Olmstead in States Without Large Institutions

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;Summary of Webinar

- National view of Olmstead enforcement in states without large institutions –and lessons learned. (Jennifer Mathis)
- Experiences and lessons learned from Disability Rights Vermont (AJ Ruben and Merry Postemski)
- Questions and audience sharing of promising practices (similar or different experiences)
- Priorities of, recent activity, and opportunities to collaborate with DOJ, Civil Rights Division (Regan Rush and Patrick Holkins)

Why focus on an Olmstead problem in Vermont? (1)

- Vermont's history of de-institutionalization
- Vermont's Olmstead Commission, created in 2002, including DRVT (then VP&A) as a member
- VT's Olmstead Plan submitted to Legislature in 2006: initial progress but state fiscal issues led to delays in implementation; the plan essentially was forgotten and disregarded

Why focus on an Olmstead problem in Vermont? (2)

- DRVT's monitoring and outreach in inpatient psychiatric hospitals/units identified an increase in delayed discharges of patients deemed no longer in need of inpatient care (sub-acute) due to insufficient community capacity – the lack of available and appropriate community based placements - resulting in prolonged unnecessary institutionalization and harm

Why focus on an Olmstead problem in Vermont?

- At first, DRVT filed several complaints under VT's Fair Housing and Public Accommodations Act (VT's version of the ADA) involving disability discrimination to VT's Human Rights Commission.
- Gained favorable traction through the HRC's investigations into these complaints, however the HRC Commissioners (a governor-appointed panel of non-lawyers) ultimately decided the State was not responsible for the harm suffered by patients unnecessarily institutionalized due to the lack of appropriate community-based placements.
- we determined that a focused, statewide systemic strategy needed to be developed setting up the potential to engage in possible litigation.

Identifying the scope of the Olmstead problems facing psychiatric patients statewide

Received PAC and Board approval to shift more PAIMI resources to this project and Issued press release to publicize the initiative: http://disabilityrightsvt.org/pdfs/Press_releases/Omlstead-Init-PR-8-15-19.pdf

- Consulted with nationally-recognized expert on State Mental Healthcare systems, Melodie Peet, M.P.H.; Consulted with other disability related organizations, providers, and peers statewide

Identifying the scope of the Olmstead problems facing psychiatric patients statewide

- Developed uniform processes to identify individual patients whose Olmstead rights were being violated;

- uniform set of data for each patient identified documenting key aspects of their situation for a more systemic analysis (see attached files: “DRVT Referral Checklist – Inpatient Hospital Barriers to Discharge Fillable PDF” and “DRVT Olmstead Case Spreadsheet - Blank”; Obtain documentation of harm

- Received referrals, obtained consent to provide legal advocacy, and then promptly engaged in that advocacy (description of what that entailed)

- Provided Olmstead case narratives to DOJ Civil Rights Division

DRVT's Olmstead Investigation - What We Found

- Clusters/cohorts of people affected and common barriers to timely discharges
- Fragmentation within Vermont's mental healthcare system
- Lack of follow through by State on their own expert consultant's report and recommendations to improve VT's mh system of care
- https://ljfo.vermont.gov/assets/docs/jfc/2012/2012_07_20/44976e86d9/2012_07_20_BHPC_VT-Act-79-Report-FINAL-7-18-2012_2.pdf

DRVT's Olmstead Investigation - What We Found

- Lack of systemic oversight by the State across the mh system of care
- State's focus on investing more money into more inpatient and other high end restrictive capacity rather than building sufficient community capacity
- Significant gaps in the development of a more robust community system of care including evidence-based practices that would reduce the need for hospitalization and create mechanisms for improved continuity of care between hospital and community providers

DRVT's Olmstead Report - "Wrongly Confined": Policy Recommendations

- http://www.disabilityrightsvt.org/pdfs/Publications/DRVT-Olmstead-Report-2020.pdf

- acknowledging and emphasizing the existence of, and the harm caused by, the ongoing Olmstead violations we are aware of in order to rally sufficient resources to adequately fund our community mental health system;

- postponing investment in expensive, restrictive inpatient hospital beds until sufficient funding is allocated to less expensive, but proven effective, community based capacities;

DRVT's Olmstead Report - "Wrongly Confined": Policy Recommendations

- expanding who is eligible to benefit from intensive HCBS;
- implementing payment structures that more effectively incentivize healthcare providers to effectively limit and reduce the amount of expensive, restrictive high end placements for their clients with MH conditions;
- formalize and centralize discharge planning procedures and resource augmentation options needed to reduce and end unnecessary hospitalizations; and
- effectively enforce anti-discrimination laws against care providers who refuse service to people with MH conditions based on illegal discrimination that results in unnecessary institutionalization

Next Steps

- Continue to work on individual cases and utilize the recommendations in the report to both facilitate appropriate and timely discharge from inpatient units and document the failures of the current system and procedures to assure that avoidable, unnecessary institutionalization is prevented

- In collaboration with Vermont Legal Aid, survey to be sent to people throughout VT receiving community mental health services to assess how their services during the pandemic have changed, the impact of those changes, and lessons learned that consumers of those services want providers and decision-makers to know. DRVT is also working on a similar survey for providers of community mental health services.

- Engage in systemic litigation if Vermont's Olmstead problem persists

Discussion and Audience Sharing of Promising Practices (use chat feature)

Feel free to recommend promising practices to your P&A peers using the chat box.

DOJ Civil Rights Division Wants to Hear from P&As

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