain level of benefits to individuals with disabilities. As noted in *Alexander*, in rejecting a similar theory under §504 of the Rehabilitation Act: "[N]othing ... suggests that Congress desired to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services" 469 U. S., at 307; see also *Bowen v. American Hospital Assn.*, 476 U. S. 610, 642 (1986) (plurality opinion) ("[N]othing in [§504] authorizes [the Secretary of Health and Human Services (HHS)] to commandeer state agencies [These] agencies are not field offices of the HHS bureaucracy and they may not be conscripted against their will as the foot soldiers in a federal crusade"). The majority's affirmative defense will likely come as cold comfort to the States that will now be forced to defend themselves in federal court every time resources prevent the immediate placement of a qualified individual. In keeping with our traditional deference in this area, see *Alexander, supra*, the appropriate course would be to respect the States' historical role as the dominant authority responsible for providing services to individuals with disabilities.

The majority may remark that it actually does properly compare members of different groups. Indeed, the majority mentions in passing the "[d]issimilar treatment" of persons with and without disabilities. *Ante*, at 15. It does so in the context of supporting its conclusion that institutional isolation is a form of discrimination. It cites two cases as standing for the unremarkable proposition that discrimination leads to deleterious stereotyping, *ante*, at 15 (citing *Allen v. Wright*, 468 U. S. 737, 755 (1984); *Manhart*, 435 U. S., at 707, n. 13)), and an *amicus* brief which indicates that confinement diminishes certain everyday

life activities, *ante* , at 15 (citing Brief for American Psychiatric Association et al. 20-22). The majority then observes that persons without disabilities "can receive the services they need without" institutionalization and thereby avoid these twin deleterious effects. *Ante* , at 15. I do not quarrel with the two general propositions, but I fail to see how they assist in resolving the issue before the Court. Further, the majority neither specifies what services persons with disabilities might need, nor contends that persons without disabilities need the same services as those with disabilities, leading to the inference that the dissimilar treatment the majority observes results merely from the fact that different classes of persons receive different services--not from "discrimination" as traditionally defined.

Finally, it is also clear petitioners did not "discriminate" against respondents "by reason of [their] disabili[ties]," as §12132 requires. We have previously interpreted the phrase "by reason of" as requiring proximate causation. See, e.g., *Holmes v. Securities Investor Protection Corp.* , 503 U. S. 258, 265-266 (1992); see also *id.*, at 266, n. 11 (citation of cases). Such an interpretation is in keeping with the vernacular understanding of the phrase. See American Heritage Dictionary 1506 (3d ed. 1992) (defining "by reason of" as "because of"). This statute should be read as requiring proximate causation as well. Respondents do not contend that their disabilities constituted the proximate cause for their exclusion. Nor could they--community placement simply is not available to those without disabilities. Continued institutional treatment of persons who, though now deemed treatable in a community placement, must wait their turn for placement, does not establish that the denial of community placement occurred "by reason of" their disability. Rather, it establishes no more than the fact that petitioners have limited resources.

* * *

For the foregoing reasons, I respectfully dissent.

FOOTNOTES

Footnote 1

The ADA, enacted in 1990, is the Federal Government's most recent and extensive endeavor to address discrimination against persons with disabilities. Earlier legislative efforts included the Rehabilitation Act of 1973, 87 Stat. 355, 29 U. S. C. §701 *et seq.* (1976 ed.), and the Developmentally Disabled Assistance and Bill of Rights Act, 89 Stat. 486, 42 U. S. C. §6001 *et seq.* (1976 ed.), enacted in 1975. In the ADA, Congress for the first time referred expressly to "segregation" of persons with disabilities as a "for[m] of discrimination," and to discrimination that persists in the area of "institutionalization." §§12101(a)(2), (3), (5).

Footnote 2

The ADA defines "disability," "with respect to an individual," as

"(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

"(B) a record of such an impairment; or

"(C) being regarded as having such an impairment." §12102(2).

There is no dispute that L. C. and E. W. are disabled within the meaning of the ADA.

Footnote 3

In addition to the provisions set out in Part A governing public services generally, see §§12131-12134, Title II contains in Part B a host of provisions governing public transportation services, see §§12141-12165.

Footnote 4

Section 505 of the Rehabilitation Act incorporates the remedies, rights, and procedures set forth in Title VI of the Civil Rights Act of 1964 for violations of §504 of the Rehabilitation Act. See 29 U. S. C. §794a(a)(2). Title VI, in turn, directs each federal department authorized to extend financial assistance to any department or agency of a State to issue rules and regulations consistent with achievement of the objectives of the statute authorizing financial assistance. See 78 Stat. 252, 42 U. S. C. §2000d-1. Compliance with such requirements may be effected by the termination or denial of federal funds, or "by any other means authorized by law." *Ibid.* Remedies both at law and in equity are available for violations of the statute. See §2000d-7(a)(2).

Footnote 5

Congress directed the Secretary of Transportation to issue regulations implementing the portion of Title II concerning public transportation. See 42 U. S. C. §§12143(b), 12149, 12164. As stated in the regulations, a person alleging discrimination on the basis of disability in violation of Title II may seek to enforce its provisions by commencing a private lawsuit, or by filing a complaint with (a) a federal agency that provides funding to the public entity that is the subject of the complaint, (b) the Department of Justice for referral to an appropriate agency, or (c) one of eight federal agencies responsible for investigating complaints arising under Title II: the Department of Agriculture, the Department of Education, the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of the Interior, the Department of Justice, the Department of Labor, and the Department of Transportation. See 28 CFR §§35.170(c), 35.172(b), 35.190(b) (1998).

The ADA contains several other provisions allocating regulatory and enforcement responsibility. Congress instructed the Equal Employment Opportunity Commission (EEOC) to issue regulations implementing Title I, see 42 U. S. C. §12116; the EEOC, the Attorney General, and persons alleging discrimination on the basis of disability in violation of Title I may enforce its provisions, see §12117(a). Congress similarly instructed the Secretary of Transportation and the Attorney General to issue regulations implementing provisions of Title III, see §§12186(a)(1), (b); the Attorney General and persons alleging discrimination on the basis of disability in violation of Title III may enforce its provisions, see §§12188(a)(1), (b). Each federal agency responsible for ADA implementation may render technical assistance to affected individuals and institutions with respect to provisions of the ADA for which the agency has responsibility. See §12206(c)(1).

Footnote 6

L. C. and E. W. are currently receiving treatment in community-based programs. Nevertheless, the case is not moot. As the District Court and Court of Appeals explained, in view of the multiple institutional placements L. C. and E. W. have experienced, the controversy they brought to court is "capable of repetition, yet evading review." No. 1:95-cv-1210-MHS (ND Ga., Mar. 26, 1997), p. 6, App. to Pet. for Cert. 35a (internal quotation marks omitted); see 138 F. 3d 893, 895, n. 2 (CA11 1998) (citing *Honig v. Doe*, 484 U. S. 305, 318-323 (1988), and *Vitek v. Jones*, 445 U. S. 480, 486-487 (1980)).

Footnote 7

After this Court granted certiorari, the District Court issued a decision on remand rejecting the State's fundamental-alteration defense. See 1:95-cv-1210-MHS (ND Ga., Jan. 29, 1999), p. 1. The court concluded that the annual cost to the State of providing community-based treatment to L. C. and E. W. was not unreasonable in relation to the State's overall mental health budget. See *id.*, at 5. In reaching that judgment, the District Court first declared "irrelevant" the potential impact of its decision beyond L. C. and E. W. 1:95-cv-1210-MHS (ND Ga., Oct. 20, 1998), p. 3, App. 177. The District Court's decision on remand is now pending appeal before the Eleventh Circuit.

Footnote 8

Twenty-two States and the Territory of Guam joined a brief urging that certiorari be granted. Seven of those States filed a brief in support of petitioners on the merits.

Footnote 9

See Brief for United States in *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564, 78-1602 (CA3 1978), p. 45 ("[I]nstitutionalization result[ing] in separation of mentally retarded persons for no permissible reason . . . is 'discrimination,' and a violation of Section 504 [of the Rehabilitation Act] if it is supported by federal funds."); Brief for United States in *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564, 78-1602 (CA3 1981), p. 27 ("Pennsylvania violates Section 504 by indiscriminately subjecting handicapped persons to [an institution] without first making an individual reasoned professional judgment as to the appropriate placement for each such person among all available alternatives."); Brief for United States as *Amicus Curiae* in *Helen L. v. DiDario*, No. 94-1243 (CA3 1994), p. 7 ("Both the Section 504 coordination regulations and the rest of the ADA make clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination within the meaning of those statutes."); *id.*, at 8-16.

Footnote 10

The dissent is driven by the notion that "this Court has never endorsed an interpretation of the term 'discrimination' that encompassed disparate treatment among members of the *same* protected class," *post*, at 1 (opinion of *Thomas, J.*), that "[o]ur decisions construing various statutory prohibitions against 'discrimination' have not wavered from this path," *post*, at 2, and that "a plaintiff cannot prove 'discrimination' by demonstrating that one member of a particular protected group has been favored over another member of that same group," *post*, at 4. The dissent is incorrect as a matter of precedent and logic. See *O'Connor v. Consolidated Coin Caterers Corp.*, 517 U. S. 308, 312 (1996) (The Age Discrimination in Employment Act of 1967 "does not ban discrimination against employees because they are aged 40 or older; it bans discrimination against employees because of their age, but limits the protected class to those who are 40 or older. The fact that one person in the protected class has lost out to another person in the protected class is thus irrelevant, so long as he has lost out *because of his age.*"); cf. *Oncale v. Sundowner Offshore Services, Inc.*, 523 U. S. 75, 76 (1998) ("[W]orkplace harassment can violate Title VII's prohibition against 'discriminat[ion] . . . because of . . . sex,' 42 U. S. C. §2000e-2(a)(1), when the harasser and the harassed employee are of the same sex."); *Jefferies v. Harris County Community Action Assn.*, 615 F. 2d 1025, 1032 (CA5 1980) ("[D]iscrimination against black females can exist even in the absence of discrimination against black men or white women.").

Footnote 11

Unlike the ADA, §504 of the Rehabilitation Act contains no express recognition that isolation or segregation of persons with disabilities is a form of discrimination. Section 504's discrimination proscription, a single sentence attached to vocational rehabilitation legislation, has yielded divergent court interpretations. See Brief for United States as *Amicus Curiae* 23-25.

Footnote 12

The waiver program provides Medicaid reimbursement to States for the provision of community-based services to individuals who would otherwise require institutional care, upon a showing that the average annual cost of such services is not more than the annual cost of institutional services. See §1396n(c).

Footnote 13

Georgia law also expresses a preference for treatment in the most integrated setting appropriate. See Ga. Code Ann. §37-4-121 (1995) ("It is the policy of the state that the least restrictive alternative placement be secured for every client at every stage of his habilitation. It shall be the duty of the facility to assist the client in securing placement in noninstitutional community facilities and programs.").

Footnote 14

We do not in this opinion hold that the ADA imposes on the States a "standard of care" for whatever medical services they render, or that the ADA requires States to "provide a certain level of benefits to individuals with disabilities." Cf. *post*, at 9, 10 (*Thomas, J.*, dissenting). We do hold, however, that States must adhere to the ADA's non-discrimination requirement with regard to the services they in fact provide.

Footnote 15

Even if States eventually were able to close some institutions in response to an increase in the number of community placements, the States would still incur the cost of running partially full institutions in the interim. See Brief for United States as *Amicus Curiae* 21.

Footnote 16

We reject the Court of Appeals' construction of the reasonable-modifications regulation for another reason. The Attorney General's Title II regulations, Congress ordered, "shall be consistent with" the regulations in part 41 of Title 28 of the Code of Federal Regulations implementing §504 of the Rehabilitation Act. 42 U. S. C. §12134(b). The §504 regulation upon which the reasonable-modifications regulation is based provides now, as it did at the time the ADA was enacted:

"A recipient shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program." 28 CFR §41.53 (1990 and 1998 eds.).

While the part 41 regulations do not define "undue hardship," other §504 regulations make clear that the "undue hardship" inquiry requires not simply an assessment of the cost of the accommodation in relation to the recipient's overall budget, but a "case-by-case analysis weighing factors that include: (1) [t]he overall size of the recipient's program with respect to number of employees, number and type of facilities,

and size of budget; (2) [t]he type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3) [t]he nature and cost of the accommodation needed." 28 CFR §42.511(c) (1998); see 45 CFR §84.12(c) (1998) (same).

Under the Court of Appeals' restrictive reading, the reasonable-modifications regulation would impose a standard substantially more difficult for the State to meet than the "undue burden" standard imposed by the corresponding §504 regulation.

FOOTNOTES

Footnote 1

We have incorporated Title VII standards of discrimination when interpreting statutes prohibiting other forms of discrimination. For example, Rev. Stat. §1977, as amended, 42 U. S. C. §1981, has been interpreted to forbid all racial discrimination in the making of private and public contracts. See *Saint Francis College v. Al-Khazraji*, 481 U. S. 604, 609 (1987). This Court has applied the "framework" developed in Title VII cases to claims brought under this statute. *Patterson v. McLean Credit Union*, 491 U. S. 164, 186 (1989). Also, the Age Discrimination in Employment Act of 1967, 81 Stat. 602, as amended, 29 U. S. C. §623(a)(1), prohibits discrimination on the basis of an employee's age. This Court has noted that its "interpretation of Title VII ... applies with equal force in the context of age discrimination, for the substantive provisions of the ADEA `were derived *in haec verba* from Title VII.'" *Trans World Airlines, Inc. v. Thurston*, 469 U. S. 111, 121 (1985) (quoting *Lorillard v. Pons*, 434 U. S. 575, 584 (1978)). This Court has also looked to its Title VII interpretations of discrimination in illuminating Title IX of the Education Amendments of 1972, 86 Stat. 373, as amended, 20 U. S. C. §1681 *et seq.*, which prohibits discrimination under any federally funded education program or activity. See *Franklin v. Winnett County Public Schools*, 503 U. S. 60, 75 (1992) (relying on *Meritor Savings Bank, FSB v. Vinson*, 477 U. S. 57 (1986), a Title VII case, in determining that sexual harassment constitutes discrimination).

Footnote 2

This Court has recognized that two forms of discrimination are prohibited under Title VII: disparate treatment and disparate impact. See *Griggs*, 401 U. S., at 431 ("The Act proscribes not only overt discrimination but also practices that are fair in form, but discriminatory in operation"). Both forms of "discrimination" require a comparison among classes of employees.

Footnote 3

Following *Wards Cove*, Congress enacted the Civil Rights Act of 1991, Pub. L. 102-166, 105 Stat. 1071, as amended, which, *inter alia*, altered the burden of proof with respect to a disparate impact discrimination claim. See *id.*, §105 (codified at 42 U. S. C. §2000e-2(k)). This change highlights the principle that a departure from the traditional understanding of discrimination requires congressional action. Cf. *Field v. Mans*, 516 U. S. 59, 69-70 (1995) (Congress legislates against the background rule of the common law and traditional notions of lawful conduct).

Footnote 4

If such general hortatory language is sufficient, it is puzzling that this or any other court did not reach the same conclusion long ago by reference to the general purpose language of the Rehabilitation Act itself. See 29 U. S. C. §701 (1988 ed.) (describing the statute's purpose as "to develop and implement, through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living, for individuals with handicaps *in order to maximize their employability, independence, and integration* into the workplace and the community" (emphasis added)). Further, this section has since been amended to proclaim in even more aspirational terms that the policy under the statute is driven by, *inter alia*, "respect for individual dignity, personal responsibility, self-determination, and pursuit of meaningful careers, based on informed choice, of individuals with disabilities," "respect for the privacy, rights, and equal access," and "inclusion, integration, and full participation of the individuals." 29 U. S. C. §§701(c)(1) - (3).

Footnote 5

Given my conclusion, the Court need not review the integration regulation promulgated by the Attorney General. See 28 CFR §35.130(d) (1998). Deference to a regulation is appropriate only "if Congress has not expressed its intent with respect to the question, and then only if the administrative interpretation is reasonable." *Reno v. Bossier Parish School Bd.*, 520 U. S. 471, 483 (1997) (quoting *Presley v. Etowah County Comm'n*, 502 U. S. 491, 508 (1992)). Here, Congress has expressed its intent in §12132 and the Attorney General's regulation--insofar as it contradicts the settled meaning of the statutory term--cannot prevail against it. See *NLRB v. Town & Country Elec., Inc.*, 516 U. S. 85, 94 (1995) (explaining that courts interpreting a term within a statute "must infer, unless the statute otherwise dictates, that Congress means to incorporate the established meaning of that term") (internal quotation marks omitted).

Footnote 6

In mandating that government agencies minimize the institutional isolation of disabled individuals, the majority appears to appropriate the concept of "mainstreaming" from the Individuals with Disabilities Education Act (IDEA), 84 Stat. 175, as amended, 20 U. S. C. §1400 *et seq.* But IDEA is not an antidiscrimination law. It is a grant program that affirmatively requires States accepting federal funds to provide disabled children with a "free appropriate public education" and to establish "procedures to assure that, to the maximum extent appropriate, children with disabilities ... are educated with children who are not disabled." §§1412(1), (5). Ironically, even under this broad affirmative mandate, we previously rejected a claim that IDEA required the "standard of care" analysis adopted by the majority today. See *Board of Ed. of Hendrick Hudson Central School Dist., Westchester Cty. v. Rowley*, 458 U. S. 176, 198 (1982) ("We think ... that the requirement that a State provide specialized educational services to handicapped children generates no additional requirement that the services so provided be sufficient to maximize each child's potential commensurate with the opportunity provided other children") (internal quotation marks omitted).

Appendix B

AMH Transformation 01 Initiative Charter

AMH Transformation Initiative O1-

Streamlining transitions through the addictions and mental health system

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| <p>Situation/Problem Definition <i>(What problems are we trying to solve with this initiative? Please create context for the initiative by referring back to the team's larger situation as described in your team charter.)</i></p> | <p>Children, adults, and older adults who receive mental health and addiction services require individualized services. There are system-wide hindrances to individualized care and appropriate transitions.</p> <ul style="list-style-type: none">▪ Criteria for admission, continued stay and discharge are not agreed upon or routinely addressed during the referral and step down processes. Roles and responsibilities are not standardized across the state.▪ No standardized means to determine what type or intensity of care a person could transition into;▪ There is disagreement in the system about the types of treatment services that need to be developed.▪ The Oregon system of community based, residential mental health system has much work to do in terms of integrating the transitional model. Residential treatment homes still often resemble “mini-institutions” with long lengths of stay. The current system is not research or criteria based resulting in a “bottleneck” phenomenon and the belief that more secure placements are needed.▪ People may have to go a long distance to receive the particular service they need because not all services are provided in all area (requires integration with Initiative 02)▪ The system of residential mental health service delivery in Oregon consists of OSH, AMH, CMHP’s, and community providers. The components are isolated from one another and lack communication or common purpose.▪ Accountability & incentives with providers are lacking, which contributes to bottlenecks in transitioning people through the system and inefficient use of resources; (requires integration with Initiative 05) |
| <p>Vision for Success, objectives, and metrics <i>(What does success look like for this initiative? What specific benefits,</i></p> | <p>The AMH vision for success means that people receive the right type and intensity of services, for the right amount of time, and that they get better. A vision of success looks like</p> |

DHS Transformation Initiatives

AMH Transformation Team

AMH Transformation Initiative O1-

Streamlining transitions through the addictions and mental health system

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| <p><i>tangible and intangible, will we achieve and when? Please create context by referring back to the team's vision for success, objectives, and metrics as described in your team charter.)</i></p> | <p>people living and healing in their communities, in the safest and least restrictive environment, with a focus on recovery and resiliency. People and their families need facilities, services, and programs in rural and urban areas, close to home.</p> <p>AMH can accomplish this by:</p> <ul style="list-style-type: none">▪ Clarifying roles, responsibilities, policies, & procedures between AMH staff and community mental health programs;▪ Adopting a standardized client assessment of acuity for people receiving mental health services;▪ Decreasing the amount of time a person remains in services that do not match their acuity or need;▪ Simplifying and standardizing documentation requirements for providers;▪ Simplifying and standardizing a funding and payment system for providers;▪ Simplifying the data process to gather real-time information from providers about the quality and quantity of services they are providing;▪ Agreeing on how the different levels, types, and intensities of care are used. For example, are placements temporary for treatment only? Or are they intended to be a home base for people stabilized in that level of care? <p>AMH will be tracking the following potential benefits:</p> <ul style="list-style-type: none">▪ Cost savings: Decrease spend in higher intensities of care than the person is assessed as needing & decrease spend in vacant beds▪ Cycle time: Decrease the amount of time it takes to transition people who are clinically ready to move to a less intense or restrictive type of care;▪ Customer satisfaction;▪ Error rates with referrals; and▪ Waitlists. |
| <p>Guiding Principles <i>(How will we operate as an initiative team as we achieve success?)</i></p> | <p>The teams working on this initiative will be creating and implementing more streamlined processes and standardized policies, with that in mind, they will operate</p> |

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| | <p>with the following principles when making decisions:</p> <ul style="list-style-type: none">▪ Integrate co-occurring assessment and treatment options into the transition process through different levels of care;▪ Responsible and accountable parties will be identified at the community level for the client at every transition through the different levels of care;▪ Documentation requirements will be kept to a minimum, decreasing the number of steps, and increasing the speed of the process of transitioning clients through the different types of care;▪ Standardized placement, continued stay and discharge criteria in all program areas;▪ Change regulatory framework to promote client transitions through the different levels of care;▪ Create a financial system to promote client transitions through the different types of care, including incentives for providers to transition clients through the different types of care;▪ Track the progress of transitioning clients through the different levels of care with a core set of outcomes and use this information to make corrections mid-stream; flexibility and making changes based on what data is telling us is a must; and▪ Include advocates, community representatives, providers, and family members in the planning process as appropriate. |
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| <p>Approaches to be used to solve the problems and achieve success <i>(What tools and techniques will we use on this initiative?)</i></p> | <p>This initiative involves children, adults, and older adults in multiple types of care across the continuum. There will be several projects and events planned to clarify definitions, roles, responsibilities, philosophies, policies, & procedures. Using the principles listed in this charter, the teams focusing on this initiative will employ:</p> <ul style="list-style-type: none">• Base lining & Benchmarking;• Current & Future State Mapping;• Rapid & Continual Process Improvement Principles;• Lean Principles;• Project Management; and▪ Metric Review & benefit tracking. |
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| <p>Scope -- organizational unit, process, function, and geographic <i>(Which parts of our agency, which processes, which functions, and which offices will be in scope for this initiative?)</i></p> | <p>This initiative includes the various systems and processes that touch the OSH system, the community mental health program system, the mental health organization system, and the addiction services system, from prevention through acute care.</p> |
| <p>Deliverables <i>(What specific documents will we develop and deliver to our sponsors as we achieve success on this initiative?)</i></p> | <p>Each event and project will have a charter, a final report, an implementation plan, and metrics to monitor. A weekly status report will track the progress of the initiative as a whole. A document describing the benefits as they are realized will also be developed.</p> |
| <p>Timing and milestones <i>(When will our work occur? What milestones must we meet for this initiative?)</i></p> | <p>By Jan 2009 Initiative leader identified By Jan 2009 Initiative roadmap By Jan 2009 Initiative charters By Feb 2009 Initiative sponsor & steering team identified By Feb 2009 Initiative status & progress reporting begins</p> |
| <p>Major activities <i>(What are the major activities required for this initiative? If you are planning to use Lean, please describe here the approximate number and scope of the RPI Events required. Note that you will have the opportunity prior to those events to create event charters.)</i></p> | <p>The O1 initiative roadmap will outline the timelines and sequencing for specific projects and events that will contribute to the success of the initiative. This initiative includes those processes and services that are touched by children, adults, and older adults, in the full continuum of care administered by AMH.</p> <ul style="list-style-type: none"> ▪ The first part of the O1 Initiative will include two projects. These projects will focus transitioning adults, including those young adults identified as in a transitional age, into community-based services from Acute care settings, long-term care (OSH and SAIP), , and high-intensity residential settings such as secure residential facilities. ▪ The second part of the O1 Initiative includes three projects that focus on services for adults, children, and older adults. For example, these projects will look at those services that don't fit in traditional mental health provisions such as the gero-psych services located at OSH, and site development for enhanced care. ▪ Part three will focus on Addiction services for children |

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| | <p>and adults, and case management between residential and outpatient treatment.</p> <p>Each event will be outlined in its own charter; will have an event team, which will include an event sponsor and an event lead. Several events will utilize Lean to assist with simplifying the current process.</p> |
| <p>Dependencies <i>(What major dependencies on others does this initiative have?)</i></p> | <p>This initiative affects children, adults, and older adults in Oregon who are a part of a large and complex system of services. AMH is dependent on the flexibility of the system to respond to the treatment and service needs of Oregonians.</p> |
| <p>Decision making <i>(How will we make decisions on this initiative?)</i></p> | <p>The initiative's work team along with the Initiative Lead will strive for consensus in the decision process. Decisions reached by the work team will be sent simultaneously to lean leaders, transformation project manager, and AMH sponsor for correction and revision if needed. The Initiative Lead will log decisions.</p> |
| <p>Issue resolution <i>(How will we identify and resolve issues that impede progress on this initiative?)</i></p> | <p>Issue resolution will follow the same path as decision making. If the initiative's work team cannot resolve issues in a reasonable period of time, the team will seek external assistance. The Initiative Lead will log issue resolutions.</p> |
| <p>Risk mitigation <i>(How will we identify and plan to mitigate risks we uncover on this initiative?)</i></p> | <p>A risk benefit analysis will be completed on all initiatives. Risk areas will be viewed in terms of dependent, independent, and extraneous variables for each initiative</p> |
| <p>Initiative Sponsor and steering body members <i>(Who will guide our work, set scope, provide resources, and approve our recommendations? When choosing, consider in particular the scope of this initiative – scope may suggest specific individuals who might be natural candidates to be sponsors.)</i></p> | <p>Initiative Sponsor: Len Ray Initiative Steering Body Members: Nancy Griffith: Oregon State Hospital Ralph Summers: Medicaid Unit Edie Woods: contracts Unit</p> |
| <p>Initiative leader <i>(Who will drive the daily work for this initiative?)</i></p> | <p>Initiative Lead: Tim Pea</p> |
| <p>Initiative core team members <i>(Who will be on the initiative's core working team?)</i></p> | <p>Rebecca Curtis, Cissie Bollinger, Shannon Casey, Elaine Sweet, Dean Carlisle, Melanie Tong, Rick Wilcox, Chris Potter</p> |

Appendix C

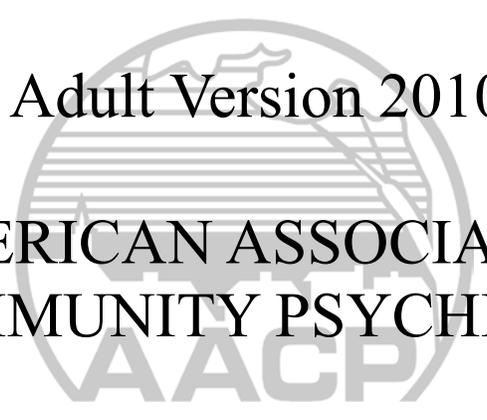
Level of Care Utilization of Services 10th edition

LOCUS

LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 2010

AMERICAN ASSOCIATION
OF COMMUNITY PSYCHIATRISTS



March 20, 2009

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INTRODUCTION TO ADULT VERSION 2010

With the arrival of managed care programs and principles, the use of quantifiable measures to guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes is increasingly important. In the past there have been no widely accepted standards to meet these needs. The development of LOCUS has provided a single instrument that can be used for these functions in a wide variety of settings, including both mental health and addictions. It provides a common language and set of standards with which to make such judgements and recommendations. Clinicians now have an instrument, which is simple, easy to understand and use, but also meaningful and sufficiently sensitive to distinguish appropriate needs and services. It provides clear, reliable, and consistent measures that are succinct, but sufficient to make care or quality monitoring judgments.

LOCUS has three main objectives. The first is to provide a system for assessment of service needs for adult clients, based on six evaluation parameters. The second is to describe a continuum of service arrays which vary according to the amount and scope of resources available at each “level” of care in each of four categories of service. The third is to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum.

This system is a dynamic one, and it has evolved over the years of its development. Since its inception, LOCUS has included content related to recovery status, stage of change, and choice. Its simple style and structure has invited use not only by a variety of clinicians with various levels of training, but by consumers themselves, allowing assessment to become a collaborative process. Engagement in this collaboration is central to person centered treatment planning. With this new revision of LOCUS, the first since 2000, language within the rating scales has been further simplified and stages of change (as conceived by Prochaska and DiClemente) have been assigned to ratings in Dimension VI, now called Engagement and Recovery Status. We strongly encourage collaboration between the clinician and the person being assessed whenever this is possible. As systems develop services and processes that facilitate recovery, these changes will allow LOCUS to be an even more powerful tool to assist these transformations.

Version 2010 makes these changes to address semantic concerns, but once again, there are no significant changes in content from Version 2000. Reliability and validity testing results will not be affected by these changes, but additional testing is planned in the future.

The instrument has multiple potential uses:

- To assess immediate service needs (e.g., for clients in crisis)
- To plan resource needs over time, as in assessing service requirements for defined populations
- To monitor changes in status or placement at different points in time.

As with previous versions, the current document is divided into three sections. The first section defines six evaluation parameters or dimensions: 1) Risk of Harm; 2) Functional Status; 3) Medical, Addictive and Psychiatric Co-Morbidity; 4) Recovery Environment; 5) Treatment and Recovery History; and 6) Engagement and Recovery Status. A five-point scale is constructed for

each dimension and the criteria for assigning a given rating or score in that dimension are elaborated. In dimension IV, two subscales are defined, while all other dimensions contain only one scale.

The second section of the document defines six “levels of care” in the service continuum in terms of four variables: 1) Care Environment, 2) Clinical Services, 3) Support Services, and 4) Crisis Resolution and Prevention Services. The term “level” is used for simplicity, but it is not our intention to imply that the service arrays are static or linear. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe levels of resource intensity. The particulars of program development are left to providers to determine based on local circumstances and outcome evaluations. Each level encompasses a multidimensional array of service intensities, combining crisis, supportive, clinical, and environmental interventions, which may vary independently. Patient placement criteria are then elaborated for each level of care. Separate admission, continuing stay, and discharge criteria are not needed in this system, as changes in level of care will follow from changes in ratings in any of the six parameters over the course of time.

The final section describes a proposed scoring methodology that facilitates the translation of assessment results into placement or level of care determinations. Both a grid chart and a decision flow chart are provided for this purpose.

We hope that this version of LOCUS will continue to stimulate considerable comment, discussion, and testing as reliability and validity studies continue. It is recognized that a document of this type must be dynamic and that adjustments or addendums may be required either to accommodate local needs or to address unanticipated or unrecognized circumstances or deficiencies. The specific needs of special populations, such as children, adolescents, and the elderly will not be adequately addressed in this adult version. It does not claim to replace clinical judgment, and is meant to serve only as an operationalized guide to resource utilization that must be applied in conjunction with sound clinical thinking. It is offered as an instrument that should have considerable utility in its present form, but growth and improvement should be realized with time and further testing. The AACP welcomes any comments or suggestions. Please send your comments to:

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Acknowledgments

This document was prepared by the American Association of Community Psychiatrists' Health Care Systems Committee Task Force on Level of Care Determinations. It was developed in cooperation with St. Francis Medical Center of Pittsburgh and the suggestions from multiple reviewers across the country. We would also like to acknowledge the intellectual stimulation provided by the review of multiple documents previously developed to address similar issues. Of particular influence in the conceptualization of LOCUS were the Patient Placement Criteria-1 of the American Society of Addiction Medicine (ASAM-PPC), the Level of Care Assessment Tool of US Healthcare (LOCAT), and the Level of Need-Care Assessment (LONCA) Method.

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Level of Care Utilization System for Psychiatric and Addiction Services

Instructions for Use

Each evaluation parameter is defined along a scale of one to five. Each score in the scale is defined by one or more criteria, which are designated by separate letters. Only one of these criteria need be met for a score to be assigned to the subject. The evaluator should select the highest score or rating in which at least one of the criteria is met.

There will, on occasion, be instances where there will be some ambiguity about whether a subject has met criteria for a score on the scale within one of the parameters. This may be due to inadequate information, conflicting information, or simply to difficulty in making a judgment about whether the available information is consistent with any of the criteria for that score. Clinical experience must be applied judiciously in making determinations in this regard, and the rating or criterion that provides the closest approximation to the actual circumstance should be selected. However, there will be instances when it will remain difficult to make this determination. In these cases the highest score in which it is more likely than not that least one criterion has been met should generally be assigned. The result will be that any errors will be made on the side of caution.

Since LOCUS is designed as a dynamic instrument, scores should be expected to change over time. Scores are generally assigned on a here and now basis, representing the clinical picture at the time of evaluation. In some of the parameters, historical information is taken into account, but it should not be considered unless it is a clear part of the defined criteria. In certain crisis situations, the score may change rapidly as interventions are implemented. In other situations, where a subject may be living under very stable circumstances, scores may not change for extended periods of time. Clinical judgment should prevail in the determination of how frequently scores should be reassessed. As a general rule, they will be reassessed more frequently at higher levels of acuity and at the higher levels of care or resource intensity.

Once scores have been assigned in all six evaluation parameters, they should be recorded on a worksheet and summed to obtain the composite score. Referring to the LOCUS Placement Grid, a rough estimate of the placement recommendation can be obtained. For greatest accuracy, the LOCUS Level of Care Decision Tree should be employed and it is recommended that it be used in most cases.

In assigning levels of care, there will be some systems that do not have comprehensive services for all populations at every level of the continuum. When this is the case, the level of care recommended by LOCUS may not be available and a choice will need to be made as to whether more intensive services or less intensive services should be provided. In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. This will again, lead us to err on the side of caution and safety rather than risk and instability.

LOCUS Instrument Version 2010

Evaluation Parameters for Assessment of Service Needs

Definitions

I. Risk of Harm

This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria:

1 - Minimal Risk of Harm

- a- No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.
- b- Clear ability to care for self now and in the past.

2 - Low Risk of Harm

- a- No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.
- b- Occasional substance use without significant episodes of potentially harmful behaviors.
- c- Periods in the past of self-neglect without current evidence of such behavior.

3 - Moderate Risk of Harm

- a- Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- b- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- c- History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.
- d- Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.
- e- Some evidence of self-neglect and/or decrease in ability to care for oneself in current environment.

4 - Serious Risk of Harm

- a- Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- b- History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
- c- Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.
- d- Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

5 - Extreme Risk of Harm

- a- Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
 - without expressed ambivalence or significant barriers to doing so, or
 - with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
 - in presence of command hallucinations or delusions which threaten to override usual impulse control.
- b- Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- c- Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

II. Functional Status

This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care. This ability should be compared against an ideal level of functioning given an individual's limitations, or may be compared to a baseline functional level as determined for an adequate period of time prior to onset of this episode of illness. Persons with ongoing, longstanding deficits who do not experience any acute changes in their status are the only exception to this rule and are given a rating of three. If such deficits are severe enough that they place the client at risk of harm, they will be considered when rating Dimension I in accord with the criteria elaborated there. For the purpose of this document, sources of impairment should be limited to those directly related to psychiatric and/or addiction problems that the individual may be experiencing. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining the placement of a given individual in the behavioral treatment continuum.

1 - Minimal Impairment

- a- No more than transient impairment in functioning following exposure to an identifiable stressor.

2 - Mild Impairment

- a- Experiencing some problems in interpersonal interactions, with increased irritability, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.
- b- Recent experience of some minor disruptions in aspects of self-care or usual activities.
- c- Developing minor but consistent difficulties in social role functioning and meeting obligations such as difficulty fulfilling parental responsibilities or performing at expected level in work or school, but maintaining ability to continue in those roles.
- d- Demonstrating significant improvement in function following a period of difficulty.

3 - Moderate Impairment

- a- Recently conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive, aggressive or abusive behaviors.
- b- Appearance and hygiene falls below usual standards on a frequent basis.
- c- Significant disturbances in physical functioning such as sleep, eating habits, activity level, or sexual appetite, but without a serious threat to health.
- d- Significant deterioration in ability to fulfill responsibilities and obligations to job, school, self, or significant others and these may be avoided or neglected on some occasions.
- e- Ongoing and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
- f- Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting.

4 - Serious Impairment

- a- Serious decrease in the quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors.
- b- Significant withdrawal and avoidance of almost all social interaction.
- c- Consistent failure to maintain personal hygiene, appearance, and self-care near usual standards.
- d- Serious disturbances in physical functioning such as weight change, disrupted sleep, or fatigue that threaten physical well being.
- e- Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.

5 - Severe Impairment

- a- Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive, aggressive or otherwise abusive behavior.
- b- Development of complete withdrawal from all social interactions.
- c- Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.
- d- Extreme disruptions in physical functioning causing serious harm to health and well being.
- e- Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

III. Medical, Addictive, and Psychiatric Co-Morbidity

This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent (here referred to as the presenting disorder). Co-existing disorders may prolong the course of illness in some cases, or may necessitate availability of more intensive or more closely monitored services in other cases. Unless otherwise indicated, historical existence of potentially interacting disorders should not be considered in this parameter unless current circumstances would make reactivation of those disorders likely. For patients who present with substance use disorders, physiologic withdrawal states should be considered to be medical co-morbidity for scoring purposes.

1 - No Co-morbidity

- a- No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder.
- b- Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition.

2 - Minor Co-morbidity

- a- Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder.
- b- Occasional episodes of substance misuse, but any recent episodes are self-limited, show no pattern of escalation, and there is no indication that they adversely affect the course of a co-existing psychiatric disorder.
- c- May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but these are transient and have no detectable impact on a co-existing substance use disorder.

3 - Significant Co-morbidity

- a- Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.
- b- Medical conditions exist which may be created or adversely affected by the existence of the presenting disorder.
- c- Medical conditions exist which may adversely affect the course of the presenting disorder.
- d- Ongoing or episodic substance use occurring despite negative consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.
- e- Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through use of a highly structured or protected setting or through other external means.
- f- Significant psychiatric symptoms and signs are present which are themselves somewhat debilitating, and which interact with and have an adverse affect on the course and severity of any co-existing substance use disorder.

4 - Major Co-morbidity

- a- Medical conditions exist, or have a very high likelihood of developing (such as a moderate, but uncomplicated, alcohol, sedative, or opiate withdrawal syndrome, mild pneumonia, or uncontrolled hypertension), which may require intensive, although not constant, medical monitoring.
- b- Medical conditions exist which are clearly made worse by the existence of the presenting disorder.
- c- Medical conditions exist which clearly worsen the course and outcome of the presenting disorder.
- d- Uncontrolled substance use occurs at a level, which poses a serious threat to health if unchanged, and/or which poses a serious barrier to recovery from any co-existing psychiatric disorder.
- e- Psychiatric symptoms exist which are clearly disabling and which interact with and seriously impair ability to recover from any co-existing substance use disorder.

5 - Severe Co-morbidity

- a- Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
- b- Presence and lack of control of presenting disorder places client in imminent danger from complications of existing medical problems.

- c- Uncontrolled medical condition severely worsens the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.
- d- Severe substance dependence with inability to control use under any circumstance and which may include intense withdrawal symptoms or continuing use despite clear worsening of any co-existing psychiatric disorder and other aspects of well being.
- e- Acute or severe psychiatric symptoms are present which seriously impair client's ability to function and prevent recovery from any co-existing substance use disorder, or seriously worsen it.

IV. Recovery Environment

This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person's efforts to achieve or maintain mental health and/or abstinence. Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities. Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and professionals, and other community members that provide caring attention and emotional comfort, are also sources of support. For persons being treated in locked or otherwise protected residential settings, ratings should be based on the conditions that would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances.

A) Level of Stress

1 - Low Stress Environment

- a- Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.
- b- No recent transitions of consequence.
- c- No major losses of interpersonal relationships or material status have been experienced recently.
- d- Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent.
- e- Living environment poses no significant threats or risk.
- f- No pressure to perform beyond capacity in social role.

2 - Mildly Stressful Environment

- a- Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties.
- b- A transition that requires adjustment such as change in household members or a new job or school.
- c- Circumstances causing some distress such as a close friend leaving town, conflict in or near current residence, or concern about maintaining material well being.
- d- A recent onset of a transient but temporarily disabling illness or injury.
- e- Potential for exposure to alcohol and/or drug use exists. *
- f- Performance pressure (perceived or actual) in school or employment situations creating discomfort.

3 - Moderately Stressful Environment

- a- Significant discord or difficulties in family or other important relationships or alienation from social interaction.
- b- Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.
- c- Recent important loss or deterioration of interpersonal or material circumstances.
- d- Concern related to sustained decline in health status.
- e- Danger in or near habitat.
- f- Easy exposure and access to alcohol and drug use. *
- g- Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

4 - Highly Stressful Environment

- a- Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
- b- Severe disruption in life circumstances such as going to jail, losing housing, or living in an unfamiliar, unfriendly culture.
- c- Inability to meet needs for physical and/or material well being.
- d- Recent onset of severely disabling or life threatening illness.
- e- Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use. *
- f- Episodes of victimization or direct threats of violence near current home.
- g- Overwhelming demands to meet immediate obligations are perceived.

5 - Extremely Stressful Environment

- a- An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
 - ongoing injurious and abusive behaviors from family member(s) or significant other.
 - witnessing or being victim of extremely violent incidents brought about by human malice or natural disaster.
 - persecution by a dominant social group.
 - sudden or unexpected death of loved one.
- b- Unavoidable exposure to drug use and active encouragement to participate in use. *
- c- Incarceration or lack of adequate shelter.
- d- Severe pain and/or imminent threat of loss of life due to illness or injury.
- e- Sustained inability to meet basic needs for physical and material well being.
- f- Chaotic and constantly threatening environment.

* These criteria apply to persons with past or present difficulties with substance use.

B) Level of Support

1 - Highly Supportive Environment

- a- Plentiful sources of support with ample time and interest to provide for both material and emotional needs in most circumstances.
- b- Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources.
(Selection of this criterion pre-empts higher ratings)

2 - Supportive Environment

- a- Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.
- b- Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
- c- Professional supports are available and effectively engaged (i.e. ICM).
(Selection of this criterion pre-empts higher ratings)

3 - Limited Support in Environment

- a- A few supportive resources exist in current environment and may be capable of providing some help if needed.
- b- Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.
- c- Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
- d- Resources may be only partially utilized even when available.
- e- Limited constructive involvement with any professional sources of support that are available.

4 - Minimal Support in Environment

- a- Very few actual or potential sources of support are available.
- b- Usual supportive resources display little motivation or willingness to offer assistance, or they are themselves troubled or hostile toward client.
- c- Existing supports are unable to provide sufficient resources to meet material or emotional needs.
- d- Client may be on bad terms with and unwilling to use supports available in a constructive manner.

5 - No Support in Environment

- a- No sources for assistance are available in environment either emotionally or materially.

V. Treatment and Recovery History

This dimension of the assessment recognizes that a person's past experience provides some indication of how that person is likely to respond to similar circumstances in the future. While it is not possible to codify or predict how an individual person may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators. Although the recovery process is a complex concept, for the purposes of rating in this parameter, recovery is defined as a period of stability with good control of symptoms. While it is important to recognize that some clients will respond well to some treatment situations and poorly to others, and that this may in some cases be unrelated to level of intensity, but rather to the characteristics and attractiveness of the treatment provided, the usefulness of past experience as one predictor of future response to treatment must be taken into account in determining service needs. Most recent experiences in treatment and recovery should take precedence over more remote experiences in determining the proper rating.

1 - Fully Responsive to Treatment and Recovery Management

- a- There has been no prior experience with treatment or recovery.
- b- Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.
- c- There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

2 - Significant Response to Treatment and Recovery Management

- a- Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.
- b- Recovery has been managed for moderate periods of time with limited support or structure.

3 - Moderate or Equivocal Response to Treatment and Recovery Management

- a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.
- b- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved.
- c- Unclear response to treatment and ability to maintain a significant recovery.
- d- At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

4 - Poor Response to Treatment and Recovery Management

- a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.
- b- Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.

5 - Negligible Response to Treatment

- a- Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time.
- b- Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

VI. Engagement and Recovery Status

This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. Factors such as acceptance of illness, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension. These factors will likewise impact a person's ability to be successful at a given level of care.

1 - Optimal Engagement and Recovery

- a- Has complete understanding and acceptance of illness and its effect on function.
- b- Actively maintains changes made in the past (Maintenance Stage).
- c- Is enthusiastic about recovery, is trusting, and shows strong ability to utilize available resources and treatment.
- d- Understands recovery process and takes on a personal role and responsibility in a recovery plan.

2 - Positive Engagement and Recovery

- a- Has significant understanding and acceptance of illness and its effect on function.
- b- Willing to change and is actively working toward it (Action Stage).
- c- Positive attitude toward recovery and treatment, capable of developing trusting relationships, and uses available resources independently when necessary.
- d- Shows recognition of personal role in recovery and accepts significant responsibility for it.

3 - Limited Engagement and Recovery

- a- Has some variability, hesitation or uncertainty in acceptance or understanding of illness and disability.
- b- Has limited desire or lacks confidence to change despite intentions to do so (Preparation Stage).
- c- Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
- d- Does not use available resources independently or only in cases of extreme need.
- e- Has limited ability to accept responsibility for recovery.

4 - Minimal Engagement and Recovery

- a- Rarely, if ever, is able to accept reality of illness or any disability that accompanies it, but may acknowledge some difficulties in living.
- b- Has no desire or is afraid to adjust behavior, but may recognize the need to do so (Contemplation Stage).
- c- Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
- d- Avoids contact with and use of treatment resources if left to own devices.
- e- Does not accept any responsibility for recovery or feels powerless to do so.

5 – Unengaged and Stuck

- a- Has no awareness or understanding of illness and disability (Pre-contemplation Stage).
- b- Inability to understand recovery concept or contributions of personal behavior to disease process.
- c- Unable to actively engage in recovery or treatment and has no current capacity to relate to another or develop trust.
- d- Extremely avoidant, frightened, or guarded.

LEVELS OF CARE

Definitions

BASIC SERVICES - Prevention and Health Maintenance

Definition:

Basic services are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. These services may be developed for individual or community application, and are generally carried out in a variety of community settings. These services will be available to all members of the community with special focus on children.

- 1. Care Environment** - An easily accessible office and communications equipment. Adequate space for any services provided on-site must be available. Central offices are likely to be most conveniently located in or near a community health center. Most services will be provided in the community, however, in schools, places of employment, community centers, libraries, churches, etc., and transportation capabilities must be available.
- 2. Clinical Services** - Twenty-four hour physician and nursing capabilities will be provided for emergency evaluation, brief intervention, and outreach services.
- 3. Support Services** - As needed for crisis stabilization, having the capability to mobilize community resources and facilitate linkage to more intense levels of care if needed.
- 4. Crisis Stabilization and Prevention Services** - In addition to crisis services already described, prevention programs would be available and promoted for all covered members. These programs would include: 1) Community outreach to special populations such as the homeless, elderly, children, pregnant woman, disrupted or violent families and criminal offenders; 2) Debriefing for victims of trauma or disaster; 3) Frequent opportunities to screen for high risk members in the community; 4) Health maintenance education (e.g., coping skills, stress management, recreation); 5) Violence prevention education and community organization; 6) Consultation to primary care providers and community groups; 7) Facilitation of mutual support networks and empowerment programs; 8) Environmental evaluation programs identifying mental health toxins; and 9) Support of day care and child enrichment programs.

Placement Criteria:

These Basic Services should be available to all members of the community regardless of their status in the dimensional rating scale.

I. LEVEL ONE - Recovery Maintenance and Health Management

Definition:

This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact. Recovery Maintenance programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. In some cases, services may be provided in community locations or in the place of residence.
2. **Clinical Services** - Treatment programming will be available up to two hours per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to four months. Medication use can be monitored and managed in this setting. Capabilities to provide individual or group supportive therapy should be available in at this level.
3. **Supportive Services** - Assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Facilitation in linkage with mutual support networks, individual advocacy groups, and with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all Basic Services (see page 17) will be accessible.

Placement Criteria:

1. **Risk of Harm** - clients with a rating of two or less may step down to this level of care.
2. **Functional Status** - clients should demonstrate ability to maintain a rating of two or less to be eligible for this level of care.
3. **Co-morbidity** - a rating of two or less is generally required for this level of care.
4. **Recovery Environment** - a combined rating of no more than four on Scale "A" and "B" should be required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less should be required for treatment at this level.
6. **Engagement and Recovery Status** - a rating of two or less should be obtained in this dimension for placement at this level of care.
7. **Composite Rating** - placement at this level of care implies that the client has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. A composite rating of more than 10 but less than 14 should generally be obtained for eligibility for this service.

II. LEVEL TWO - Low Intensity Community Based Services

Definition:

This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but the way out cannot be restricted. In some cases services may be provided in community locations or in the place of residence.
2. **Clinical Services** - Treatment programming will be available up to three hours per week, but usually not less than one hour every two weeks. Psychiatric or physician review and/or contact should be available according to need as indicated by initial and ongoing assessment. Medication use can be monitored and managed in this setting. Capabilities to provide individual, group, and family therapies should be available in these settings.
3. **Supportive Services** - Case management services will generally not be required at this level of care, but assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Liaison with mutual support networks and individual advocacy groups, and coordination with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all other Basic Services (see page 17) will be accessible.

Placement Criteria:

1. **Risk of Harm** - a rating of two or less would be most appropriate for this level of care. In some cases, a rating of three could be accommodated if the composite rating falls within guidelines.
2. **Functional Status** - ratings of three or less could be managed at this level.
3. **Co-Morbidity** - a rating of two or less is required for placement at this level.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three could be attempted at this level if stepping down from a more intensive level of care and a rating of two or less is obtained on scale "B" of dimension four.

6. **Engagement and Recovery Status** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three may be placed at this level if unwilling to participate in treatment at a more intensive level.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 14 but no more than 16 is required for treatment at this level.

III. LEVEL THREE - High Intensity Community Based Services

Definition:

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. These services may be provided in community locations in some cases, including the place of residence.
2. **Clinical Services** - Treatment programming (including group, individual and family therapy) will be available about three days per week and about two or three hours per day. Psychiatric/medical staffing should be adequate to provide review and/or contact as needed according to initial and ongoing assessment. On call psychiatric/medical services will generally not be available on a 24-hour basis. Skilled nursing care is usually not required at this level of care, and medication use can be monitored but not administered. Capabilities to provide individual, group, family and rehabilitative therapies should be available in these settings.
3. **Supportive Services** - Case management or outreach services should be available and integrated with treatment teams. Assistance with providing or arranging financial support, supportive housing, systems management and transportation should be available. Liaison with mutual support networks and individual advocacy groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. All other Basic Services (see page 17) will also be available.

Placement Criteria:

1. **Risk of Harm** - a rating of three or less can be managed at this level.
2. **Functional Status** - a rating of three or less is required for this level of care.
3. **Co-Morbidity** - a rating of three or less can be managed at this level of care.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the “A” and “B” scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.
6. **Engagement and Recovery Status** - a rating of three or less is required for this level of care.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

IV. LEVEL FOUR - Medically Monitored Non-Residential Services

This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings, but whose treatment needs require intensive management by a multi disciplinary treatment team. Services, which would be included in this level of care, have traditionally been described as partial hospital programs and as assertive community treatment programs.

1. **Care Environment** - Services may be provided within the confines of a clinic setting providing adequate space for provision of services available at this level, or they may in some cases be provided by wrapping services around the client in the community (i.e. ACT team).
2. **Clinical Services** - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available than about 40 hours per week. Physical assessment should be provided on-site if possible and access to ongoing primary medical care should be available. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered.
3. **Supportive Services** - Case management services will be integrated with on site treatment teams or mobile treatment teams and will provide assistance with providing or arranging financial support, supportive housing, systems management, transportation and ADL maintenance. Liaison with mutual support networks and individual groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

- 4. Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, as will other Basic Services.

Placement Criteria:

- 1. Risk of Harm** - a rating of three or less is required for placement at this level independent of other variables, and a rating higher than three should not be managed at this level.
- 2. Functional Status** - a rating of three is most appropriate for this level of care independent of other variables. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment (ACT) would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in conjunction with ACT).
- 3. Co-Morbidity** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in that circumstance).
- 4. Recovery Environment** - an “A” scale rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “B”. (Availability of Assertive Community Treatment would merit a rating of one on scale “B”). A “B” scale rating of three or less could otherwise generally be managed at this level.
- 5. Treatment and Recovery History** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in conjunction with ACT).
- 6. Engagement and Recovery Status** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in conjunction with ACT).
- 7. Composite Rating** - in many cases, utilization of this level of care will be determined by the interaction of a variety of factors. A composite rating of 20 requires treatment at this level with or without ACT resources available. (The presence of ACT reduces scores on dimension four enabling these criteria to be met even when scores of four are obtained in other dimensions.)

V. LEVEL FIVE - Medically Monitored Residential Services

Definition:

This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level. Level five services must be capable of providing the following:

1. **Care Environment** - Facilities will provide adequate living space for all residents and be capable of providing reasonable protection of personal safety and property. Physical barriers preventing egress or access to the community may be used at this level of care but facilities of this type will generally not allow the use of seclusion or restraint. Food services must be available or adequate provisions for residents to purchase and prepare their food must be made.
2. **Clinical Capabilities** - Access to clinical care must be available at all times. Psychiatric care should be available either on site or by remote communication 24 hours daily and psychiatric consultation should be available on site at least weekly, but client contact may be required as often as daily. Emergency medical care services should be easily and rapidly accessible. On site nursing care should be available about 40 hours per week if medications are being administered on a frequent basis. On site treatment should be available seven days a week including individual, group and family therapy. In addition, rehabilitation and educational services must be available either on or off site. Medication is monitored, but does not necessarily need to be administered to residents in this setting.
3. **Supportive Services** - Residents will be provided with supervision of activities of daily living, and custodial care may be provided to designated populations at this level. Staff will facilitate recreational and social activities and coordinate interface with educational and rehabilitative programming provided off site.
4. **Crisis Resolution and Prevention** - Residential treatment programs must provide services facilitating return to community functioning in a less restrictive setting. These services will include coordination with community case managers, family and community resource mobilization, liaison with community based mutual support networks, and development of transition plan to supportive environment.

Placement Criteria:

1. **Risk of Harm** - a rating of four requires care at this level independently of other parameters.
2. **Functional Status** - a rating of four requires care at this level independently of other dimensional ratings, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).
3. **Co-Morbidity** - a rating of four requires care at this level independently of other parameters, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).
4. **Recovery Environment** - a rating of four or higher on the "A" and "B" scale and in conjunction with a rating of at least three on one of the first three dimensions requires care at this level.

5. **Treatment and Recovery History** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.
6. **Engagement and Recovery Status** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.
7. **Composite Rating** - while a client may not meet any of the above independent ratings, in some circumstances, a combination of factors may require treatment in a more structured setting. This would generally be the case for clients who have a composite rating of 24 or higher.

VI. LEVEL SIX - Medically Managed Residential Services

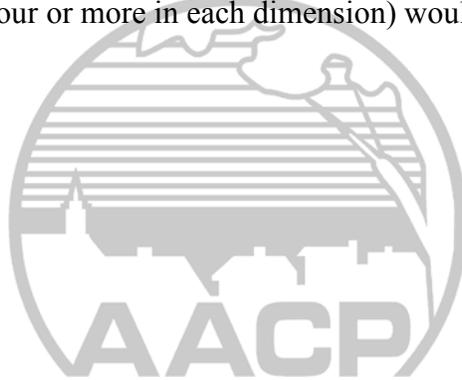
Definition:

This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings. Whatever the case may be, such settings must be able to provide the following:

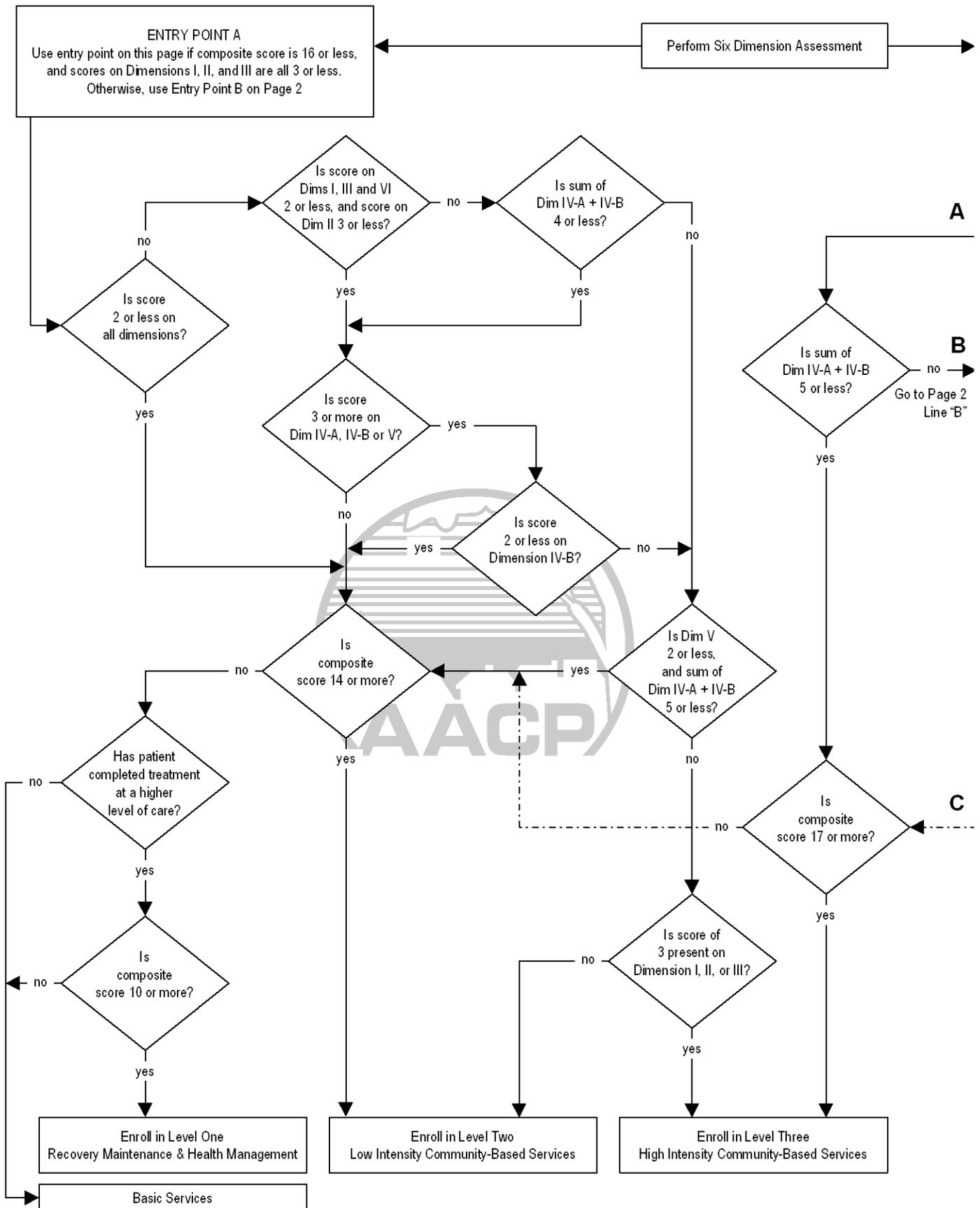
1. **Care Environment** - The facility must be capable of providing secure care, usually meaning that clients should be contained within a locked environment (this may not be necessary for services such as detoxification, however) with capabilities for providing seclusion and/or restraint if necessary. It should be capable of providing involuntary care when called upon to do so. Facilities must provide adequate space, light, ventilation, and privacy. Food services and other personal care needs must be adequately provided.
2. **Clinical Services** - Clinical services must be available 24 hours a day, seven days a week. Psychiatric, nursing, and medical services must be available on site, or in close enough proximity to provide a rapid response, at all times. Psychiatric/medical contact will generally be made on a daily basis. Treatment will be provided on a daily basis and would include individual, group and family therapy as well as pharmacologic treatment, depending on the client's needs.
3. **Supportive Services** - All necessities of living and well being must be provided for clients treated in these settings. When capable, clients will be encouraged to participate in and be supported in efforts to carry out activities of daily living such as hygiene, grooming and maintenance of their immediate environment.
4. **Crisis Resolution and Prevention Services** – These residential settings must provide services designed to reduce the stress related to resuming normal activities in the community. Such services might include coordination with community case managers, family and community resource mobilization, environmental evaluation and coordination with residential services, and coordination with and transfer to less intense levels of care.

Placement Criteria:

1. **Risk of Harm** - a rating of five qualifies an admission independently of other parameters.
2. **Functional Status** - a rating of five qualifies placement independently of other variables.
3. **Medical and Psychiatric Co-Morbidity** - a rating of five qualifies placement independently of other parameters.
4. **Recovery Environment** - a rating of four or more would be most appropriate for this level, but no rating in this parameter qualifies placement independently at this level, nor would it disqualify placement if otherwise warranted.
5. **Treatment and Recovery History** - a rating of four or more would be most appropriate for this level but, no rating in this dimension qualifies placement independently at this level, nor would it disqualify an otherwise warranted placement.
6. **Engagement and Recovery Status** - a rating of four or more would be most appropriate for this level but no rating in this parameter qualifies or disqualifies placement independently at this level.
7. **Composite Rating** - in some cases, patients not meeting independent criteria in any one category, may still need treatment at this level if ratings in several categories are high, thereby increasing the risk of treatment in a less intensive setting. A composite rating of 28 (an average rating of four or more in each dimension) would indicate the need for treatment at this level.

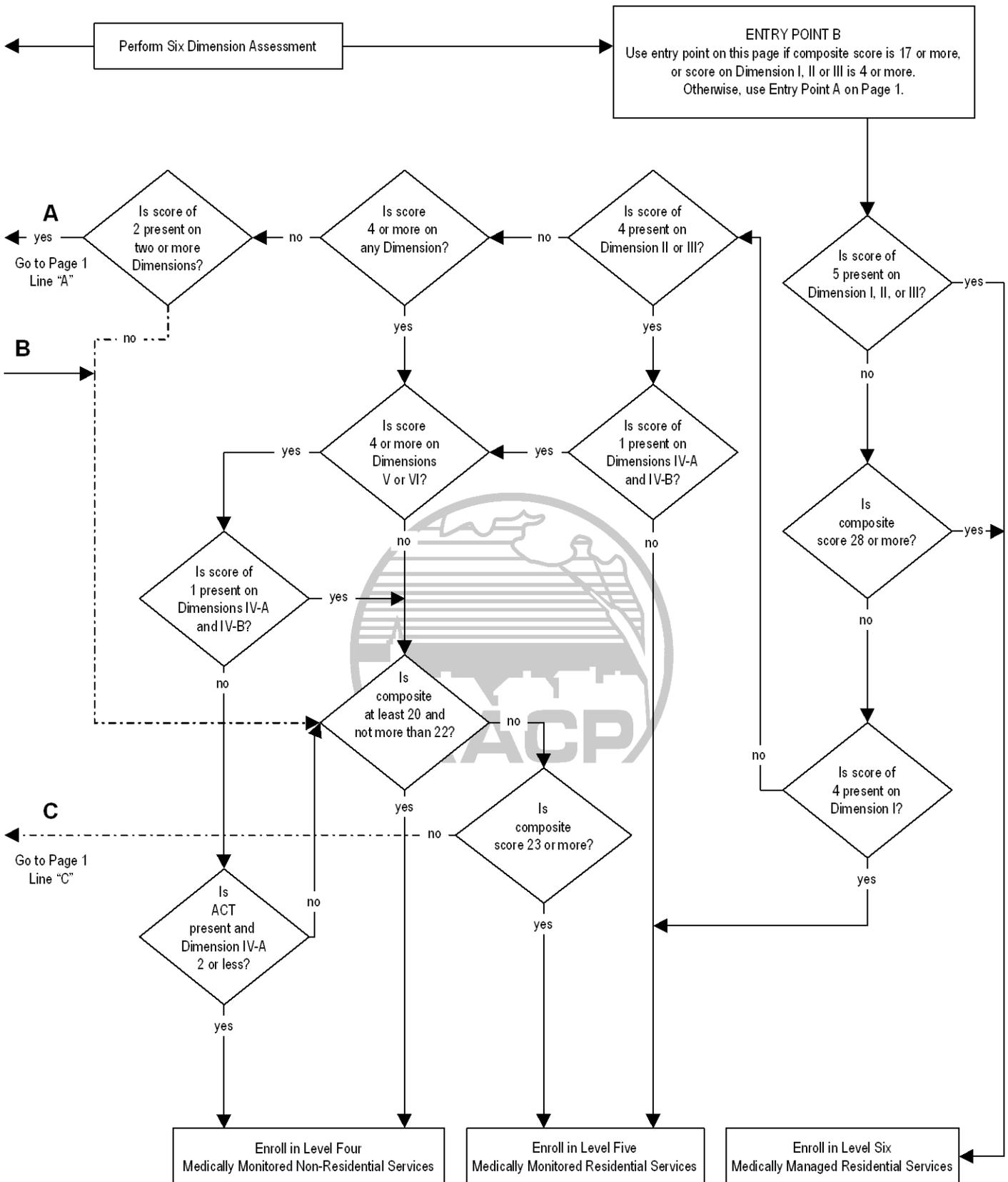


AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 1

AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 2

AACP LEVEL OF CARE DETERMINATION GRID

| Level of Care Dimensions | Recovery Maintenance Health Management Level 1 | Low Intensity Community Based Services Level 2 | High Intensity Community Based Services Level 3 | Medically Monitored Non-Residential Services Level 4 | Medically Monitored Residential Services Level 5 | Medically Managed Residential Services Level 6 |
|---|---|---|--|---|---|---|
| I. Risk of Harm | 2 or less | 2 or less | 3 or less | 3 or less | ④ 3 | ⑤ 4 |
| II. Functional Status | 2 or less | 2 or less | 3 or less | 3 or less | ④* 3 | ⑤ 4 |
| III. Co-Morbidity | 2 or less | 2 or less | 3 or less | 3 or less | ④* 3 | ⑤ 4 |
| IV A. Recovery Environment "Level of Stress" | Sum of IV A + IV B is 4 or less | Sum of IV A + IV B is 5 or less | Sum of IV A + IV B is 5 or less | 3 or 4 | 4 or more | 4 or more |
| IV B. Recovery Environment "Level of Support" | 2 or less | 2 or less | 3 or less | 3 or less | 3 or more | 4 or more |
| V. Treatment & Recovery History | 2 or less | 2 or less | 3 or less | 3 or 4 | 3 or more | 4 or more |
| VI. Engagement & Recovery Status | 2 or less | 2 or less | 3 or less | 3 or 4 | 3 or more | 4 or more |
| Composite Rating | 10 to 13 | 14 to 16 | 17 to 19 | 20 to 22 | 23 to 27 | 28 or more |

* Unless sum of IV A and IV B equals 2

○ indicates independent criteria - requires admission to this level regardless of composite score

Appendix D

Community Services Work Group Report

&

Funding Recommendations



**Oregon Department of Human Services
Community Services Workgroup Report**

*A Complement to the Master Plan Phase II Report
on the Replacement of the Oregon State Hospital*

Version II, March 2009

Introduction

The State Hospital Master Plan Phase II Report released in February 2006 recommended significant investment in community mental health services in Oregon. The report stated, “Without the enhanced community programming, demand for Oregon State Hospital (OSH) beds will substantially exceed projections of size and cost.”

To address in more detail the need for community mental health services, the Addictions and Mental Health Division (AMH) convened the Oregon State Hospital Master Plan Community Services Workgroup (CSWG) in September 2006. Over the succeeding months, the CSWG received extensive input into the types of services needed, especially for those services that prevent individuals from needing more expensive and intensive services. The report provided a narrative description of each type of service, systematic estimates of the need for and costs of these services, and a timeline for implementing the services. The CSWG issued its report, including comprehensive program and financial recommendations in February 2007.

Update on 2007 recommendations

The Oregon Legislature provided an additional \$20.9 million in general fund for adult-focused community mental health services. This initial investment was a first step in improving Oregon’s mental health system. However, the amount provided was only 1/6 the amount recommended by the Community Services Workgroup. The funding was released to local Community Mental Health Programs (CMHPs) in late 2007 and early 2008.

The following are examples of how local communities utilized funds to develop and/or enhance services:

- **Crisis and Acute Care Services**
 - Development of programs to assist in the diversion of clients from hospital level of care.
 - Development of respite beds.

- **Jail Diversion**
 - Implementation of mental health courts and other programs that enhance the relationship of the mental health care system with law enforcement and county jails.

- **Supported Employment**
 - Funding for 440 indigent clients, who for various reasons were not able to be part of the Oregon Health Plan.
- **Early Assessment and Support Alliance (EASA)**
 - Program staff trained, and programs are in the early phases of implementation.
 - Approximately 180 additional non-Medicaid youth, age 16-24, and their families are being served.
- **Case Management**
 - Enhancement of existing services to improve quality of services for clients.

Current Status

In 2008, AMH reconvened the CSWG to update the original report as Oregon moves forward on building the new state hospitals. The 2008 CSWG agreed with the philosophy and recommendations in the 2007 report. The CSWG continued to stress that there is one mental health system and the full continuum of mental health services needs to be enhanced to successfully improve the quality and efficiency of services. The significant difference in this report is that the CSWG no longer defines front-end and back-end services. The CSWG recommends that the system should be seen as a continuum of services that individuals may need to access at different points in their lives, as they manage their illness and progress in their recovery.

The CSWG issues this revised report as an addendum to the previous year's report, in order to inform the Department of Human Services (DHS)/AMH, the Governor, and the Legislature on the continuum of services required to complement the replacement of the state hospital facilities and to assure the new hospitals' success.

The CSWG acknowledges that the realities of available funding will influence the decisions made in response to this report. The CSWG recognizes that there are not yet sufficient numbers of qualified mental health professionals and other trained staff to fully implement the recommendations in the immediate future. However, the community system must be fully funded and functional by 2015. This allows both funding and staff development to occur over the next three biennia.

Regardless of funding realities, this revised report needs to be seen in its entirety. The components of the system are interconnected and interdependent. An array of services must be available that support individuals in recovery by allowing them to access services that meet their needs and desires. These services must be available regardless of the individual's location. Funding must be sufficient to develop sustainable programs throughout the state, and not to be so small that there is no way to create and maintain the programs and services.

Values

As has been articulated in previous reports and recommendations, community mental health services must be developed with values that support and empower individual recovery. The following statements, adapted from the Governor's 2004 Mental Health Task Force Report, summarize the values that drive the recommendations in this report.

- Recovery is a journey of personal healing and transformation, and is the goal of all mental health services.
- Treatment and supports must be consumer-directed.
- Services provided by persons who are recovering from mental health problems serve an invaluable role in supporting other people in recovery.
- Services must be available in communities where people live.
- Services must be evidenced-based.
- Safe and affordable housing is key to recovery.
- Services must be culturally and age specific.
- Services must recognize the effects of and support recovery from trauma.
- An effective mental health system coordinates and collaborates with the broader system of community services.

Determining the level of unmet need in Oregon

The prevalence rate for severe mental illness among adults in Oregon is 5.4 percent, which translates into 154,867 individuals in Oregon.¹ Some of these individuals are served in the public system while others receive services through the private sector.

¹ Based on estimates from the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration.

A national research report states that approximately one-third of individuals with a serious mental illness are uninsured.² The same report states that under-insurance, even in states with parity, is a large barrier to accessing mental health services. Therefore, these rates under-report the number of individuals needing publicly funded services.

Extrapolating this data to Oregon, approximately 27,609 persons with a mental illness are currently uninsured and not receiving services in Oregon. Due to the nature of mental illness, with people fluctuating in their level of need during different stages of their illness, this report estimates that approximately 21,000 additional individuals need publicly funded mental health services at some time during a biennium.

These recommendations also assume a three percent population growth per biennium. All funding for services described in this report are General Fund dollars. This report assumes that new funding invested in one biennium will be included in the department's Essential Budget Level for the following biennium, so funding identified for each biennium is new funding.

Another category of unmet need is for the individuals who are not able to fully access services. They may be receiving some services through community programs. However, due to funding restrictions, regional differences, lack of treatment providers or other barriers, these individuals cannot obtain the full array of services they need. At this time, AMH cannot determine this level of unmet need. Still, the CSWG believes that the recommendations and assumptions specified in this report under represent the true need in our communities.

Traditional funding and targeted programmatic funding silos do not serve the best interest of the individuals we need to serve. Services must be seen as an array of options that allow people to access appropriate services depending on their individual need and desires. Local communities should be encouraged to develop innovative services that meet the needs of their communities and the people they serve.

² Coverage for All: Inclusion of Mental Illness and Substance use Disorders in State Healthcare Reform Initiatives
June 8th, 2008, NAMI

Recommendations for community services

Services needed in an effective community mental health system are outlined in these recommendations. In addition to identifying new services, the expansion of current services to meet the unmet needs is outlined. The costs for this expansion are stated in terms of additional funds needed each biennium from 2009-2011 through 2013 - 2015. Actual funding estimates are attached in Appendix A.

The recommendations are encompassed in the following categories:

- Expand early intervention and prevention services;
- Increase the availability of crisis services;
- Ensure access to acute care and alternative services;
- Increase the availability of case management services;
- Provide access to medications and medication management services;
- Develop supported employment and supported education services;
- Decrease criminal justice involvement with the correct treatment and services;
- Treat co-occurring disorders;
- Reduce health disparities through wellness;
- Increase safe, affordable and permanent housing;
- Institute culturally appropriate mental health services;
- Create services and programs for elders and young adults;
- Invest in peer-delivered and trauma informed services;
- Develop appropriate residential capacity; and
- Ensure proper oversight of the mental health service delivery system.

Recommendations details

Early intervention and prevention services

Overview

Early intervention and prevention services provide the best opportunity for ensuring an individual's long-term recovery. These services focus on early identification, support and mental health treatment for the individual, including supports for the family as well. Educating individuals regarding their illnesses and assisting them in developing skills to manage their symptoms are key components of the services.

Recommendations

All newly identified individuals should have access to early assessment and support. The state needs to invest enough resources to provide a complete range of services to this population.

Assumptions

Based on epidemiological research, the statewide need for services is estimated to be 360 new clients and their families per year. About 270 persons per year would require services funded by General Fund monies. The average length of service would be 24 months.

Crisis services

Overview

Crisis services at the community level are critical. Mobile Crisis Outreach Services provide crisis intervention in the community, at the location of need. Mobile crisis outreach increases the opportunity of stabilization in a client's community and not in the hospital. Crisis respite services provide a place in the community to stabilize a crisis, avoiding unnecessary hospitalization.

Recommendations

Oregonians should have access to appropriate crisis services in every community. The particular services would vary depending upon the specific needs in each community. The state should provide guidance on a core set of services.

Assumptions

To accurately determine the unmet need for crisis services can be difficult. Individuals without ongoing supports often bounce in and out of crisis. The Mental Health Alignment Workgroup (MHAWG) estimated that 25% of those not receiving ongoing services will need crisis services.³ CSWG believes this is still a valid starting point.

Acute care and alternative services

Overview

Acute care hospitals serve as an entry point to the public mental health system and play a vital role in the continuum of care. Unfortunately, due to lack of funding, limited number of mental health professionals and expertise, acute in-patient psychiatric services are limited to just a few hospitals. Access in community hospitals for Psychiatric Hold Rooms (for short term involuntary care) and sub-

³ Report to the Governor from the Mental Health Alignment Work Group; January 2001.

acute residential programs are also limited. Access issues are compounded in rural areas due to the considerable distance from hospitals with psychiatric units.

Recommendation

Acute care hospitals must be adequately compensated for the services they provide. Aside from the challenges facing hospital acute care service, options need to be expanded to provide sub-acute care when appropriate. This opportunity provides less expensive care options for patients who do not need hospital level of care, as well as providing a “step down” level of care for people leaving the hospital. Special consideration must also be given to the challenges in rural communities.

Assumptions

In calendar year 2007, AMH served 5873 adults in acute care;⁴ local hospitals have estimated that this is only 50% of the need. The existence of significant administrative burdens, financial losses for community hospitals and the shortage of state-owned psychiatric beds have contributed to the closure of hospital acute care beds. It is likely that if these issues are not addressed additional acute care beds will close, placing increased pressure on other parts of the system.

Case management services

Overview

Case management services are provided to persons in and out of a clinic setting. As part of the continuum of care, these services provide the linkage to services and supports. Case managers help individuals stay in their local communities and provide the additional supports for successful community reintegration after stays in the state hospitals.

Recommendation

Case managers play a critical role in an individual’s recovery by linking them to treatment services, community services and naturally occurring supports. Individuals needing ongoing mental health services and supports should have regular access to case managers. Every person leaving the state hospital should also have access to case management services. The level of case management services should be determined based on each individual’s specific needs.

⁴ Oregon Patient Resident Care System.

Assumptions

The MHAWG estimated that 85 percent of the individuals not currently receiving mental health services would need access to case management services.

Approximately 15 percent of persons with a serious mental illness require Assertive Community Treatment (ACT) level of service.

Access to Medications and Medication Management

Overview

For many persons with a serious mental illness medications are essential to healthy living in the community. However, for individuals without medical coverage, medications are too expensive to obtain. Accessing the medical professionals who can prescribe medications and monitor reactions is also problematic for individuals without medical coverage.

Recommendation

Community mental health programs need funding to cover the cost of medications for persons who have a gap in medical coverage and do not qualify for medication scholarship programs. Medication funding and access to licensed medical professionals who can assess and prescribe medications are a necessity.

Assumption

The MHAWG estimated that 85 percent of the individuals not currently receiving mental health services would need access to medications subsidized by the state.

Supported employment and education

Overview

Ensuring access for persons with a serious mental illness to evidenced based services that place and support them in competitive employment or education that leads to employment is necessary for continued recovery. As part of the continuum of care, supported employment and supported education assist clients in becoming productive community members and improves quality of life.

Recommendation

Oregon is a leader in the development of both supported employment and supported education. Supported employment is an evidence-based practice that has proven results. Supported education is a promising best practice. These services are currently only available in select Oregon counties; however, they should be available to all individuals who want them.

Assumptions

Studies estimate that 70 percent of persons with a serious mental illness express a desire to work. This means that more than 14,000 individuals may need supported employment or supported education services. Because studies have not been conclusive regarding the optimum length of supported employment services, this report assumes that 25 percent of those not receiving services should have supported employment or education services.

Reducing criminal justice involvement

Overview

In 2005 AMH and the Oregon Jail Managers Association survey reported nine percent of inmates have severe mental illness and the Oregon Sheriffs Jail Command Council reports 20 percent of their inmates have a mental illness. Jail systems are ill equipped to handle inmates with mental illnesses. When incarcerated, individuals with mental illness deteriorate quickly due to lack of treatment services. Reducing criminal justice involvement includes: jail diversion services, mental health courts and re-entry programs, all of which help individuals successfully manage their illness while they are in prison or jail, and develop a plan for when they return to their community.

Recommendation

As a result of inadequate resources for non-Medicaid eligible individuals, law enforcement has had to accept a far more central role in handling mental health crises in the community than it should have to assume. Services need to be in place to divert people with a serious mental illness from the criminal justice system, providing immediate services when a person is released from a local jail. These services are not widely available in every Oregon county.

Assumptions

According to the survey referenced above, the average number of daily jail bookings in Oregon is 540, which means that about 100 people with a serious mental illness are booked every day. Assuming that some of the bookings are repeat offenders, and some individuals can be served in traditional ACT programs, approximately 1,030 non-Medicaid eligible people per year will need forensic intensive case management services. Every county needs enhanced liaisons with local law enforcement.

Co-occurring disorder services

Overview

Individuals with Co-occurring Disorders (COD) are more likely to be homeless and die at the average age of 43.9 years compared to 74.9 for the rest of the population. COD is defined as a person with both a severe psychological disorder and a substance abuse disorder. Treatment for persons with a co-occurring disorder is most effective when addiction and mental health services are integrated.

Recommendation

Communities need access to specialized COD services. The system needs a standardized and universal screening protocol for all persons enrolling in mental health and addictions services. Addictions and mental health providers and physical health care providers must be trained to use these screening tools. Communities throughout Oregon have also identified detox for people with COD services as a high priority. Beds are particularly needed to serve the indigent population, which is growing as a result of the economic downturn.

Assumptions

Research indicates that the prevalence of co-occurring disorders in the population of adults accessing community-based mental health services averages between 20-30 percent, with outlying variables being age and mental health diagnosis.⁵ Washington State prevalence data note that 27 percent of individuals entering state treatment programs have a COD.⁶

Focusing on wellness

Overview

In its report, *Measuring Premature Mortality among Oregonians* (AMH, 2008) AMH reported that clients with mental illness die almost 25 years younger than the average population. Individuals with dual diagnosis die even earlier. This disparity is due to heart disease, diabetes and problems related to side effects of medications, smoking, obesity and lack of holistic medical care, according to research by a national mental health council.

⁵ Rush, B. & Koegel, C.J. (2008). Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders Within a Comprehensive Mental Health System. *Canadian Journal of Psychiatry*; 53 (12): 810-821. **Note:** Research conducted in the United States.

⁶ Washington State Department of Social and Health Services; Division of Alcohol and Substance Abuse. (2008). *Abuse Trends in Washington State*.

Recommendation

Oregon must develop and support a statewide initiative to improve the integration and collaboration among providers of mental health, substance abuse treatment and physical health care. Coordinated care for people accessing publicly funded health services will maximize early intervention for mental health and substance abuse issues. This intervention will help prevent avoidable illnesses and provide treatment of chronic conditions.

AMH should build on current activities within the Wellness Initiative. This should include the establishment and ongoing support of a wellness task force. AMH should also develop a quality improvement process that supports increased access to physical health care and ensures appropriate prevention, screening and treatment services for persons with addictions and/or mental health disorders.

Assumption

In the study referenced above, DHS gathered data on 527,564 persons who were treated for substance abuse, mental health problems or both, between 1996 and 2005, and matched with death records from 1999 to 2005. The data showed that people with mental illness die much younger than others in their age cohort. Based on these numbers, an important tool to adequately address this level of disparity is for Oregon to develop a wellness model focused on people with mental illness.

Housing that is safe, affordable and permanent

Overview

Stable housing is an essential element for anyone living with mental illness. Unfortunately many individuals become homeless, or lack safe and affordable housing. The stability of safe, permanent housing plays a vital role in an individual's recovery.

Recommendations

To help individuals locate and remain in safe, affordable and permanent housing, there needs to be:

- Appropriate transitional housing,
- Supportive housing options, and
- Rental assistance.

Additional funding is critical to the ongoing ability of the system to provide stable and affordable housing for individuals with mental illness. While developing additional facilities and providing supported housing are critical, rental assistance plays a vital role in keeping individuals in safe and stable environments. In

combination, supportive housing and rental assistance provide critical alternatives to group homes and other structured facilities.

Assumption

A 2005 state survey conducted by AMH found that more than 12,861 people were in immediate need of affordable housing, that over 2,500 needed supportive or structured housing, and that an estimated 3,000 adults with mental illness were homeless at the time of the survey.

Institute culturally appropriate mental health services

Overview

Oregon population is mostly Caucasian with a growing percentage of population being Hispanic, African American, Native American, Asian, and other ethnic populations. AMH data indicate that African Americans and American Indians/Alaska Natives tend to be represented in outpatient services at rates higher than their rates in the general population while Asian and Hispanic populations are served at lower rates.

Recommendation and Assumptions

The mental health system needs to provide culturally competent mental health services. The state and community mental health programs must provide culturally competent services. This requirement must go beyond the current requirement that information be provided to potential consumers, family members and others in a multi-lingual format.

AMH should develop outreach and intervention tailored to communities and populations by providing resources to pay for culturally-specific positions. These positions would function as project *promotores de salud* or community mental health workers to act as links between communities and the mental health care system, organizing their communities to achieve better mental health.

AMH should also continue efforts to reach African-Americans. Services should be delivered close to where individuals live, in settings that these individuals are willing to attend. Services could be modeled after many of the peer-programs that have proven successful.

Age specific services

Overview

Two populations of Oregonians require specific attention in the development of mental health resources due to barriers preventing their access to the mental health

system. These are youth, ages 16 to 24, and older adults, age 65 and over.

According to AMH's 2009 Report to the Oregon Legislature on Planning for Mental Health Services, almost every county noted a gap in mental health services for its older adult population.

Transition age youth and young adults are difficult to engage in services. They often do not understand how to access benefits. They do not have access to professionals who can help them navigate into adult services. The system has not developed the appropriate tools to be relevant to this age cohort. Additionally, the children's delivery system and the adult delivery system speak different languages and there is little connection and interface between the two distinct system. Currently, service rates drop by 80 percent for these youth and young adults.

Recommendation

CMHPs should have specialized staff that can help coordinate services and develop the capacity needed to serve these youths and older adults.

Assumptions

According to US census data, Oregon is projected to have the fourth highest proportion of elderly people (age 65+) by 2025. Oregon needs to position itself to provide more services for this age cohort.

More than 34,000 children under the age of 17 receive mental health services. Since 80 percent drop from services, often entering the adult system much more impaired, Oregon is missing the opportunity to help more than 27,000 youths transition to adulthood smoothly and with the resources that they need.

Peer delivered services

Overview

Research is mounting that demonstrates the effectiveness of peer delivered services, and people receiving mental health services voice the positive effect of services provided by people that have had similar experiences. Mental health disorders are chronic conditions requiring treatment of acute symptoms and on-going management, supports and monitoring to avoid relapse. Individuals with mental health disorders need recovery support services to help them navigate systems, understand the issues related to these chronic diseases and provide them with the tools and skills to begin healing and rebuilding their lives. These support services are often best provided by people who themselves have received mental health services.

An excellent example of peer-supported services is the establishment of Dual Diagnosis Anonymous of Oregon, Inc. (DDA). DDA conducts meetings throughout Oregon that are based on the 12 Steps of Alcoholics Anonymous plus 5 steps that focus on dual disorders of substance abuse and mental illness. In less than 3 years, DDA has grown to over 2,500 people attending meetings with more than 90 groups in 24 counties. As another example, the David Romprey Oregon Warm Line, staffed by peers, is a valuable companion to the delivery system.

Recommendation and Assumptions

Peer delivered services can and should be included in all the categories described above. For example, ACT services are enhanced when the team includes a peer counselor or case manager, and peers can provide support even in acute care settings. As the mental health services are funded and directed to the CMHPs, peer-delivered services should be incorporated into the development of services.

Contractual oversight

The community mental health system in Oregon relies on a strong partnership between AMH and CMHPs. Nearly all of the community mental health services are contracted through the CMHPs. Frequently when mental health service funding is enhanced, the CMHPs are expected to implement additional services without consideration of the costs associated with the administration of those services. Proper administration ensures that the planning, development, and delivery of mental health services occur with regulatory assurance and quality.

Residential Programs

Overview

Community residential programs provide a stepping-stone for people leaving the state hospital. The State Hospital Master Plan Phase II Report emphasizes the importance of a strong residential system as part of an effective mental health system. The report states, "...availability and access to these programs (*community residential*) are keys to 1) reducing the patient population, 2) decreasing the length of stay at the State Hospital, and 3) maximizing mental health services in the community."⁷ The table below demonstrates the needed residential services by region between 2005 and 2030.

⁷ Oregon State Hospital Master Plan Phase II Report.

Community Residential Bed Need by Region⁸

| Region | 2005 ^a | | 2011b | | 2030b | |
|--------------------------------|-------------------|------------|--------------|------------|--------------|------------|
| | Civil | Forensic | Civil | Forensic | Civil | Forensic |
| North Willamette Valley | 749 | 118 | 865 | 233 | 996 | 365 |
| South Willamette/Central Coast | 356 | 27 | 380 | 51 | 430 | 101 |
| North Coast | 22 | 8 | 38 | 24 | 41 | 28 |
| Southern Oregon | 281 | 11 | 292 | 25 | 318 | 52 |
| Central Oregon | 29 | 7 | 67 | 45 | 87 | 66 |
| Eastern Oregon | 116 | 5 | 119 | 9 | 129 | 20 |
| TOTAL | 1,553 | 176 | 1,761 | 387 | 2,001 | 632 |

a Actual distribution of beds in 2005

b Assumes 50% civil and 50% forensic development

AMH developed 283 community placements in the 2005-2007 biennium and is projected to develop 299 in the 2007-2009 biennium. If funding for mandatory caseload growth is continued as part of the department’s base budget, AMH has determined that the need for community residential placements can be met with projected budget. AMH will plan future development to address current disparities in residential bed distribution. Special attention will need to be paid to the Central Oregon region, as it is the region that is most in need for residential development.

Further considerations

The CSWG identified additional issues but did not make specific recommendations for funding. The following warrant consideration as “front end” services are implemented:

Transportation

Mental health services need to be accessible to all who need them. While a majority of the population is located in areas with a public transportation system, many counties and municipalities have limited or non-existent public transportation. Distances to mental health services are significant in the rural areas. These issues need to be addressed as communities plan mental health services.

⁸ Ibid.

Rural costs

Another concern for rural communities is delivering mental health services on a much smaller scale. This often increases the cost of those services. CMHPs should work closely with AMH to assure the cost of rural services is considered as new funding is allocated. Additionally, rural communities should be encouraged to partner across traditional county lines. Regionalization could provide a mechanism to maximize resources.

Improved information system infrastructure

Effective planning for mental health services and effective monitoring of outcomes require information systems that can produce timely meaningful data. Electronic medical records would improve the coordination of individuals care across the system. Funding for the replacement state hospital facilities includes some funding for the Behavioral Health Improvement Project (B-HIP) to replace the hospital components of the archaic data systems upon which the mental health system relies. It is critical that the community services portion of the new data system also be funded.

Funding disparities

Each community or regional system of care in our State must have enough resources to fund a set of core services and supports. The Oregon State Hospital Master Plan will not be successful in operating with limited beds, shorter lengths of stay and a manageable occupancy rate unless every region is funded comprehensively and comparably, based on objective analysis of the relative need in each geographic area.

Our current system has great disparity in the level and type of state investment in our regions and communities. Historical precedent, insufficient funding of behavioral health care, significant cuts in indigent and Oregon Health Plan funds in recent years, extraordinary population growth in a handful of counties and an inability to fully address disparity all contribute to the current unmet need. AMH should work with the CMHPs as plans for the allocation of new funds are determined. AMH and the CMHPs have agreed that the use of the Kessler Prevalence Formula⁹ would guide future allocations of new funds.

⁹ Epidemiological estimate of how common a condition is within a population over a certain period of time.

Conclusion

The Oregon State Hospital Master Plan Phase II Report focuses on the replacement of hospital facilities. However, the number of patients to be served and the costs associated with building and running the new facilities, are predicated on a significant enhancement of the community mental health system. Without the investment in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant investment must also be made to develop and enhance a robust array of community services that support individual recovery goals.

This report serves as an addendum to the 2007 report, informing the Governor, the Legislature and DHS what community-based services are needed to support the new state hospitals.

**Community Services Workgroup Report 2009
Funding Recommendations**

| Service Categories | Early intervention & prevention | Crisis services | Acute Care | Case management services |
|-------------------------------------|--|---|--|--|
| Unmet need: 21,000 | 270 | 5,250 | 6,000 | 17,850 |
| <i>Assumptions</i> | 360 newly identified individuals per year - 75% would need state funded services | 25% of those not receiving services will need crisis services | Currently only funding approximately 50% of need | 85% of not receiving services need access to CM & medication support; 15% need ACT level of services |
| Length of Service | 2 years | 1.5 episodes | 7 days acute, 14 days sub acute | Ongoing |
| Other | Includes statewide coordination & evaluation | | Need funding for acute care specialist - \$200,000 | ACTs serve 10-12 people |
| Cost per person, per: | \$14,000 (year) | \$735 (episode) | \$1,000(acute daily) \$800 (daily subacute) | \$14,000 (ACT - year) \$2,500 (CM - year) \$600 (medications - |
| <i>Funding Need</i> | | | | |
| 100% | \$7,560,000 | \$5,788,125 | \$131,396,800 | \$92,820,000 |
| 50% | \$3,780,000 | \$2,894,063 | \$65,698,400 | \$46,410,000 |
| 25% | \$1,890,000 | \$1,447,031 | \$32,849,200 | \$23,205,000 |
| <i>New Biennial Funding Targets</i> | | | | |
| 07-09 LAB | \$4,300,000 | \$3,000,000 | \$2,500,000 | \$2,000,000 |
| 09-11 (50%) | \$3,091,000 | \$4,342,748 | \$66,252,955 | \$47,045,345 |
| 11-13 (50%) | \$86,866 | EBL | \$32,198,936 | \$26,582,577 |
| 13-15 | \$84,434 | EBL | \$31,297,366 | \$28,032,750 |

**Community Services Workgroup Report 2009
Funding Recommendations**

| Service Categories | Supported employment & education | Alternatives to criminal justice involvement | Co-occurring disorder services | Focus on wellness |
|-------------------------------------|--|---|--------------------------------|--|
| Unmet need: 21,000 | 5,250 | 1,030 | 3,659 | 154,867 |
| <i>Assumptions</i> | 25% need support at any given time | The majority of those involved in the criminal justice system can be served by ACTs | | Provide ongoing leadership & coordination on statewide wellness activities |
| Length of Service | Ongoing | Ongoing | Ongoing | Support task forces |
| Other | Includes 1 time investment of new VR staff (\$8,700,000) | | | 3 staff |
| Cost per person, per: | \$6,000 (year) | \$25,000 (year) | \$5,000 per client | |
| <i>Funding Need</i> | | | | |
| 100% | \$71,700,000 | \$51,500,000 | \$36,590,000 | \$602,463 |
| 50% | \$35,850,000 | \$25,750,000 | \$18,295,000 | \$301,232 |
| 25% | \$17,925,000 | \$12,875,000 | \$9,147,500 | \$150,616 |
| <i>New Biennial Funding Targets</i> | | | | |
| 07-09 LAB | \$2,000,000 | \$4,000,000 | | |
| 09-11 (50%) | \$33,850,000 | \$24,415,000 | \$18,807,260 | \$602,463 |
| 11-13 (50%) | \$17,925,000 | \$11,865,690 | \$9,140,328 | EBL |
| 13-15 | \$17,925,000 | \$11,533,451 | \$8,884,399 | EBL |

Community Services Workgroup Report 2009
Funding Recommendations

| Service Categories | Safe & affordable housing | Culturally appropriate services | Age specific services | Peer Programs |
|-------------------------------------|--|---|--|--|
| Unmet need: 21,000 | 5,420 | | | |
| <i>Assumptions</i> | 5,420 need rental assistance (RA), 2,000 people need supportive housing (SH) | Support for Afrocentric center & outreach to targeted communities | Need specialized staff in CMHPs to serve older adults & transition age youth | Establish peer services coordinators in every CMHP, Support Peer Bridgers & Dual Diagnosis Anonymous |
| Length of Service | Ongoing | | Ongoing | Ongoing |
| Other | Need additional supports for people in Villebois | | Need to provide training for the specialists | |
| Cost per person, per: | \$500 (RA - month) \$1,875 (SH - month) | | \$92,226 (Youth - year) \$72,000(Older Adults - year) | \$92,226 (Peer Specialists - yearly) |
| <i>Funding Need</i> | | | | |
| 100% | \$15,504,000 | \$2,924,606 | \$10,838,916 | \$6,086,916 |
| 50% | \$7,752,000 | \$1,462,303 | \$5,419,458 | \$3,043,458 |
| 25% | \$3,876,000 | \$731,152 | \$2,709,729 | \$1,521,729 |
| <i>New Biennial Funding Targets</i> | | | | |
| 07-09 LAB | \$1,000,000 | \$1,000,000 | | |
| 09-11 (50%) | \$7,455,056 | \$1,924,606 | \$7,943,012 | \$3,128,675 |
| 11-13 (50%) | \$3,623,157 | EBL | \$1,488,495 | \$1,520,536 |
| 13-15 | \$3,521,709 | EBL | \$1,446,817 | \$1,477,961 |

Community Services Workgroup Report 2009
Funding Recommendations

| Service Categories | Local oversight | Total |
|---|---|----------------------|
| Unmet need: 21,000 | | |
| <i>Assumptions</i> | Provide CMHPs 10% of new funding to ensure proper programmatic oversight | |
| Length of Service | | |
| Other | | |
| Cost per person, per: | | |
| <i>Funding Need</i> | | |
| 100% | \$43,331,183 | \$476,643,009 |
| 50% | \$21,665,591 | \$238,321,504 |
| 25% | \$10,832,796 | \$119,160,752 |
| <i>New Biennial Funding Targets</i> | | |
| 07-09 LAB | \$2,100,000 | \$21,900,000 |
| 09-11 (50%) | \$21,192,828 | \$240,050,948 |
| 11-13 (50%) | \$10,299,714 | \$114,731,300 |
| 13-15 | \$10,011,322 | \$114,215,209 |

Appendix E

AMH Strategic Planning 2009 – 11 Initiatives

DHS Addictions and Mental Health Division (AMH)
Strategic Planning 2009-11 Initiatives
October 13, 2009

**1915(i) Medicaid Home and Community Based State Plan Amendment –
Ralph Summers**

AMH will submit to the federal Centers for Medicare and Medicaid Services an amendment to the Oregon, Medicaid State Plan. The State Plan Amendment will authorize both Rehabilitative and Habilitative services for people with serious mental illness, a history of hospitalization and need for daily service contact. AMH expects to be able to expand the array of services available in community based settings to better meet needs of consumers and simplify the billing and documentation requirements for providers. Target date for submitting the request is January 1, 2010. Target date for authorization is July 1, 2010.

Alcohol and Drug Policy Commission – Karen Wheeler

HB 3353 abolished the Governor's Council on Alcohol and Drug Abuse and established the Alcohol and Drug Policy Commission. AMH is responsible for hiring the Executive Director to support the commission. The commission will provide the following deliverables: A blueprint for funding and effective delivery of alcohol and drug treatment and prevention services in Oregon. This includes:

- A strategy for organizing and delivering state-funded treatment and prevention services.
- Funding priorities for treatment and prevention services.
- Strategies to maximize accountability and measure performance of treatment and prevention services.
- Methods for standardizing data collection and reporting.
- A policy and funding strategy that supports a consolidated treatment and prevention system, reducing fragmentation in the delivery of services.
- A plan for sustaining focus and leadership on alcohol and drug services and for building a lasting constituency for continuing effective state action.
- A plan for evaluating the state action based upon the "blueprint" in future years/biennia.

Blue Mountain Recovery Center: The Future – Richard Harris

The purpose of this initiative is to consider alternative and current use of the facility and program to determine what use would best meet the needs of Oregonians, patients, staff and the local community and region. The goal is to develop a plan for the future of BMRC. The first objective is to develop a plan and strategy to determine the method of developing an array of options for the future BMRC. The second phase would engage all stakeholders in developing and defining the realistic possible options for the future of BMRC. The third phase would be to engage DHS, the Legislature and the community, staff and patients/consumers in developing a plan for the future of BMRC.

OSH Geriatric Downsizing – Linda Hammond

The purpose of this initiative is to develop a new program called the Community Based Care (CBC) Hospital Diversion program. Service models within this new program will be designed to provide the intensity and type of services that will address behaviors that cause people to be referred to the state hospital and that slow their return to the community. The program would target persons with psychiatric and medical needs who qualify for the SPD 1915© Home and Community Based Care waivers or the “Dollars Follow the Person” initiative and who have needs that exceed all existing CBC resources. Models will promote policies of self direction, and person centered care; provide access to necessary medical, nursing and licensed specialists and care planning necessary to support the persons return to a permanent placement. The pilot is expected to lead to a new service model that will retain or rapidly return to community care, people with physical disabilities, head injuries or dementia that frequently spend too much time in the Oregon State Hospital.

Impaired Health Professionals – Karen Wheeler

The 2009 Legislature passed HB 2345-B which will become effective July 1, 2010. HB 2345-B requires DHS, AMH to establish a consolidated impaired health professionals program. This program monitors the substance use disorder and mental health treatment of impaired health professionals who are either self-referred or diverted by their licensing boards in lieu of disciplinary action. AMH will work closely with the health licensing boards during 2009/2010 to build a

consolidated program including a plan to transition participants who are participating in the separate programs by July 1, 2010.

Integrated Services and Supports Rule Implementation – Mike Morris

The Integrated Services and Supports Rule was filed for public review September 15, 2009 and is expected to be finalized this fall. This rule integrates the standards for most of the mental health and addiction services in the state. The implementation will address training for providers, developing guidelines for reviewers and providers, and redesigning site review processes.

Children's Wraparound – Bill Bouska

Near the end of the 2009 Legislative session, Governor Kulongoski signed House Bill (HB) 2144, and the Children's Wraparound Initiative became law. The implementation of children's Wraparound is a major cross-division transformation initiative. The beginning phase of the Children's Wraparound Initiative is to develop an integrated system of care to maximize positive outcomes for children with behavioral health care needs and who are in the custody of DHS. Initially efforts will focus on children, from birth to age 18, who have been in the custody of DHS for more than one year and have had at least four placements or who come into custody and immediately need specialized behavioral health services and supports. In late fall, DHS will release system of care project site descriptions. This will give communities the opportunity to evaluate their readiness as a system of care project site and decide if they are ready to apply. Applications will be due during the month of January 2010. In February, as part of HB 2144, the work group must present its findings and a progress report to the legislature. Community system of care project sites will begin to take shape in March 2010.

Integrated Services & Management Demonstration – Jane-ellen Weidanz

The Addictions and Mental Health Division recommended to the legislature a system change effort focused on an integrated management and service model including health, mental health and addictions services. The legislature directed AMH to initiate demonstration projects to test different methods of integrating management, financing and services. The goal is to discover system improvements that will result in a simpler, more efficient use of state, federal and local resources and provide better services to those in need.

Peer Delivered Services – Len Ray

AMH believes that developing, funding and supporting peer delivered services (PDS) follows a national trend that is proving to be a key component of a successful service delivery system and an important addition to the health care workforce. AMH recognizes the indisputable value of PDS in transforming the mental health and addiction service delivery system that is based on a recovery model. AMH will work with service population stakeholder groups to develop strategies to increase the use and availability of PDS. The focused investment in this initiative is an investment in the future, an investment in the workforce, and an investment that will demonstrate significant results in transforming and redesigning the service delivery system in the development of new policies, procedures, and partnerships within the state and across the nation.

Strategic Prevention Framework – Rick Cady

SAMHSA's Center for Substance Abuse Prevention awarded Oregon a State Prevention Framework Grant July 1, 2009; \$2,135,724 per year for five years. AMH must submit and have approved by April, 2010 a statewide plan. Once approved, AMH will be able to begin working with ten counties – communities and tribes. The implementation of the Strategic Prevention Framework will provide the Oregon prevention system a common framework for assessing state and local needs and priorities, making data-driven decisions about the right Evidence-based Programs delivered to the right audiences and mobilize communities and tribes in the implementation of the Evidence-based Programs. Also, the SPF will identify gaps in the prevention system infrastructure and afford AMH and the communities and tribes methods for evaluating Evidence-based Program outcomes. The initial phase of the implementation process will install the prevention framework in ten communities/tribes. Of the ten communities at least two to three will be rural and one or more of the recognized tribes. The long term five year plan is to roll out the framework to the balance of the state.

Supportive Housing Increase – Darcy Strahan

AMH is transitioning housing development for people with mental illness to a supportive housing model and away from a structured housing model (residential

treatment homes or facilities) to more fully integrate individuals into their communities. The current focus on structured housing development has been to fill the gaps in the housing needs for people leaving the state hospital. Residential facilities should be seen as one part of the service delivery system, not an end placement as some have become. As individuals move through the service delivery system, the end result should be full integration into their community of choice, living in their own homes with appropriate and flexible support services available as needed.

MH Adults Residential Utilization Analysis – Jon Collins

To better understand current efficiency, effectiveness, and utilization, a comprehensive review of adult mental health residential services is being conducted. Results will help guide planning for further usage and development of this level of care. The review includes but is not limited to analysis of current utilization data to better understand:

Capacity

- In-flow and out-flow
- Exchange between various levels of care
- Length of stay impact
- Financial modeling

In addition to a review of data, information will be gathered through direct interviews with providers and chart reviews and interviews with two or three model states. Information from all sources will be synthesized to better describe current state and future goals for service delivery to clients currently utilizing residential services.

Wellness – Pat Davis-Salyer

The AMH Wellness Initiative strengthens integration efforts already underway between physical health and behavioral health. It blends the excellent work of the AMH Wellness Task Force, DHS Core Integration Team, the Public Health Division, Oregon State Hospital, mentors, consumers, family members, community stakeholder groups and providers with national experts to move from knowing about health inequities to taking immediate action steps to prevent these disparities. It gives voice to those who have not been heard and acknowledges the tragedy of life lost of those who have passed. AMH is restructuring how we work

to better share resources, reconfigure provider systems to improve access, remove barriers to health care, equip community grass root organizations to provide healthy lifestyle education, enhance prevention, and early intervention programs across the lifespan, and therefore, promote and ensure recovery. Wellness is the goal of all interventions.

Young Adults in Transition – Damien Sands

The Young Adults in Transition includes young adults aged 14 to 25. The initiative will promote access to a system of services and supports that are young adult-directed, and developmentally appropriate. This initiative will implement strategies that promote a Young Adult system through the elimination of barriers to access and through the creation of developmentally appropriate and effective services and supports. This initiative will effectively bridge adolescent and adult systems; and thereby provide young adults with opportunities to realize their full potential and have healthy, productive lives.

The Criminal Justice Door to the Mental Health Systems – Richard Harris and Jane-ellen Weidanz

AMH funds, administers, coordinates, regulates and provides direct mental health and restorative services to individuals who have been determined to be unfit to stand trial or who have been found Guilty Except for Insanity. Both entry points do not allow the community mental health system or AMH the ability to determine if someone needs the level of services provided by the state hospital or if the person could be appropriately served in other settings or if the person does not need mental health services at all. The state is the recipient not the participant in the entire process.

This initiative will begin the dialogue between all parties, including consumers, the court system, community mental health programs, law enforcement, to determine if there are more appropriate processes and options available so that only those individuals who need services, receive them, and only those individuals in need of hospital level services are committed to the hospital. The goals are to identify and implement system changes to improve the “criminal justice door” to the mental health system and may result in legislation, rule or policy process changes.

