Investigation of South Carolina's Use of Adult Care Homes to Serve Adults with Serious Mental Illness

United States Department of Justice
Civil Rights Division

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After an extensive investigation, the United States Department of Justice (DOJ) concludes there is reasonable cause to believe that the State of South Carolina violates Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, by failing to provide services to individuals with serious mental illness in the most integrated setting appropriate to their needs. It is critically important to ensure that these individuals are afforded the opportunity to live and receive services in their own homes and communities, consistent with the ADA's integration mandate.

I. Summary of Findings

South Carolina does not provide individuals with serious mental illness adequate community-based services to avoid unnecessary institutionalization. Instead, it relies on segregated Community Residential Care Facilities (CRCFs) to serve individuals with serious mental illness (SMI). These facilities, also known as "adult care homes", are congregate settings where people with disabilities have limited choice and independence, and rarely engage with the broader community. Residents typically live with roommates they did not choose, have meals with set menus at set times, and only leave the facilities occasionally. Some facilities affirmatively restrict residents' ability to leave unaccompanied, while at others, access to the community is limited because the facilities are not in walkable locations and lack access to public transportation.

There are approximately 2,000 people with a serious mental illness residing in CRCFs in South Carolina. Adults with SMI experience lengthy stays in these facilities. Among a sample of people with SMI living in CRCFs, we found lengths of stay up to 35 years, with an average stay of 5 years. Nearly half of the people in the sample also had at least one other placement in a congregate facility, meaning that the typical amount of time spent in these types of institutions is likely longer than 5 years.

These lengthy stays continue even though the State acknowledges that individuals with SMI can be served in integrated settings when provided necessary community-based services. The State's service system was designed to provide community-based services, such as Assertive Community Treatment (ACT), permanent supportive housing, peer support, supported employment, independent living skills services, crisis services, and case management. As explained further below, these services are effective alternatives to CRCFs; they support and integrate people into their communities. Nonetheless, South Carolina does not:

- ensure that key community-based services are available across the state to people who are in, or at risk of institutionalization in, CRCFs;
- connect individuals with services that are necessary to divert them from placement in a CRCF; or
- connect individuals who reside in CRCFs with community-based services so they can return to the community and remain there successfully.

While the State provides community-based services that individuals with SMI need to live successfully in the community, thousands who need these services to avoid CRCF placement cannot access this community-based care. In part, this is because the actual availability of critical community-based services varies across the State, and these services are not available to many people with serious mental illness who need them. For instance, ACT is only available in three areas of the State, and even those areas have limited capacity. Maintaining and increasing the availability of such community-based services to support people living in more integrated settings is consistent with the State's own goals and plans.

South Carolina's deficiencies are illustrated by the experiences of Brad.[1] At age 36, he has lived in his current CRCF for three years and in two others previously. His placement in the first CRCF was precipitated by a crisis and a two-week inpatient hospital stay. Because he is unable to accomplish many of his goals, including being reunited with family, while living at a CRCF, he has repeatedly asked for help transitioning back to the community. He wants to find a job, and live with his two teenage children, and he has asked for assistance from his case managers at the state-run Community Mental Health Center (CMHC) multiple times since June 2019. More than two years later, in October 2021, CMHC case notes indicated he "plans to move out" of the CRCF, though he is "vague in terms of how he is preparing to make this happen." Despite Brad's identified need for support in finding appropriate integrated housing and accessing services that could support him in that housing, he receives only medication management from the CMHC. He remained in the CRCF when we visited in May 2022, years after proactively seeking help to get out. We spoke with many others who had similar experiences.

South Carolina could reasonably modify its existing community-based programs to prevent unnecessary segregation of adults with SMI in CRCFs. Such modifications would allow individuals to live and thrive in their own homes and communities instead of entering or remaining in CRCFs to access care. Despite the State's lack of focus on reducing unnecessary institutionalization in CRCFs, South Carolina has established many of the necessary community-based services. If offered throughout the state at the intensity level required to meet these individual's needs, community-based services can prevent unnecessary segregation for adults with serious mental illness.

II. Investigation

After receiving a complaint, DOJ opened an investigation, on January 12, 2022, to determine whether South Carolina unnecessarily segregates individuals with serious mental illness in adult care homes, known in the State as Community Residential Care Facilities. After opening the investigation, DOJ attorneys and expert consultants conducted an extensive review of documents and data, including policies, reports, Medicaid billing information, and individual treatment records of a sample of adults who are living in CRCFs. We conducted dozens of interviews of State officials and staff, including interviews with staff of community mental health centers. We also conducted on-site visits to a wide array of CRCFs where we spoke with residents and facility staff.

[1] All individuals discussed in this Notice are identified using random pseudonyms.

DOJ appreciates the State's exceptional assistance, cooperation, and candor throughout the investigation. We thank the individuals with serious mental illness who shared their own stories, and the community stakeholders who provided valuable information.

III. Legal Framework

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[2] Congress found that "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] Accordingly, the "ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them."[4]

Under Title II of the ADA, public entities must "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[5] The most integrated setting appropriate is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[6] The regulations also require public entities to make reasonable modifications in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that such modifications would fundamentally alter the nature of the service, program, or activity.[7]

In *Olmstead v. L.C.*, the Supreme Court held that Title II requires public entities to provide community-based services to people with disabilities when (a) such services are appropriate; (b) the affected people do not oppose community-based services; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other people with disabilities.[8] The Court explained that unnecessary segregation "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."[9] Further, such segregation causes harm when it "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[10] The ADA's integration mandate applies both to people who are currently segregated and to people who are at serious risk of unnecessary segregation. When assessing whether a setting is segregated, courts consider factors such as whether the setting is primarily

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[2] 42 U.S.C. § 12101(b)(1).
[3] 42 U.S.C. § 12101(a)(2).
[4] *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995).
[5] 28 C.F.R. § 35.130(d); *see also* 42 U.S.C. § 12101(b).
[6] 28 C.F.R. Part 35, App. B.
[7] 28 C.F.R. § 35.130(b)(7).
[8] *See* 527 U.S. 581, 607 (1999).
[9] *Id.* at 600.
[10] *Id.* at 601.

for people with disabilities, how people in that setting exercise choice over their living situation and autonomy in day-to-day life, and how much they interact with people without disabilities.

If a state fails to reasonably modify its service system to provide care in the most integrated setting appropriate, it violates Title II of the ADA. Courts have found proposed modifications that expand existing services to be reasonable, particularly when the modifications align with the jurisdiction's own stated plans and obligations.

South Carolina has a separate legal obligation to ensure the availability of community-based services provided under its Medicaid State Plan. The State must ensure that State Plan services are available with reasonable promptness statewide to everyone who meets South Carolina's Medicaid eligibility criteria and for whom the services are medically necessary.

IV. South Carolina's System for Serving Adults with Serious Mental Illness

South Carolina divides responsibility for overseeing its adult mental health system between two agencies: The Department of Mental Health (DMH) and the Department of Health and Human Services (HHS).[11] DMH directly provides services for people with serious mental illness, and HHS funds services and housing supports.

DMH operates two adult psychiatric hospitals and eight CRCFs for individuals with serious mental illness. DMH also provides mental health services through 16 State-operated CMHCs. In recent years, DMH budgeted approximately $56 million for state hospital services, $196 million on community mental health centers, and $5 million on its CRCFs.

DMH establishes the list of services provided through its regional network of CMHCs and oversees that system of services. Currently, the CMHCs provide housing supports, crisis services, Assertive Community Treatment, peer support, supported employment, independent living skills services, and psychiatric and psychological services. However, not all services are available at every CMHC throughout the State, and even in CMHC catchment areas where a service is technically available, it is often provided in very small amounts.

HHS has two main roles in the State's system for serving adults with serious mental illness. First, HHS is South Carolina's Medicaid agency, which funds many of the State's community-based mental health services and is responsible for ensuring their availability. Second, HHS administers an Optional State Supplementation (OSS) program and its companion Optional Supplemental Care for Assisted Living Participants (OSCAP). These two programs provide financial support to CRCFs for participants with disabilities to live there. OSS and OSCAP payments are state-funded, and may only be used toward the cost of residing in a CRCF. Between state fiscal year 2017 and 2022, the State spent an average of $19 million per year on OSS, and $7 million per year on OSCAP. As of state fiscal year 2022, the average monthly expenditure per person for OSS and OSCAP was $756, or approximately $9,000 annually.

[11] South Carolina's Department of Health and Environmental Control licenses community residential care facilities in the state. S.C. Code of Regulations R. 61-84.103A. Otherwise, it is not involved in serving adults with mental illness.

V. South Carolina Relies on Community Residential Care Facilities to Serve Adults with Serious Mental Illness

a. The State Funds Services for Thousands of Adults with SMI in CRCFs

South Carolina uses CRCFs to provide housing and support to thousands of individuals with serious mental illness and physical disabilities who do not meet the eligibility requirements for nursing facility care. CRCFs offer room, board, and personal care to individuals with serious mental illness or other disabilities. CRCF staff prepare and serve food to residents, dispense medication at specific times, clean individual and shared spaces, do laundry, and may assist in arranging transportation to medical appointments. Through OSS, the State supplements room and board in these facilities, and through OSCAP, the State also subsidizes some personal care. To supplement the CRCF services, people may also get support through their local CMHC. Typically, individuals who get services through a local CMHC receive medication management, case management, and, in some cases, therapy.

The State supports approximately 2,000 people with a serious mental illness in CRCFs through OSS or OSCAP. Among these CRCF residents, there is a broad range in age; we met CRCF residents who were as young as 28 and as old as 80. At the eight DMH-run CRCFs, all residents have an SMI. Even at private CRCFs that are not run by DMH but are licensed by the State, people generally live alongside others with SMI.

There are approximately 250 State-run or State-licensed CRCFs where individuals with serious mental illness live. These CRCFs vary in size, with some licensed for over 100 beds. The vast majority of individuals with SMI living in CRCFs are in facilities licensed for 10 or more beds. Of those individuals, 35% are in facilities licensed for 50 beds or more. In some cases, a smaller licensed size does not accurately reflect individuals' lived experience because several separately licensed facilities are clustered together and administered as one larger facility.

b. CRCFs are Congregate, Segregated Settings

"*Something like a little asylum in here*." – person living in CRCF

"*I felt like I was running a mini institution*." – CRCF administrator

We visited CRCFs located throughout the State and found them, regardless of the facility's size, to be segregated settings that do not afford opportunities for engagement with the broader community. Day-to-day life for residents is regimented. All of the facilities we visited serve meals to all residents together, at specific times, and most restrict access to snacks. Unlike a home, most of the CRCFs did not have designated space where residents could receive visitors, and where they did, none of these areas offered privacy. Most residents receiving OSS or OSCAP live with one or two roommates whom they do not choose. The facilities' phones are sometimes located in common areas that do not afford privacy. Many facilities have security cameras in the common areas and outside. A few of the CRCFs we visited were fenced in; of these, one had a padlock locking the front gate, and another had a gate with an alarm that

sounded upon exit. Even without locks and alarms, CRCFs are often located in areas where residents cannot safely walk or take mass transit to destinations in the local community. In addition, a doctor's permission is generally required for a resident to cook or to take their own medication, and our review indicated this permission was rarely given. As a result, many residents lose family connections; lose skills such as cooking, cleaning, and organizing their own lives; and are kept separate and apart from the broader community, the very harms identified in *Olmstead*.

People living in CRCFs rarely leave them. CRCF staff take residents on occasional trips to stores like Walmart or Dollar General, but not to other locations in the community for more substantive engagement or contact with people without disabilities. The State requires CRCFs to post up-to-date activity calendars on the wall. These calendars almost never include going into the community other than for store trips and instead are composed of activities like arts and crafts, "name that tune," Bible study, bingo, "bubble-blowing fun," and coloring pages.

One State employee who regularly visits CRCFs noted that, other than trips to stores like Walmart, residents do not go out into the community as much as they would like to. Another employee stated that in CRCFs:

> "[T]here's no vision of ever getting out. There's no vision of having a real life… There's no vision of anything. They just feel stuck. That's almost like hospitals used to be, 150 years ago. We've just diverted them from the hospital into group homes."

These descriptions are consistent with DOJ observations. Many people described their day-to-day life as consisting of watching TV, sleeping (partly to take a break from other residents or from the noise of many people sharing space), and smoking. Other than medical appointments or store trips, some people had not left the CRCF in months. Many of the individuals in the DOJ review have worked in the past, and would like to do so again, but only a very few current CRCF residents are working.

c. CRCFs are a Default Placement for People Transitioning from State Hospitals

Many people with SMI enter CRCFs when they discharge from State Hospitals because the State fails to provide community alternatives, such as permanent supportive housing, and ACT. Indeed, the State recognizes that, "Persons with a serious mental illness are less likely to require hospitalization if they are residing in safe and appropriate housing."[12] However, DMH relies on CRCFs to provide that housing for people who need a place to live after leaving the hospital. The DMH case managers working with people transitioning out of the hospital often

[12] Solicitation for Fixed Price Bid, Provide Community Residential Care Facilities (CRCF) for Patients at High Risk for Hospitalization, South Carolina Department of Mental Health (2020).

focus on identifying CRCF placements, rather than integrated options.[13] In fact, transition staff identified CRCFs as the location for discharge for the vast majority of people.

Instead of seeking to decrease CRCF placements and expand integrated housing, the State continues to invest in CRCFs. For example, DMH requested funds to help people leave State Hospitals in fiscal year 2020, and proposed to use some of the funds to "increase availability of CRCF beds." Recognizing the difficulty in finding housing after State Hospital discharges, South Carolina also created an enhanced CRCF rate. The enhanced rate is meant to encourage CRCFs to accept people who are discharging from the State Hospital and have a history of repeated readmissions to the State Hospital. The State recently sought to expand this program.

VI. Adults in or at Serious Risk of Living in a CRCF Could be Served in the Community

The vast majority of adults with serious mental illness who are currently living in CRCFs could be served in integrated settings with necessary community-based services. Indeed, a senior State official acknowledged that not everyone who discharges from a State Hospital to a DMH-run CRCF needs to be there, but the hospital staff still recommend DMH CRCF placements.

During our investigation, we reviewed a representative sample of individuals with SMI who are living in CRCFs across the state. We interviewed them and reviewed their CMHC and (where relevant) State Hospital records. The sample included representation of people living in urban and rural counties, different sizes of CRCFs, some receiving only OSS and others also receiving OSCAP, and those living in both DMH-run and private CRCFs. Based on this review, nearly all of the individuals in our sample could live successfully in the community with support.

However, we saw sparse evidence that CRCF residents had access to the services that would support them in living in more integrated settings. There are community-based services that are effective in serving people with SMI in the community such as crisis services, Assertive Community Treatment (ACT), peer support, supported employment, permanent supportive housing, and psychosocial rehabilitative services. These services are designed to meet the needs of people who have multiple hospitalizations and to transition from an institutional setting such as the CRCFs. Though these services are available to some people in South Carolina, they are not often available to individuals living in CRCFs or those at risk of moving into CRCFs. *See Infra* Section VIII.

To successfully transition from CRCFs, many people in our sample would require community-based services that provide support with regaining skills to live independently, manage medications, access housing, regain employment, and build connections in the

[13] Although services provided while an adult is inpatient are not billable to Medicaid, 42 C.F.R. § 441.13(a), case management—including many of the services required to find new housing—in transition and after discharge would be billable. 42 C.F.R. § 440.169(a); Centers for Medicare and Medicaid Services, *Informational Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*, (June 26, 2015), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf.

community. To meet these needs, people may need to access some combination of services including ACT, intensive case management, peer support, supported employment, permanent supportive housing, independent living skills services, and crisis services. Some would also require personal care due to physical health needs. *See Infra* Section VIII.g. Instead of relying on these kinds of community-based services, the State uses CRCFs to serve people where they see a need for support in taking medications or have a history of repeat hospitalizations—needs that are routinely addressed by these services.

Although CRCF residents in the sample were unable to access the services they need to live successfully in the community, the State provides these services to some South Carolinians. The State designed its CMHC services to serve people with a wide range of needs. As of July 2021, CMHCs were reportedly serving nearly 6,100 adults whose level of need for support was four on a scale of one to five, and more than 500 with a level of care of five, with five indicating the most intensive level of need. Given this capacity to serve individuals with intensive needs for mental health services, the State could support people who are diverted or transition from CRCFs. For instance, a case manager reported working with a woman who was ready to be discharged from the State Hospital and was waiting for a placement. She had previously lived in a CRCF and did not want to return to a CRCF placement. For that reason, she remained at the hospital for a year until she could access supportive housing, which is an integrated, community-based service described in more detail, below. When she finally accessed supportive housing and services through the CMHC, she transitioned and was successful.

In addition to the need for community-based services, people remain in CRCFs because CMHCs set unnecessary requirements for transition to the community. Requiring people to be symptom-free or medication-compliant contributes to unnecessarily long CRCF stays. This approach ignores the community-based services that support individuals in taking medications in integrated settings. Rather than identifying services to meet identified needs, like ACT, the State considers whether the person can transition to independent housing without additional supports. CRCF stays may also extend because State staff expect a resident to demonstrate specific skills before transitioning. For someone who wants to live alone but has not previously done so, DMH CRCF staff sometimes assign the person tasks to prove they have the ability to perform certain skills before discharge. This creates unnecessary barriers to discharge when services are available that support individuals in developing skills once in the community.

VII. Adults in, or at Serious Risk of Admission to, a CRCF Do Not Oppose Being Served in the Community, But Many are Stuck in CRCFs

> "*Back to normal in my own place: That's my dearest wish.*" – person living in a CRCF
>
> "*I wish that I could get back to my independent life.*" – person living in a CRCF
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> "*The longer you stay here, the less likely you are to leave.*" – person living in a CRCF

The vast majority of adults with SMI in CRCFs do not oppose living in the community. Indeed, many CRCF residents with SMI did not choose to move to a CRCF in the first place. Instead, they often entered CRCFs upon discharge from a State Hospital because they or their family members were concerned about their living alone without support, or because they needed support in taking necessary medications. Some individuals in our review wanted to live independently after a State Hospital admission and were told instead to go to a CRCF. Others said that when they needed additional support in the community, the CMHC directed them to a CRCF to ensure that they took medications regularly and had assistance maintaining their living environment.

Many expressed the desire to leave the CRCF and to live in the community with appropriate supports, but they were unaware of how to obtain such services. For instance, Ilene, age 64, was living in a family home before moving to a CRCF in October 2020. She would like to return to that home, as long as someone could visit to assist her with taking medication. Alyce, age 43, moved into the CRCF in January 2020; previously, she lived with her parents. Although initially she was willing to move to the CRCF because her parents told her the CRCF and CMHC would help her build independence, that has not occurred, and her parents are now helping her identify options to get out. Describing her experience with the CRCF and CMHC, she said, "They wanted this to be my end, and I don't think so." Although she identified needs for support in the community, she had not heard of CMHC services to assist with these needs. Gary, age 48, moved to the CRCF five years ago; he had been living independently and receiving CMHC services, but was having financial difficulty, and moved to the CRCF because his uncle thought he could not take care of himself. He preferred an inpatient admission at Bryan Psychiatric Hospital to his CRCF: At Bryan, he could smoke and keep more of his disability check, and there were more young people around. He wants to live alone, where he "could walk free."

Once people have moved to a CRCF, the State offers little help to transition them to a home or community setting. Many CRCF residents in our review who want to leave did not experience the CMHC as a resource to support this goal; some even said they do not believe the CMHC would help. For instance:

- Mitchell, age 39, has lived in a CRCF for seven years. He used to work on a farm; he "loved it—that's my world right there." He wants to work, and to live independently with appropriate services, but he did not report receiving any outreach from the State to be considered for such a transition.

- Russell, age 40, had been living independently for three years, when someone broke into his apartment. In crisis and without support, "I had to lock myself [in] to be out of trouble on the street," so he called 911 on himself. After several months in an inpatient hospital setting, he was discharged to the CRCF, where he has lived for eleven years. His CMHC doctor believes he could live more independently but has offered no help. Russell hopes instead that his family will assist.

- Barry, age 37, has lived in his current CRCF since April 2016, and in another for over four years before then. He told his CMHC case manager well over a year ago that he wants to live alone, and was told to be patient.

- Parker, age 36, said he was not sure who decides when he would leave the CRCF; he tries not to talk about wanting to leave and instead, he was "just being patient – I pray sometimes."

Even where people make substantial efforts to get out of CRCFs, they may remain stuck there. For example, DMH learned in 2021 from the State's Protection and Advocacy organization that Douglas, age 55, wanted to leave his CRCF. He has lived there since 2017, and he reported having lived at several other CRCFs before then. He wants to move out and "has said this over the years to everyone," including a number of case managers and clubhouse staff. He was referred to targeted case management for assistance with transition in January 2022, but the care coordinator closed the case in March "due to his goals being met." When we met him at his CRCF during our review in May 2022, he maintained the goal of leaving it. Our expert found he could live in the community with appropriate supports.

Many others expressed a desire to move when asked. Despite this common wish to leave a CRCF for the community, many people are unable to do so with the services and supports currently available in South Carolina. A case manager working on Hospital discharges noted that living in a CRCF can help someone for a few months after a State Hospital discharge, but it should not be forever. Yet our review showed that individuals with SMI lived in CRCFs between 6 months and 33 years, with an average stay of 8 years. And when people do leave a CRCF, our review indicated that it is often for another CRCF or a nursing facility.

VIII. South Carolina Offers Community-Based Services to Adults with Serious Mental Illness but Fails to Provide those Services in Sufficient Quantity and Quality to Support People Seeking to Leave or Avoid CRCF Placement

Community-based services are effective alternatives to institutionalization for people with SMI.[14] These services include community-based housing options, crisis services, Assertive Community Treatment (ACT), peer support, supported employment, psychiatric and psychological services, and individualized support to regain community living skills.[15] The State acknowledges the value of community-based services. For instance, a State employee identified living in the most integrated setting combined with evidence-based practices—like peer support and supported employment—as key to recovery for individuals with serious mental illness. Another State employee described peer support as a way to build a social network in the community and learn new coping skills, which provide different benefits than speaking with a

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[14] Centers for Medicare & Medicaid Services, *Dear State Medicaid Director Letter: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*, (Nov. 13, 2018) at 7.

[15] Centers for Medicare & Medicaid Services, *Dear State Medicaid Director Letter: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*, (Nov. 13, 2018) at 22-25.

doctor or therapist. Yet another staff person described the significant impact of supported employment on individuals with SMI.

South Carolina provides the key community-based services that individuals with SMI need to live successfully in the community. However, the actual availability of these services varies across the State, and many people who need them cannot get them. For instance, only three of 16 catchment areas provide ACT. Even in areas where a particular service is available, there are very few people actually receiving the service. In addition, CMHC services are primarily offered in clinic settings or via telehealth. Research shows that providing services in the person's home or other location in the community, such as a library, can be particularly important for people who have struggled with accessing traditional office-based services.[16]

The State also offers services that could support people in transitioning out of a CRCF, though few CRCF residents currently receive those services. CMHCs have staff, such as housing coordinators, who could provide assistance with looking for integrated housing options. This could also be provided through the CMHC's targeted case management (TCM) program. Because TCM can be provided in the community as well as at the CMHC office, it may be particularly useful to support transitions. However, very few of the people in CRCFs received any TCM support in 2021, the last year for which we have complete data. Based on Medicaid claims data for individuals with SMI residing in CRCFs, the State billed for TCM with travel for just 136 individuals and office-based TCM for only 166 people in 2021. Expanding transition support and ongoing community-based services would enable people with SMI to avoid or move out of CRCFs.

a. The State Provides Insufficient Community-Based Housing, Resulting in Unnecessary CRCF Placements

Permanent supportive housing (PSH) is a service that combines long-term housing with supportive services to help an individual with SMI retain stable, affordable housing.[17] The Substance Abuse and Mental Health Services Administration recognizes PSH as an evidence-based practice, which means that it has been proven to work.[18] PSH typically includes a lease in the individual's name for an apartment or house that is scattered among housing where people without disabilities live.[19] Housing must be affordable, meaning that no more than 30% of the individual's income goes to rent and utilities.[20] Supportive services are offered to the individual, but must be voluntary.[21] South Carolina recognizes the importance of this service, noting that

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[16] *See* Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: Building Your Program*, (2008) at 5-6, 12.
[17] Substance Abuse and Mental Health Services Administration, *Permanent Supportive Housing: Building Your Program* (2010) at 1.
[18] Substance Abuse and Mental Health Services Administration, *Permanent Supportive Housing: How to Use the EBP Kit* (2010) at 1.
[19] Substance Abuse and Mental Health Services Administration, *Permanent Supportive Housing: Building Your Program* (2010) at 2-4.
[20] Substance Abuse and Mental Health Services Administration, *Permanent Supportive Housing: Building Your Program* (2010) at 3.
[21] Substance Abuse and Mental Health Services Administration, *Permanent Supportive Housing: Building Your Program* (2010) at 3.

"[a]ppropriate housing is often the single biggest factor in determining whether a patient with serious psychiatric impairments is able to be successfully discharged [from a State Hospital] or is able to remain successful in their recovery in the community."

State employees repeatedly reported that PSH is a critical area of unmet need. When people are seeking PSH, they typically must wait for lengthy periods for availability, and State staff indicate that accessing the service can be delayed because turnover is low. Despite this, the State does not appear to regularly assess where additional housing support is needed or how much. Instead, a State agency employee acknowledged that the amount of permanent supportive housing currently in development is not sufficient to meet the need. Further, PSH is rarely available to individuals living in CRCFs because the State does not focus on providing those individuals with access to the PSH units that do exist.

Although the State offers PSH,[22] it has provided substantially less PSH than is sufficient to enable people who have serious mental illness to avoid or transition out of unnecessary CRCF placements. A decade ago, the South Carolina Institute of Medicine and Public Health (IMPH) identified a significant gap in the availability of PSH.[23] Beginning in February 2019, the State committed to develop 30-40 units per year of PSH for a period of five years, and set aside $6.5 million to meet this goal. In addition, the State allocates approximately $2,350,000 annually for PSH rental assistance, with an average cost per unit between $6,000 and $7,000 per year. This funding supports up to 374 units at any given time. However, the combination of existing PSH and the planned development falls far short of the IMPH's recommended target for PSH.

The State's limited capacity to provide supportive housing contributes to the challenges people experience when they seek to transition to more integrated settings, and ultimately results in the State's continued reliance on CRCFs. The existing programs that offer financial assistance with housing in South Carolina are not sufficient to meet the need, including for people leaving a State Hospital. In addition, no designated PSH units are set aside for people transitioning from CRCFs, and only a tiny fraction of rental assistance units are targeted to support this group. As of 2021, there is $106,000 in annual funding, supporting 15 units of rental assistance, dedicated to individuals transitioning out of CRCFs. Unsurprisingly, in recent years, the State's monthly

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[22] South Carolina also operates a program called Towards Local Care, which includes Homeshare, a program in which people are matched with a family to live with them and receive support in their home. The goal of Homeshare is to transition individuals out of the hospital into a community setting, but staff at one CMHC noted that sometimes people "get stuck" in Homeshare and do not move to a more integrated setting. Individuals living in a Homeshare may receive any services offered by the local CMHC. The Homeshare family enters into a contract with DMH, and receives a monthly stipend of $1,393 to cover the person's room and board. Homeshare participants often have SSI, and contribute the majority of that income to cover a portion of the monthly stipend. During fiscal year 2022, South Carolina spent approximately $3.2 million on Homeshare. As of October 2022, there were 130 individuals utilizing the Homeshare program. However, Homeshare is not available in a quarter of the CMHC catchment areas, and there are currently Homeshare providers in fewer than half of South Carolina's counties.

[23] The IMPH recommended that the State fund over 5,000 additional units of supportive housing based on the needs identified in 2013. South Carolina Institute of Medicine and Public Health, Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems 25 (2015).

reporting found that only about 5% of individuals receiving rental assistance had previously lived in a CRCF.

b. South Carolina Provides Insufficient Flexible, Intensive, Multidisciplinary Support, Resulting in Unnecessary Segregation in CRCFs

i. South Carolina Provides Insufficient Assertive Community Treatment

Assertive Community Treatment (ACT) is a service that provides individualized support in the community to people with the most significant mental health needs, including those with multiple inpatient admissions.[24] The Substance Abuse and Mental Health Services Administration recognizes ACT as an evidence-based practice.[25] ACT involves a team-based approach with small caseloads where 10 to 12 staff members serve no more than 100 people, resulting in a 1 to 10 ratio.[26] The team includes an ACT leader (who is a mental health professional), at least one psychiatrist, at least two psychiatric nurses, employment specialists, substance abuse specialists, one peer specialist, one program assistant, and additional mental health professionals.[27] Services are often provided in people's homes rather than in a clinic and can include physical health care in addition to mental health services.[28] ACT provides mental health crisis services at all times, even though teams often anticipate and prevent crises from happening.[29] Across the country, ACT has been used to support people in transitioning from State Hospitals and other institutions to independent living, and in remaining successfully in the community.[30] Our expert found that a substantial number of people in the CRCFs would need the flexible, intensive supports that are provided through ACT to transition to the community.

South Carolina provides limited access to ACT. Four providers in the State operate ACT teams. These teams do not provide statewide coverage: Two of these teams are located in the Columbia area, one is located in Greenville, and one in Dillon County. The capacity of these teams is also fairly low. For example, the Greenville team can serve only 50 individuals. As a result, people in most parts of the State do not have access to ACT, and DMH staff do not rely on this service to support people with significant needs to transition to integrated settings from State Hospitals and CRCFs. Even where ACT teams are present, the services provided are often

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[24] Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: Building Your Program*, (2008) at 5, 7.
[25] Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: How to Use the Evidence-Based Practice KITs*, (2008) at 2.
[26] Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: Building Your Program*, (2008) at 5.
[27] Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: Building Your Program*, (2008) at 14.
[28] Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: Building Your Program*, (2008) at 5, 38.
[29] Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: Building Your Program*, (2008) at 5.
[30] *See* Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: The Evidence*, (2008).

inconsistent with national standards, which likely reduces their efficacy in serving people in the community.[31]

The limited availability of ACT derives in part from the lack of funding for the service. South Carolina funds ACT using two sources: grants and Medicaid billing. However, the State does not currently permit providers to bill ACT as a Medicaid bundled service; instead, providers must bill for each ACT service separately. HHS is planning to permit providers to bill for ACT as a bundled service in July 2023.

ii. South Carolina Provides Insufficient Intensive Community Treatment

The State also created its own team service called Intensive Community Treatment (ICT), but it is does not have the intensity of ACT. Similar to ACT, intensive community treatment is meant to be a multi-disciplinary service, typically provided in a community-based location, and requiring contact with the individual at least once a week. However, the staff to recipient ratio is significantly higher, at 1 to 35, and ICT teams do not include all the disciplines in an ACT team.

There is an expectation that every CMHC operate an ICT team, but limited staffing creates variability in access to this service. For instance, one mental health center has only one person assigned to staff the ICT team, while another has six. During 2022, the State served a total of 1,526 individuals through ICT. But capacity varied widely by CMHC catchment area; for example, one mental health center served just 20 people, while another provided services to 250. Additionally, it is rare for individuals living in CRCFs to receive ICT to support a transition to an integrated setting. Nearly 40% of CMHCs reported that they were not serving any CRCF residents in the ICT program. None of the individuals in our review were receiving the service, though a number had previously identified transition as a goal.

c. South Carolina Provides Peer Support, But It Is Insufficient to Support People Transitioning Out of and Avoiding CRCF Placement

Peer support specialists are individuals who have succeeded in their own recovery process, and then help others experiencing similar situations.[32] Peers provide non-clinical support by sharing their own lived experience and practical guidance.[33] Peer support specialists help people develop goals for living a fulfilling life, and support the person in meeting those

[31] Evidence-based practices result in specific outcomes—such as successfully serving people in the community-when they are provided consistent with the required standards. In South Carolina, ACT is not always provided consistent with ACT standards. For instance, a psychiatrist for one ACT team is only assigned to devote 10% of their time to the team's work, and does not regularly attend the team's daily meeting. Sometimes mobile crisis teams take on part of the responsibility that ACT typically would for responding to crises of individuals on the ACT caseload.
[32] Substance Abuse and Mental Health Services Administration (SAMHSA), *Value of Peers*, (2017) at 5.
[33] Substance Abuse and Mental Health Services Administration (SAMHSA), *Value of Peers*, (2017) at 4-5.

goals.[34] Peers also conduct outreach and improve community engagement.[35] Peer support can be especially helpful when individuals with SMI are transitioning out of institutions.[36]

South Carolina provides very little peer support to people transitioning from CRCFs. As of June 2022, there were at most 40 peer support specialists employed by DMH in the entire State. Although each CMHC is expected to employ at least one peer support specialist,[37] one CMHC did not employ a peer support specialist when we visited, and several other mental health centers employ only one full-time peer support specialist.

Recognizing the value of peers in helping people transition to integrated settings, one employee noted the potential for the State to establish a system for peer support specialists to do in-reach at hospitals and CRCFs to assist individuals who want to transition to the community. Although case managers who help people transition from State Hospitals to the community refer people for peer support on discharge, it is not always available due to staffing limitations.

While peer support is a Medicaid billable service, the State only permits peer support specialists employed by particular state agencies to bill Medicaid. In addition, the State's payment rate is low in comparison to the average payment rate for other jurisdictions. CMHC staff reported providing peer support to only a few CRCF residents. Based on Medicaid claims data for individuals residing in a CRCF, the State billed a median of 12 hours per person of peer support for just 17 people with SMI living in CRCFs in 2021.

d. South Carolina Provides Supported Employment, But Does Not Focus on Assisting People Who Are Unnecessarily Institutionalized Attain and Maintain Jobs

> "*Employment helps in recovery. It is essential. I think everybody—if you can work—you should be in our program, and we should be helping you with employment. That includes the CRCFs*." – State Employee

Supported employment assists people with SMI to attain integrated, paid, competitive employment, and provide supports so that they are successful in that job.[38] Individual Placement and Support (IPS) is an evidence-based supported employment service, which means it has been proven to work.[39] IPS incorporates the principle that anyone with an SMI can work in the right

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[34] Substance Abuse and Mental Health Services Administration (SAMHSA), *Value of Peers*, (2017) at 4.
[35] Substance Abuse and Mental Health Services Administration (SAMHSA), *Value of Peers*, (2017) at 7.
[36] Centers for Medicare & Medicaid Services, Dear State Medicaid Director Letter: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, (Nov. 13, 2018) at 15.
[37] There is not consistency across mental health centers regarding the way peer support is provided. One state employee indicated that peers are often treated like "mini-clinicians" sitting in offices, and indicated that it is unlikely that an individual receiving services would be able to explain what the difference is between a peer and a clinician. In contrast, another employee indicated that it is one CMHC's practice to have peer support specialists remind individuals that they are not the person's therapist. Use of Wellness Recovery Action Plans (WRAP), one tool that peers typically use to provide non-clinical support, is only available in two CMHC catchment areas.
[38] Substance Abuse and Mental Health Services Administration, *Supported Employment: Building Your Program* (2009) at 3.
[39] Substance Abuse and Mental Health Services Administration, *Supported Employment: The Evidence* (2009) at 7.

type of job and environment for them.[40] Every person with serious mental illness who is interested in working is eligible for IPS.[41] Supported employment should be integrated with other mental health services the person receives, and the job search should start as soon as someone says they are interested in working.[42] Research shows that when participation in supported employment leads to competitive employment, individuals experience improvements in self-esteem, reduced mental health symptoms, less social isolation, and other benefits.[43]

Since 2020, South Carolina has required all 16 mental health center catchment areas to provide IPS supported employment. Each Center is expected to have at least two employment specialists and one supervisor. IPS services require that each employment support specialist's caseload is limited to 20 or fewer individuals. In reality, there are fewer employment specialists, and less capacity statewide than planned. For example, IPS has been on hold at one CMHC since 2020 due to insufficient staffing, and another CMHC had a supervisor but no employment specialists.

Even where it is available, some DMH staff do not refer all eligible individuals to this service. For example, people discharging from a State Hospital to a CRCF are not referred for supported employment, due in part to a belief that these individuals must first achieve a certain level of stability before trying to work. This practice contradicts evidence that shows competitive employment can reduce mental health symptoms and provide other benefits. Our review identified very few individuals who were receiving supported employment while residing in a CRCF. In 2021, the average statewide caseload for all individuals with SMI in supported employment was only 474, or just under 30 people per catchment area.

e. South Carolina Provides Services Aimed at Individualized Independent Living Skill Development, But Does Not Provide Sufficient Individual Support Necessary for People to Regain Skills During Transitions to Integrating Living

Individualized, person-directed services aimed at enabling people to develop or regain independent living skills, sometimes provided through Psychosocial Rehabilitative Services (PRS), can promote recovery, full community integration, and improved quality of life for individuals with SMI.[44] These services help people establish goals, and identify what skills they have and what they need to achieve those goals.[45] Providers then assist the person in developing

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[40] Substance Abuse and Mental Health Services Administration, *Supported Employment: Building Your Program* (2009) at 3.
[41] Substance Abuse and Mental Health Services Administration, *Supported Employment: Building Your Program* (2009) at 4.
[42] Substance Abuse and Mental Health Services Administration, *Supported Employment: Building Your Program* (2009) at 4-5.
[43] IPS Employment Center, *Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment*, at 5 (updated Jul. 4, 2022), https://docs.google.com/presentation/d/1RFqFrzidP_EwUEb_tgZ57LUJGpodbCM-7oQIQDda1P8/edit#slide=id.p1.
[44] Anthony, W. A., & Farkas, M. D. (2009). Primer on the psychiatric rehabilitation process. Boston: Boston University Center for Psychiatric Rehabilitation, at 9, https://cpr.bu.edu/wp-content/uploads/2013/12/prprimer.pdf
[45] Anthony, W. A., & Farkas, M. D. (2009). Primer on the psychiatric rehabilitation process. Boston: Boston University Center for Psychiatric Rehabilitation, at 10, https://cpr.bu.edu/wp-content/uploads/2013/12/prprimer.pdf

the skills or obtaining the supports needed to achieve their goals.[46] Skills that may be addressed include social, communication, household management, and budgeting skills.[47] This service should occur in the place where the person will typically be performing the skill, such as the person's home or workplace.[48]

In South Carolina, these services are Medicaid-billable, and they can be provided individually or in a group. There appears to be wide variation by CMHC catchment area in how they are provided, with some offering the services primarily as a group activity and others providing it on an individual basis. These services could be provided to individuals in the period after a transition out of the hospital or a CRCF to support the development or re-development of community-living skills. A similar service called Community Integration Service is also intended to assist people in building skills, but it is only delivered in groups, making it less likely to meet the needs of some individuals.

f. The State Provides Insufficient Crisis Services to Prevent Unnecessary Admissions to CRCFs

SMI can be episodic, and symptoms can vary over time.[49] Sometimes symptoms may increase unexpectedly, or external factors may precipitate a mental health crisis. With necessary services like mobile crisis and crisis stabilization units, people can often manage crises without the need for an inpatient stay.[50] But, without crisis services, someone experiencing a mental health crisis may enter a cycle of hospitalization and, ultimately, CRCF admission. Our review found that many people with SMI followed a path to a CRCF that started with a crisis. These crises could often be resolved in the community with sufficient crisis services, or avoided altogether with appropriate ongoing community-based services.

i. Mobile Crisis

Mobile crisis teams provide community-based intervention to individuals experiencing a crisis.[51] Mobile crisis teams respond to situations at any community location, and do not restrict the days or times of service.[52] National guidelines recommend that mobile crisis teams

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[46] Anthony, W. A., & Farkas, M. D. (2009). Primer on the psychiatric rehabilitation process. Boston: Boston University Center for Psychiatric Rehabilitation, at 10, https://cpr.bu.edu/wp-content/uploads/2013/12/prprimer.pdf
[47] Anthony, W. A., & Farkas, M. D. (2009). Primer on the psychiatric rehabilitation process. Boston: Boston University Center for Psychiatric Rehabilitation, at 14, https://cpr.bu.edu/wp-content/uploads/2013/12/prprimer.pdf
[48] Anthony, W. A., & Farkas, M. D. (2009). Primer on the psychiatric rehabilitation process. Boston: Boston University Center for Psychiatric Rehabilitation, at 14, https://cpr.bu.edu/wp-content/uploads/2013/12/prprimer.pdf
[49] Centers for Medicare & Medicaid Services, *Dear State Medicaid Director Letter: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*, (Nov. 13, 2018) at 7.
[50] Centers for Medicare & Medicaid Services, *Dear State Medicaid Director Letter: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*, (Nov. 13, 2018) at 7.
[51] Substance Abuse and Mental Health Services Administration (SAMHSA), National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (2020) at 18.
[52] Substance Abuse and Mental Health Services Administration (SAMHSA), National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (2020) at 18.

incorporate peer support specialists, respond without law enforcement unless special circumstances require it, and provide direct connections to outpatient follow up care.[53]

South Carolina has operated a statewide mobile crisis program since 2019. The State established the current statewide program with the goal of diverting individuals from going to the hospital when they are experiencing a crisis situation. The program aims to stabilize the person in the community, and then have them follow up with the local mental health center the following day. Mobile crisis is expected to provide immediate telephonic response, and teams are expected to arrive onsite within 60 minutes. During regular business hours, staff at the mental health centers provide crisis services. During evening and weekend hours, a central call center located in Charleston triages calls. If call center staff are unable to address the person's needs remotely, they dispatch the local mobile crisis team.

South Carolina's mobile crisis teams consist of two clinicians, who are always accompanied by law enforcement. DMH staff did not indicate any special circumstances that would warrant participation of police officers, but instead provided a general reason that law enforcement involvement is necessary for the safety of the individual and the responding clinicians. The practice of default involvement of law enforcement is in direct contradiction to national guidelines and may discourage people from using the service.[54]

Due to vacancies, nearly half of the CMHCs did not have sufficient staff to meet the expectation that two clinicians go out on crisis response calls. Additionally, some catchment areas only have one mobile crisis team to cover a substantial geographic region. For instance, one CMHC only has the equivalent of two full-time staff allocated to serve its catchment area, which covers seven counties and represents 12% of the state's total square mileage.

ii. Crisis Stabilization

Crisis stabilization can also be provided in community settings with significant involvement of peer support specialists.[55] Crisis centers, sometimes run by peers and other times managed by clinical staff, are comfortable home-like spaces for short-term visits that serve as an alternative to emergency rooms and hospital admission.[56] At these centers, recovery support staff, including peer support specialists, help individuals resolve crises.[57]

As of October 2022, one CMHC catchment area had established a Peer Support Living Room, and there was one additional crisis stabilization unit operating in the State. Other

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[53] Substance Abuse and Mental Health Services Administration (SAMHSA), National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (2020) at 18.
[54] *See* Substance Abuse and Mental Health Services Administration (SAMHSA), National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (2020) at 18.
[55] Substance Abuse and Mental Health Services Administration (SAMHSA), *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (2020) at 28.
[56] Substance Abuse and Mental Health Services Administration (SAMHSA), *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (2020) at 12.
[57] Substance Abuse and Mental Health Services Administration (SAMHSA), *Crisis Services: Meeting Needs, Saving Lives*, (2020) at 10.

CMHCs are considering establishing crisis stabilization, including two CMHCs that are partnering to develop a center for the Midlands region.

g. South Carolina Provides Personal Care Services

Personal care services are non-medical services that help with activities of daily living, such as movement, bathing, and dressing.[58] These services can also help with instrumental activities of daily living, such as meal preparation, shopping, and money management.[59] Personal care services can be covered through Medicaid under one or more waivers[60] or as an optional State Plan service.[61]

The State primarily funds personal care services for people who are not eligible for Medicaid waivers using State dollars. Because this is offered through the OSCAP program, this personal care is only provided in CRCFs. In contrast, people transitioning out of a CRCF who need personal care services cannot access it under the State's current programs.[62] The vast majority of people living in the CRCFs can provide for their own activities of daily living with the supports discussed above, but our review found a small proportion of those transitioning from CRCFs have physical health needs that would require regular personal care services to live successfully in the community.

IX. It Is a Reasonable Modification to Serve Adults in the Community

States must reasonably modify their service systems to avoid discrimination on the basis of disability.[63] South Carolina could reasonably modify its existing community-based programs, without fundamentally altering its current system, to prevent unnecessary segregation of adults with serious mental illness in CRCFs. Such modifications would allow people with SMI to live and thrive in their own homes and communities instead of entering or remaining in CRCFs to access appropriate care.

Currently, the State does not focus on transitioning people away from unnecessary CRCF placement. The State views CRCFs as having an "important role . . . in providing residential care for persons with mental illnesses." Although the State's Continuity of Care policy[64] states that DMH intends to "provide needed treatment in local communities whenever possible", it treats CRCFs as potential discharge destinations from State Hospitals, instead of segregated

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[58] Centers for Medicare and Medicaid Services, *Informational Bulletin: Strengthening Program Integrity in Medicaid Personal Care Services*, (December 13, 2016) at 2.
[59] Centers for Medicare and Medicaid Services, *Informational Bulletin: Strengthening Program Integrity in Medicaid Personal Care Services*, (December 13, 2016) at 2.
[60] Section 1915(c) of the Social Security Act, 42 CFR 440.180; section 1915(d), and section 1115.
[61] Section 1905(a)(24) of the Social Security Act, 42 CFR 440.167; section 1915(i), 42 CFR 440.182; section 1915(j), 42 CFR Part 441, Subpart J; and 1915(k), 42 CFR Part 441, Subpart K.
[62] South Carolina does not currently have an HCBS waiver geared toward people with SMI, and the State does not have plans to establish such a waiver. It also does not have plans to add personal care for adults as a State Plan service.
[63] *See* 28 C.F.R. § 35.130(b)(7)(i); *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999).
[64] The State holds out the Continuity of Care policy as its *Olmstead* plan.

settings to be avoided.[65] At the same time, the State has long recognized the goal of transition from CRCFs to more integrated settings. For instance, the standard memorandum of agreement between CMHCs and CRCFs notes that the goal is for everyone with mental illness to "live as independently as possible," which "may include obtaining employment and moving from the CRCF to more independent living where they assume responsibilities for the activities of daily living such as cooking, laundry, etc."

South Carolina has established many of the community-based services needed to support individuals with serious mental illness in the most integrated setting appropriate for their needs. For example, South Carolina offers permanent supportive housing, crisis services, Assertive Community Treatment, peer support, supported employment, psychosocial rehabilitative services, and some personal care. Existing case management programs, including targeted case management, could assist with transitions from CRCFs to integrated settings. However, some of these services are not available throughout the State, and there is insufficient supply to meet the needs of people institutionalized in CRCFs. As noted above, the quantity and geographic location of these services are not based on an overall assessment of what is needed, and many such services are underdeveloped.

Although insufficient to meet the need, community-based services are available to be expanded. One example is permanent supportive housing. As noted earlier, the State spends $2,353,000 annually on rental assistance for permanent supportive housing units. Spending per person in the program is less than $7,000 per year. In contrast, the State spends nearly $19 million annually on OSS. Spending per person in the OSS program is approximately $9,000 per year. The State could expand its rental assistance program or modify its OSS program—which currently requires residence in a CRCF—to enable people to live in a more integrated setting.

Increasing community-based services availability would support individuals living in more integrated settings and is consistent with the State's own goals and plans. DMH's "mission and policy is to support the recovery of people with mental illness, serving them in the most appropriate, integrated, and least restrictive setting consistent with professional standards, needs, and individual choice." DMH has highlighted the importance of access to community-based services including ICT, community housing assistance, peer support, crisis services, and targeted case management to implementing its mission. The Department of Health and Human Services has identified services for people with SMI as a priority, and recently convened the Master Plan Advisory Committee (MPAC) to recommend ways to increase mental health services capacity across the State. MPAC was formed after the legislature gave approximately $65 million in one-time funds to HHS to support a pilot project in one region of the State. MPAC initially focused on in-patient hospital bed capacity, but has also identified crisis services as one area for

[65] The State has long been on notice that CRCFs are segregated settings. Public filings from a lawsuit brought by Disability Rights South Carolina include a 2016 report noting that the State's "ongoing reliance on CRCFs and other congregate settings, calls into question South Carolina's ability to ensure that individuals with disabilities are living in the most integrated settings." The report also noted that the State's continued use of OSS in CRCFs "may make South Carolina vulnerable for Olmstead activity." *AW et al. v. McGill et al.*, No. 2:17-cv-01346-RMG, Doc. 26-12 at 5, 11 (D.S.C. Apr. 3, 2018).

expansion. While this focus on increasing services for people with SMI is a positive development, the plans do not resolve the State's unnecessary reliance on CRCFs.

South Carolina could serve adults in the most integrated setting appropriate to their needs and comply with Title II of the ADA by reasonably modifying its service system. Remedial measures should include:

- **Ensuring that community-based services are accessible and available with sufficient intensity to prevent unnecessary institutionalization.** Services the State should ensure are available and accessible include Assertive Community Treatment, peer support, supported employment, individual psychosocial rehabilitation, crisis services, and personal care. The State should consider input from adults with lived experience in adjusting its service array.

- **Ensuring that integrated housing options are accessible and available in sufficient quantities to prevent unnecessary institutionalization.** This would include adequate funding for permanent supported housing.

- **Ensuring that transition services from CRCFs are accessible and available with sufficient intensity to assist individuals who do not oppose living in a more integrated setting to do so.** This will include conducting regular in-reach to CRCFs to identify people who wish to transition to, or are interested in learning more about, integrated housing with supports; providing individualized education on available community-based services and supports (including through peer support); conducting comprehensive transition planning; and ensuring that the individuals have access to services they need to be successful post-transition.

- **Ensuring appropriate diversion from CRCFs for people experiencing a mental health crisis or hospitalization.** This would include connecting people who are experiencing a crisis to the needed services to avoid inpatient admission whenever possible, and transitioning people directly from hospitals to integrated housing rather than CRCFs.

X. Conclusion

For the foregoing reasons, we conclude that there is reasonable cause to believe the State fails to provide services to adults with serious mental illness in the most integrated setting appropriate, in violation of the ADA.[66] Because of deficiencies in its community-based service array and the manner in which the State administers its adult mental health system, the State relies on segregated settings to serve adults with serious mental illness who could be served in their homes and communities.

[66] *See* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d).

We look forward to working cooperatively with the State to reach a resolution of our findings. We are obligated to advise you that if we are unable to reach a resolution, the United States may take appropriate action, including initiation of a lawsuit, to ensure the State's compliance with the ADA. Please also note that this Report is a public document. It will be posted on the Civil Rights Division's website.