Investigation of Kentucky's Unnecessary Use of Psychiatric Hospitals to Serve Adults with Serious Mental Illness in Louisville

United States Department of Justice
Civil Rights Division

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TABLE OF CONTENTS

SUMMARY OF FINDINGS

After an extensive investigation, the United States Department of Justice (DOJ) concludes there is reasonable cause to believe that the Commonwealth of Kentucky 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 Louisville/Jefferson County Metro area ("Louisville") in the most integrated setting appropriate to their needs.

Each year, thousands of people are admitted to psychiatric hospitals in Louisville, and more than a thousand people experience multiple admissions. Many people spend more than a month out of their year in psychiatric hospitals. These hospitals are highly restrictive, segregated settings in which people must forego many of the basic freedoms of everyday life. Admission to these institutions can be traumatizing, and it can upend the lives of people who experience them. With the right community-based services, many of these hospitalizations could be prevented. Kentucky already offers these community-based services in Louisville, but access to them is insufficient to prevent avoidable hospitalizations. Kentucky also fails to ensure people are connected to those services following hospitalizations. These failures have led to unnecessary and preventable segregation in psychiatric hospitals in Louisville and leave many people at serious risk of this segregation.

In addition, because of the lack of community-based services, law enforcement officers are routine responders to mental health crises in Louisville. Many of these encounters could have been avoided with community-based services, and those community services could have provided an alternative to incarceration in Louisville Metro Detention Center.

Kentucky's failure to provide adequate community-based services to avoid hospitalization is exemplified by people like Alexis.[1] At one of the local hospitals in Louisville, we met Alexis, who has bipolar disorder, is blind, and has two sons. She has had multiple recent psychiatric hospitalizations and law enforcement encounters. She needs more support at home but when she goes to the hospital, she is typically discharged with only an outpatient appointment for future treatment. Alexis told us she enjoyed her last job and wants to work again to keep herself occupied and busy. She also wants assistance with getting a guide dog. We found little evidence that treatment staff assessed or planned for the more intensive mental health community-based supports, that Alexis needs and wants. She would also benefit from access to crisis services but told us the mental health crisis line is "for the birds." She said she has called them for help, but no one came. Alexis would also benefit from supported employment, a service that is quite effective at helping avoid mental health crisis and maintain community living. If these services and supports had been available, at least some of her hospitalizations could have been avoided. A family member whose loved one had a similar experience told us that she wished appropriate services were available in the community because "[t]his would be more humane and less costly than frequent hospitalizations, police and criminal justice encounters."

Despite these deficiencies, Kentucky can reasonably modify its service system to avoid this discrimination.

[1] All the people discussed in this report are identified using random pseudonyms.

INVESTIGATION

On May 24, 2022, DOJ opened an investigation under Title II of the ADA, focused on whether Kentucky subjects adults with serious mental illness to unnecessary segregation in psychiatric hospitals in Louisville.[2] This included examining whether people are experiencing psychiatric hospitalizations in conjunction with repeated law enforcement encounters or incarceration, and whether they are at serious risk of future institutionalization in psychiatric hospitals.

This investigation is separate from DOJ's pattern or practice investigation into the Louisville Metro Government (Louisville Metro) and the Louisville Metro Police Department (LMPD), which examined issues including Louisville Metro's and LMPD's systems for responding to people with behavioral health disabilities. On March 8, 2023, DOJ concluded that there is reasonable cause to believe Louisville Metro and LMPD are engaged in a pattern or practice of conduct that deprives people of their rights under the Constitution and federal law. The 2023 Findings Report identifies several legal violations and describes the types of changes necessary to address them. Relevant here, DOJ found reasonable cause to believe that Louisville Metro and LMPD violate the ADA in their response to people with behavioral health disabilities.[3]

During the investigation of Louisville Metro and LMPD, we uncovered information indicating that limited access to a range of community mental and behavioral health services contributes to unnecessary law enforcement responses, and also to unnecessary hospitalization of people in Louisville. The investigation discussed in this Report further examines whether Kentucky's service system contributes to these outcomes. Importantly, Kentucky has an obligation to administer services in compliance with the ADA throughout the State. However, this investigation focused on Louisville, and we did not assess the services provided in other areas of the State.

The Special Litigation Section of the Department of Justice's Civil Rights Division, in Washington, D.C., and the United States Attorney's Office for the Western District of Kentucky, in Louisville, jointly conducted both investigations. The team conducting this investigation consists of career attorneys, investigators, and analysts, as well as consultants with expertise in behavioral health services and public mental health administration.

During this investigation, DOJ staff and experts participated in hundreds of interviews with Kentucky officials, community mental health and social service providers, and a wide array of stakeholders, including judges, advocates, and family members and individuals with lived experience. We conducted on-site visits to Central State Hospital (CSH) and several local psychiatric hospitals in Louisville, where we spoke with individuals receiving treatment and facility staff and reviewed individual records. We also visited numerous community-based

[2] We received a complaint that the Commonwealth of Kentucky was discriminating against people with disabilities, and we accepted and investigated that complaint pursuant to Title II of the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq*.

[3] People with behavioral health disabilities are individuals who have a diagnosable mental illness and/or substance use disorder. This population includes individuals with co-occurring intellectual or developmental disabilities.

providers and conducted an extensive review of documents and data obtained from Kentucky and outside sources.

We greatly appreciate the Commonwealth's assistance and cooperation throughout this investigation. We thank the many individuals with serious mental illness who shared their own experiences, and the local providers and stakeholders who provided valuable information.

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."[4] 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."[5] Accordingly, the "ADA is intended to [ensure] 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."[6]

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."[7] The most integrated setting appropriate is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[8] 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."[9]

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.[10] The Court explained that unnecessary segregation is a form of discrimination because it "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."[11] Further, such segregation "severely diminishes the everyday life activities of individuals, including family

[4] 42 U.S.C. § 12101(b)(1).

[5] 42 U.S.C. § 12101(a)(2).

[6] *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995).

[7] 28 C.F.R. § 35.130(d); *see also* 42 U.S.C. § 12101(b).

[8] 28 C.F.R. Part 35, App. B.

[9] 28 C.F.R. § 35.130(b)(7).

[10] *See Olmstead v. L.C.,* 527 U.S. 581, 607 (1999).

[11] *Id.* at 600.

relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[12] It also reflects dissimilar treatment, because people with disabilities must "relinquish participation in community life they could enjoy given reasonable accommodations," to receive needed services, while people without disabilities "can receive the medical services they need without similar sacrifice."[13] The ADA's integration mandate applies both to people who are currently segregated and to people who are at serious risk of unnecessary segregation.[14]

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.[15] 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.[16]

KENTUCKY'S SYSTEM FOR SERVING ADULTS WITH SERIOUS MENTAL ILLNESS IN LOUISVILLE

Louisville is the largest city in Kentucky. The city merged with Jefferson County in 2003 to create a coextensive Louisville/Jefferson County Metro Government ("Louisville"). The Kentucky Cabinet for Health and Family Services is responsible for the development and operation of publicly funded mental health services in Louisville. Within the Cabinet, Kentucky administers and controls its mental health system primarily through the Department of Medicaid Services (DMS) and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). Together, these Departments plan, fund, regulate, and oversee Kentucky's mental health system.

DBHDID is Kentucky's State Mental Health Authority, which means it is the primary state agency responsible for planning and overseeing state and federally funded mental health services. It administers the community-based system of behavioral health care for adults with serious mental illness through contracts with 14 state-licensed Community Mental Health Centers (CMHCs) and other providers.[17] DBHDID is responsible for monitoring and enforcing those contracts. Seven Counties Services is the CMHC for Louisville/Jefferson County and six other neighboring counties in Kentucky. It is one of the primary behavioral health services providers in Louisville. DBHDID contracts with CMHCs like Seven Counties to provide adults

[12] *Id.* at 601.

[13] *Id.*

[14] *See Waskul* v. *Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426, 460-461 (6th Cir. 2020).

[15] *Olmstead*, 527 U.S. at 607; 28 C.F.R. § 35.130(b)(7).

[16] *See, e.g.*, *Messier v. Southbury Training Sch.*, 562 F. Supp. 2d 294, 344-45 (D. Conn. 2008).

[17] Kentucky describes this as a comprehensive, community-based system of behavioral health care for adults with serious mental illness (SMI). In addition, eligibility for some critical community-based mental health services requires a primary diagnosis of SMI. Because of this, we focus on people with SMI throughout this Report. Kentucky defines SMI to include Schizophrenia, Bipolar and Related Disorders, Depressive Disorders, and Post Traumatic Stress Disorder that cause an impairment in one or more major life activities. *See* 908 Ky. Admin. Regs. 2:065.

with serious mental illness an array of services and supports. Seven Counties reports that there are 15,500 adults with serious mental illness in Louisville. It has provided services to approximately 6,000 of these individuals annually.

DMS administers Kentucky's Medicaid Program, which funds most of the Commonwealth's publicly funded behavioral health services. DMS plays an important role in determining which services are reimbursable by Medicaid, within confines set by federal law and regulations, and it is responsible for ensuring the availability and quality of the services. DMS also contracts with six Managed Care Organizations (MCOs) that serve about 90 percent of Medicaid beneficiaries, including those receiving mental health services. On behalf of DMS, the MCOs must ensure access to a network of services covered by Medicaid. Using Kentucky Medicaid funds, they pay CMHCs and other providers to deliver community-based services. In Kentucky, inpatient and outpatient adult mental health services are paid for through this managed care program.[18]

Kentucky's DBHDID contracts with Seven Counties and the University of Louisville (UofL) Hospital to operate the only psychiatric emergency department in the area, named Emergency Psychiatric Services (EPS). Located within UofL Hospital, it provides emergency psychiatric treatment and stabilization to approximately 2,250 adults with serious mental illness each year, on average. Many of those adults have multiple stays per year. DBHDID relies on EPS to provide short-term crisis stabilization and refer people to community-based services or hospitalization.

DBHDID also operates or contracts with several adult mental health inpatient facilities, including the state-operated Central State Hospital in Louisville. Further, Kentucky relies on private hospitals with specialized psychiatric services as part of its network of emergency behavioral health and crisis services. For adults in the Louisville area, this includes UofL Hospital, UofL Peace Hospital, The Brook Hospitals (Dupont and KMI), and Norton Hospital. Currently, Kentucky Medicaid funds time-limited stays for inpatient treatment in these facilities.

[18] Managed care is a system for delivering healthcare in which state Medicaid agencies pay external MCOs a predetermined monthly payment, which the MCOs use to pay service providers to deliver contracted Medicaid covered health care services.

FINDINGS

A. Kentucky Relies on Psychiatric Hospitals to Serve Adults with Serious Mental Illness in Louisville

1. Adults with Serious Mental Illness in Louisville Experience Repeated, Preventable Psychiatric Hospitalizations

Each year, adults with serious mental illness are repeatedly admitted to psychiatric hospitals in Jefferson County. Specifically, over the course of State Fiscal Years 2021 and 2022, approximately 7,400 unique adults were admitted to Central State Hospital or had a psychiatric inpatient admission in Louisville that was billed to Medicaid. More than 2,300 of these individuals had at least two admissions during this time frame. Many experienced even more frequent admissions. During State Fiscal Year 2022 alone, more than 1,100 people had two or more psychiatric admissions, and more than 500 people had three or more psychiatric admissions. Often, these hospitalizations consumed more than a month out of the person's year.[19]

In Fiscal Year 2022,

> 1,100

people had two or more psychiatric admissions.

> 500

people had three or more psychiatric admissions.

During our investigation, we interviewed adults with serious mental illness who were either at a psychiatric hospital or who had experienced a recent psychiatric hospitalization in Louisville, and we reviewed their records. Many had a history of repeated hospitalizations. For example, 42-year-old Charles has had approximately ten hospitalizations at Central State Hospital in recent years, in addition to many stays at local hospitals. In between hospitalizations, he often moved between extended stay hotels, subsidized apartments, his parents' home, and jail, without the intensive services and in-home supports he needs. Charles's parents described him as bright and intelligent. But, throughout this experience, his condition significantly deteriorated, and he has lost many independent living skills. Charles was convicted of a serious offense about a decade ago and released from prison to his parents' home in 2019. We met Charles during what would turn out to be more than a year-long hospitalization at CSH. Notwithstanding the fact that CSH was already familiar with Charles and had over a year to prepare for discharge, his family observed that "there was no thought given to his release" during most of his lengthy hospitalization. He was abruptly discharged to a boarding home, which his family said was unsafe, then moved to a hotel.

We also met Elizabeth, a college graduate in her 30s who works as an office assistant. Elizabeth has had multiple admissions to CSH and local hospitals in recent years. Although she is connected to the CMHC for services like therapy, she said it is difficult to get transportation to these appointments, and we found her support needs would not be met by office-based

[19] We identified at least 380 people who spent 30+ days in a Louisville psychiatric hospital in State Fiscal Year 2022, and at least 402 such individuals in State Fiscal Year 2021. This is likely an undercount, because data limitations prevented us from identifying the combined length of stay for everyone. Most of these people had multiple admissions over the course of the year. During each of these years, there were several hundred additional individuals with three or more hospitalizations for whom we were unable to calculate length of stay.

appointments alone. With access to flexible and intensive community-based services like Assertive Community Treatment (ACT),[20] peer support services, and supported employment, many of these hospitalizations could have been avoided.

These are just two of many people we reviewed who experienced repeated hospitalizations in Louisville. We found that most of the hospitalizations these individuals experienced could have been prevented with appropriate crisis intervention and ongoing community-based services. Yet, as discussed throughout this Report, many people with serious mental illness are caught in a cycle of law enforcement contacts, EPS visits, and inpatient hospitalizations.

EPS is often at the center of this cycle. Although EPS is not located at Central State Hospital, people usually go to EPS before being admitted to Central State and, in practice, many also go to EPS before admission to one of the other hospitals in the area providing in-patient services. And people often arrive at EPS in police custody. Police officers are by far the most common mode of transportation to EPS.[21] They are charged with taking people into custody and transporting them to a designated facility for mental health evaluations,[22] and in Louisville, typically transport people to EPS.

EPS is also Kentucky's primary method for diverting hospital admissions in Louisville. However, as senior Kentucky officials acknowledge, EPS is still a hospital-based emergency room that can be "a highly chaotic" and "sometimes very traumatic experience." It is a small, "relatively sterile" space that serves the limited purpose of evaluating whether a hospital admission is needed and is not well-suited to ensuring long-term engagement in outpatient services. Officials said they would prefer for people to avoid EPS altogether by accessing community-based crisis services, and believe that with a robust crisis response system, they could divert a significant portion of people from both EPS and inpatient admissions.

Instead, for many individuals in Louisville today, police officers, EPS, and hospitals are the primary options for help. And without a connection to long-term services, many simply reappear at EPS the next time a crisis occurs. A knowledgeable provider told us that the emergency

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[20] ACT is an intensive service where a team of healthcare workers support an individual by providing them mental health treatment and services to help with housing, employment, and other basic needs. Services are provided in the person's home and in the community. *See Assertive Community Treatment: Building Your Program*, SAMHSA 5-6 (2008), https://perma.cc/B38V-V42H. ACT is discussed in Section A.6 below.

[21] For instance, out of all EPS encounters involving people with SMI in State Fiscal Year 2023, people arrived by law enforcement 51% of the time (1,651/3,227). In 32% of encounters (1,021 / 3,227) people walked in or arrived by private vehicle, and in 16% (517 / 3,227) they arrived by ambulance. On nine occasions, someone arrived via the new Louisville Metro Government mobile crisis program, described in Section A.6.a.

[22] Pursuant to the Kentucky Mental Health Hospitalization Act, involuntary hospitalizations require an evaluation by a mental health professional. Ky. Rev. Stat. § 202A.028. Any police officer who has "reasonable grounds to believe that an individual is mentally ill and presents a danger or threat of danger to self, family, or others if not restrained" is required to take the person into custody and transport them to a hospital or psychiatric facility designated by the Cabinet for evaluation. Ky. Rev. Stat. § 202A.041. Police officers also transport people in the event of a court-ordered hospitalization. Ky. Rev. Stat. § 202A.028.

room visit stops the individual's mental health crisis from escalating, but only for that moment. People are "just going in and out of these last-minute emergency places" without "getting those services that will help stabilize them." This is borne out in data. Although Kentucky does not appear to monitor this information, we found that hundreds of adults with SMI have visited EPS three or more times in recent years. And, as discussed in Section B, deficiencies in Kentucky's community-based service system not only contribute to preventable EPS visits and hospitalizations; they also contribute to avoidable law enforcement encounters and incarceration.

2. Adults with Serious Mental Illness Are Appropriate for Community-Based Services

We found that many psychiatric hospitalizations in Louisville could be avoided with appropriate community-based services. We also found that most people we met in Louisville psychiatric hospitals were appropriate for community treatment at the time of the interview. In one striking example, according to medical records, a person remained at CSH awaiting placement for at least five months after he was determined to be stable. Hospital staff report that it is not uncommon for individuals to experience inappropriately long stays at psychiatric hospitals due to a lack of discharge placements.

"If he just gets a stable environment, he'd do great," said the social worker at the private Louisville psychiatric hospital where we met 52-year-old Gregory, who told us he enjoys fishing, after learning it from his grandfather. The social worker told us that Gregory would "thrive" if he had stable housing. Instead, because of a lack of permanent supportive housing in Louisville,[23] Gregory's discharge plan was to move to a residential provider in Tennessee or Georgia. Gregory has persistent depression, anxiety, and suicidal thinking, likely exacerbated by his recurring lack of income and housing instability. Gregory told us he has been to half the hospitals in Kentucky, including hospitalizations at CSH and all the local psychiatric hospitals in Louisville. "I really would like to see some more options for people," he said. Though Gregory previously received some outpatient services, including case management and psychiatric medications, he was homeless and not receiving services at the time of his most recent hospitalization. He said he has never even been offered permanent supportive housing, peer support services, or supported employment. Consistent access to these services could have prevented Gregory's hospitalizations. Notably, there was little documentation in Gregory's medical records of records of efforts to find him stable housing or connect him to permanent supportive housing services.

We found many other instances where access to community-based services could have prevented a hospitalization. For example, we met 33-year-old Brian, who told us he would like to join the Special Olympics and hopes finding a new place to live will bring him calm. Brian experienced at least six psychiatric hospitalizations since 2021. With access to the appropriate community-based services, at least some of these hospitalizations could have been avoided. In one instance, Brian expressed suicidal thoughts during a routine visit to the community mental health center in Louisville. He agreed to meet with a crisis worker from the community mental health center, but one was not available. Brian then requested admission to a crisis stabilization unit—a community-based hospital diversion program offering mental health care[24]—but those

[23] Permanent supportive housing is further explained in Section A.6.

[24] Crisis stabilization services are further explained in Section A.6.a.

services were full. In the end, he was sent to the emergency room, which led to a hospitalization.

While experiences like Brian's and Gregory's were common, we also met people who said that receiving community-based services helped them break the cycle of hospitalization. "Coming here has kept me out of the hospital," said Jillian, who was hospitalized nine times in 2015, before being connected to community-based mental health services she describes as a "game changer." She now receives services at a community provider that offers peer support services, medication, and therapy. Another provider helped her get food stamps and an apartment.

Kentucky state officials recognize that community-based services can help people with serious mental illness avoid psychiatric hospitalization, and they would like to see more people avoid those outcomes. As one senior official put it, Kentucky wants to reduce readmissions to hospitals and emergency department visits because "there are much better ways to help individuals with SMI get the treatment that they need." However, we found that, while many individuals who had experienced psychiatric hospitalization did have access to some type of outpatient mental health and/or substance use services, the services were often insufficient to meet their needs and avoid psychiatric hospitalization.

3. Adults Experiencing Psychiatric Hospitalizations Do Not Oppose Receiving Services in the Community Instead

"I don't know too many people who would prefer to be in the hospital."
– Kentucky State Official

Almost all of the individuals we reviewed do not oppose receiving community-based services and would prefer it to being segregated in a psychiatric hospital. "I don't feel safe" in hospitals, said Kristen, who had been hospitalized in five of the psychiatric hospitals in Louisville, with stays altogether exceeding three years. Now, she receives services from a community-based provider, where she said she has come to trust the peer support specialist. One official from Central State Hospital said individuals are not happy to be at CSH. Another state official said: "I don't know too many people who would prefer to be in the hospital. That would be very rare. I would say [there is] a strong preference for the community."

Yet inadequate access to intensive community-based services in Louisville leaves people with SMI with little choice but to receive care in a psychiatric hospital. Dana, who told us she enjoys attending art and women's support groups, has been hospitalized multiple times at five different psychiatric hospitals in Louisville. She told us that she knows when it's time to go to the hospital because she has "no other choice." "I hate it there, but it keeps me safe," she said.

Often, the individuals we spoke to who had experienced multiple psychiatric hospitalizations were not aware of—but would have been open to receiving—community-based alternatives. For example, when we described mobile crisis services to Dana, she asked, "Is that a thing?" and said it would be "really cool" and helpful for her. Ruben, who said he loves his dogs and enjoys going to the park with friends, has had five hospitalizations at CSH in the last three years. He told us he has been "just going in and out of hospitals with no real treatment team." He said he was open to trying community-based services beyond the therapy appointment and medication he is usually given when discharged. Henry expressed interest in case management and crisis services, saying: "Case management would be wonderful."

4. Psychiatric Hospitals are Congregate, Segregated Settings

Central State Hospital and the local psychiatric hospitals in Louisville provide services in congregate, segregated settings. They are populated primarily by people who have mental illnesses, substance use disorders, or both. People receiving treatment in these hospitals only interact with other patients and treatment staff, apart from possible visitors, and they are housed mostly in shared rooms, with little to no privacy. Their day-to-day life is highly restrictive and consists almost entirely of treatments and related activities. A Central State Hospital employee told us that patients are expected "to be calm and quiet with absolutely nothing to do," and a resident there said both CSH and a local psychiatric hospital where she was admitted "felt like jail." Admission to these facilities clearly upends people's lives by limiting their relationships with loved ones and their community, interrupting their education and jobs, and interfering with their ability to manage their finances and affairs. These are hallmarks of an institution.

5. Kentucky Offers Community-Based Services to Adults with Serious Mental Illness in Louisville but Fails to Provide Sufficient Services to Prevent Avoidable Hospitalizations

"Really what we need is more services for people, somewhere between hospitalization and being on the streets." – Local Advocate

"If they're not accessing services. . . . these folks don't disappear. . . . They're in jail. They're in the ER waiting for services. They're in homeless shelters. They're on the street." – Representative for Kentucky Community Mental Health Centers

Kentucky already offers many of the critical community-based services and supports that are needed to prevent stays in emergency departments and inpatient facilities, as well as criminal justice involvement. This includes mobile crisis, crisis intervention, residential crisis stabilization services, ACT, peer support, supportive housing assistance, supported employment, targeted case management, and comprehensive community support services designed to allow individuals with mental illness to live with maximum independence in the community. Kentucky provides a combination of state and federal block grant funds to the CMHCs to deliver these services to people with serious mental illness who meet eligibility criteria.[25] Most are also funded through Kentucky's Medicaid program and may be offered by other community-based providers as well. If accessible, these services would allow many with SMI to avoid hospitalization.

Yet, in practice, needed services and supports are often inaccessible. As discussed below, Kentucky's own data show that, among those people who are experiencing repeated hospitalizations in Louisville, few are receiving the key community-based services that are known to stop this cycle. Throughout the course of this investigation, state officials, facility and community-based providers, and other stakeholders routinely reported that access to community-based mental health services in Louisville is insufficient.

[25] This is even after a settlement agreement with the Kentucky Protection & Advocacy Agency, focused on Kentuckians with SMI who are in or at risk of entry into Personal Care Homes, which required the Commonwealth to provide sufficient access to many of these services.

Some described a dramatic reduction in services upon discharge from inpatient facilities, which contributes to re-hospitalization and other negative outcomes. As one Louisville provider explained, when people leave the hospital, they transition immediately from round-the-clock care to what probably feels like a "black hole." Another provider reported that there are "a lot of gaps" in services, lamenting that "we just don't have what it takes to help people live a life of recovery."

In addition, insufficient access to practical help with things like housing and transportation can make it more difficult for people to engage in and continue care. Several people told us that not having transportation kept them from appointments. We also met many people who need more intensive services like ACT or Permanent Supportive Housing, which are typically provided at the person's home, rather than in an office. *See* Section A.6, below. As one senior official explained, in-office appointments are not a realistic option for everyone, and relying exclusively on them can prevent people from continuing with community-based services. This is especially true for individuals with SMI who are unhoused. "We shouldn't be sitting in our office waiting for someone to come to us, we should go to them," he said.

State officials agree that it is important to provide intensive and responsive services that are matched to the individual's needs and preferences, including in-home supports, peer supports, and crisis services. Further, to sustain engagement in treatment, it is essential to build a strong therapeutic relationship where the person receiving treatment feels listened to and has a genuine say in decisions about their care. These strategies do not appear to be consistently implemented in state-funded mental health services in Louisville. For example, Troy, who has had multiple psychiatric hospitalizations and told us he has previously stopped taking medication, said he was open to—but never offered—peer support services or in-home services like ACT. Instead, he was placed in an involuntary outpatient treatment pilot program.[26] Overall, a mental health provider told us the system does not support individuals who are ambivalent about treatment. To serve these individuals, she said, there needs to be more engagement to see what people are amenable to and understand their barriers, which could include a previous negative experience with treatment.

[26] Kentucky has piloted a court-ordered Assisted Outpatient Treatment (AOT) initiative specifically to stop "the revolving door of jails, hospitals and homelessness" that results in "high treatment costs and low quality of life" for some individuals. Under Kentucky's Tim's Law, Ky. Rev. Stat. 202A.0811-0.831, a judge can mandate a person to receive involuntary community-based mental health treatment if, among other criteria, the person "has a history of repeated nonadherence with mental health treatment" which has led to them being arrested or hospitalized at least twice in the last 48 months; or acting, threatening, or attempting serious physical injury to self or others in the last 24 months. However, SAMHSA has warned, "[i]f badly designed, poorly implemented, or under-resourced, [involuntary outpatient programs] pose the risk of subjecting individuals they commit to services that are non-existent or of poor quality, further alienating these individuals from the services system."

> "[T]here are many individuals in Kentucky with SMI who have unmet treatment and health related social needs. Due to current limitations of treatment options for these individuals, there are higher rates of utilization of emergency departments and readmission to inpatient treatment facilities which are costly services."
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> – Kentucky Department of Medicaid Services, 2023 Submission to the Department of Health and Human Services (HHS)

Kentucky acknowledges that limited community-based options cause people to seek costly treatment in emergency department and inpatient treatment facilities. To its credit, Kentucky is taking steps to obtain Medicaid funding for some of the services that are effective at preventing needless hospitalization.

6. Kentucky Provides Insufficient Access to the Community-Based Services Needed to Prevent Hospitalization

Assertive Community Treatment (ACT) is designed to support people with the most significant mental health needs, including people with frequent emergency department and inpatient admissions. It delivers services directly to people in the community, typically in people's homes, but wherever support is needed. A team of 10-12 people with different training and skills provides a customized array of services that fits each person's needs and goals. This may include initial and ongoing assessments, case management, counseling and psychotherapy, psychiatric services, employment support, housing support, and substance use treatment. Crisis services are also available 24 hours a day, 7 days a week, although the ACT teams can often anticipate and prevent crises from happening.

ACT is an evidence-based model, which when implemented properly, greatly reduces psychiatric hospitalizations and improves housing stability, among other positive outcomes. State officials and community providers agree that ACT is effective at preventing psychiatric hospitalizations and criminal justice involvement. According to Kentucky staff, it is "one of those things that actually helped individuals get out" of hospitals, and it is the ideal service for people experiencing multiple hospitalizations.

Kentucky funds ACT through a combination of Medicaid, federal block grant, and state funds. According to Kentucky's standards, eligibility for this service rests in part on the individual being hospitalized for mental illness more than once in the last two years. This is consistent with Kentucky's view, as expressed in state planning documents, that people with SMI who have been hospitalized for mental illness two or more times in a year are at risk for institutionalization. Two providers operate ACT teams in Louisville. Combined, they provide ACT to about 150 people in the area.[27] This appears to be insufficient capacity to meet the needs of the roughly 2,300 people who have been hospitalized more than once in the last two years.

[27] The ACT teams are designed to serve people with serious mental illness who are at risk of future institutionalization or involvement in the criminal justice system. One works primarily with people who are also experiencing homelessness.

In fact, Kentucky's Medicaid claims data show that ACT is rarely provided to people with multiple recent psychiatric hospitalizations in Louisville. Even among the highest utilizers—people who experienced three or more stays, or spent at least 45 cumulative days, in psychiatric hospitals in Louisville over the course of a year—fewer than ten percent received ACT in Louisville at any point during a recent three-year period. Many providers and community stakeholders report that more ACT teams are needed in Louisville and that, in practice, it is often difficult to connect individuals to these services.

> "Among individuals served through Kentucky's 14 Community Mental Health Centers and state psychiatric hospitals, the SMI population has **higher utilization** rates than national average of **psychiatric inpatient facilities** and higher than average state hospital readmissions within 180 days. Kentucky also reports **a lower percentage of utilization of evidence-based practices** like assertive community treatment, supportive housing, and supported employment . . .
>
> . . . the SMI population in Kentucky also has **higher rates of homelessness** and sheltered homelessness than the national average indicating an even greater need for the expansion of support services. . .".
>
> – Kentucky Department of Medicaid Services, 2023 Submission to HHS (emphasis added)

Permanent Supportive Housing (PSH) is an evidence-based model that combines long-term affordable housing with flexible individualized services that help people keep their housing and live with maximum independence in the community. People typically live in an apartment or house in the community, where people with and without disabilities live. Supportive services vary in intensity depending on individual needs and might include helping people who do not have housing find it; case management; regular in-home visits; support with medication management and household skills such as cooking, housekeeping, and budgeting; peer mentoring; mental health, physical health, and substance use services; and crisis intervention. Though these services should be offered through PSH, they must be voluntary. As Kentucky officials acknowledge, PSH is effective at reducing emergency room visits, hospitalizations, and incarceration.

Kentucky has embraced the PSH model, recognizing that "[w]ith flexible supports, people with serious mental illness can live in housing of their choice, just like any other member of the community." However, state officials, providers, and advocates universally report that there is a critical, unmet need for PSH in Kentucky—and in Louisville in particular. Kentucky reportedly contracts with the CMHC and one other community provider to deliver housing supports to about 70 adults with SMI in Louisville. This other community provider, and other nonprofits in Louisville, also operate PSH using other funds. Still, the capacity for PSH is insufficient.

Kentucky officials and providers confirm that, for Kentuckians with SMI, one of the greatest needs is PSH, and that this need has persisted for years. Officials and providers also say that housing is "the biggest barrier for anyone getting out of a hospital," and that insufficient access to PSH results in inappropriate discharges to emergency shelters and other congregate settings. Additionally, staff at one local hospital said that they have many patients who return a week or two after discharge simply because they do not have a place to go. One provider compared the issue to a game of musical chairs, explaining there are many more adults who

need PSH than there are chairs and the only question is, "who's going to be left out when the music stops?" According to a senior DBHDID official, "it's often stable housing that is preventing us from supporting a person" in their recovery. But it "has been a persistent challenge to get it recognized as a priority."

The need for PSH is exacerbated by a "huge deficit in affordable housing." The Louisville Metro government committed $32 million to the development of PSH units. But city officials estimate that much more is needed. Providers agree the PSH investments are "a drop in the bucket" compared to the need, and a DBHDID official says staff have been "waiting, asking, and screaming for more supported housing."

Comprehensive Community Support Services (CCS) refers to a state-created service that covers a range of activities that allow people with mental illness to live with maximum independence in the community. The service is designed to be provided in a person's home or other community locations, and may include "a variety of psychiatric rehabilitation techniques to improve daily living skills, self-monitoring of symptoms and side effects, improve emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills."[28] According to Kentucky guidance, CCS can be provided up to three hours per day. If utilized, it has the potential to offer the kind of flexible, in-home supports, such as daily visits and medication management, that could help many people with SMI avoid hospitalization.

However, Kentucky's Medicaid claims data show that even among the highest utilizers—people who experienced three or more stays or spent at least 45 cumulative days in psychiatric hospitals in Louisville over the course of a year—fewer than six percent have received CCS in Louisville at any point during a recent three-year period. On average, these individuals received less than 20 hours of CCS over the course of an entire year—or less than two hours per month.

Case Management services are intended to help people obtain needed supports and services. This includes conducting comprehensive, periodic assessments of the person's needs and goals; developing an individualized service plan based on those assessments; arranging for needed services; ensuring services are adequate; and monitoring the person's progress. Case management may be provided on its own, or as part of a package of services such as PSH. Kentucky offers standalone Targeted Case Management (TCM) services that are specifically designed for people with intensive needs, such as people with SMI. Kentucky funds TCM for adults with SMI through a combination of Medicaid, federal block grant, and state funds. Caseloads for this service may not exceed 25 people. Senior Kentucky officials recognize that TCM is a "critical benefit for people with SMI," which can be instrumental in ensuring people remain engaged in the healthcare system and have access to medication and services. It can also help people obtain housing, employment, and transportation.

Kentucky considers TCM for adults with SMI "a critical need" statewide. Louisville's CMHC agrees that there is a great unmet need for the service, reporting that individuals may have to wait months before receiving TCM. Indeed, Louisville's CMHC serves approximately 42 percent of all adults with SMI in their seven-county catchment area, most of whom reside in Louisville. Yet, in State Fiscal Year 2022, they provided TCM to only nine percent of their Louisville clients

[28] *Kentucky State Plan under Title XIX of the Social Security Act,* Kentucky Cabinet for Health and Family Services, Department for Medicaid services, Attachment 3.1-A Page 7.6.1(w), *available at* https://perma.cc/6Z9N-T8TS.

with SMI. And Kentucky's Medicaid claims data show that among the highest utilizers of psychiatric hospitals, less than half received TCM in Louisville at some point during a recent three-year period. Providers also report that even when TCM is provided, it is often not delivered with the frequency and intensity needed to prevent avoidable hospitalization.

Peer Support Services are provided by individuals with lived experience of SMI, SUD, or both, who are in recovery and certified by the State to work with other mental health professionals to support people with SMI. Peer support specialists may lead therapeutic groups, meet individually with clients, engage in outreach, and assist people with navigating community resources. Services can be provided at the provider's location or in the person's own home. Peer support specialists can also help people gain meaningful social connections, which can be crucial to recovery.

Kentucky funds peer support services through a combination of Medicaid, federal block grant, and state funds. But peer support services do not appear to be sufficiently available. A large majority of the individuals we reviewed would benefit from peer support services. Several had not heard of peer support services but were receptive to receiving them once we explained. Among the highest utilizers—people who experienced three or more stays, or spent at least 45 cumulative days, in psychiatric hospitals in Louisville over the course of a year—less than 40 percent received peer support services in Louisville at any point during a recent three-year period. And Louisville currently has no peer-run drop-in centers, which are community-based locations that provide a welcoming environment and a wide range of meaningful activities and social supports. This is despite the need for more social opportunities for people with SMI. In fact—other than a well-regarded provider funded by Kentucky whose service delivery model incorporates relationship building and socialization—services aimed at addressing isolation and providing access to meaningful activities for people with SMI are generally lacking in Louisville. An expansion of the State's use of peers could address this gap.

Supported Employment is a service that assists people with SMI in attaining integrated, paid, competitive employment, and provides supports to help them do well in the job. Individual Placement and Support (IPS) is an evidence-based supported employment model. A key tenet of IPS is that everyone with SMI can work and everyone with SMI is eligible for the service right away. 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.[29] According to state planning documents, IPS is one of the services Kentucky offers to divert people with SMI from institutions and is "crucial to its recovery oriented system of care." State employees and providers agree that IPS can prevent hospitalizations. One former state official

> "[W]hen a person with SMI has some productive things to do and they're working at a job they love and making money and able to support themselves, that's a very effective program in keeping people out of mental hospitals."
>
> – Former Kentucky State Official, describing IPS

[29] *Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment*, IPS Employment Center 5 (updated Jul. 4, 2022), *available at* https://perma.cc/N982-VZLT

emphasized that it is "a very effective program in keeping people out of mental hospitals."

Kentucky contracts with providers in Louisville to offer IPS. The State has identified a great need for both supported employment and supported education statewide and plans to make Medicaid funding available for both services through an amendment to its Medicaid State Plan.[30]

a. Kentucky Provides Insufficient Access to the Community-Based Crisis Services Needed to Prevent Hospitalization

Serious mental illness can be episodic, with symptoms that can change over time. With a sufficient crisis response system, people can often manage mental health crises without hospitalization. Conversely, the absence of such a system often leads to unnecessary reliance on psychiatric inpatient hospitals and law enforcement.[31]

Community-based crisis services decrease psychiatric emergency department visits, psychiatric hospitalizations, encounters with law enforcement, arrest rates, and incarceration.[32] Essential crisis services are available 24/7 and include: a regional clinically staffed crisis call center that provides crisis intervention capabilities; mobile crisis response teams available to reach any person, anywhere in the community in a timely manner; and crisis stabilization settings, which provide short-term observation and stabilization services in a home-like, non-hospital environment. Effective crisis systems allow for "seamless transitions" to connect people in crisis to longer-term mental health care.

Kentucky acknowledges the vital importance and effectiveness of crisis services and offers funding for these important crisis system components. However, as Kentucky said in a 2021 grant application, Louisville's need for crisis system improvements is "dire." And in an assessment of crisis services, Kentucky acknowledged "a need for a more coordinated statewide delivery and financing of [crisis] services."[33] Despite some efforts to improve services, including making changes to its Medicaid State Plan and seeking an outside entity to oversee the crisis system, critical gaps in crisis services in Louisville remain.

These deficiencies result in needless EPS visits and hospitalizations. They also result in avoidable law enforcement encounters and incarceration, as discussed further in Section B. Among the individuals we reviewed, we found that many psychiatric hospitalizations could have been avoided with access to appropriate crisis services.

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[30] Supported education is a service that assists people with SMI with pursuing their individual educational goals by helping them plan, prepare for, enroll in, finance, and complete an educational program. It is offered in tandem with supported employment. *See Supported Education: Building Your Program,* Substance Abuse and Mental Health Services Administration 9-10 (2011), available at https://perma.cc/2XT4-QKEB .

[31] *National Guidelines for Behavioral Health Crisis Care*, Substance Abuse and Mental Health Services Administration, 8 (2020), available at https://perma.cc/L7N2-MNUY.

[32] *Id. at 10-12, 39*.

[33] *Kentucky Mobile Crisis Intervention Services Needs Assessment*, Kentucky Cabinet for Health and Family Services, 189-90 (April 2022), https://perma.cc/J3JA-4LM4.

Regional call centers "offer real-time access to a live person every moment of every day for individuals in crisis" and "provide telephonic crisis intervention services to all callers."[34] They should "dispatch[] support based on the assessed need of the caller."[35] Direct dispatch from the regional call center allows for efficient connection to mobile crisis teams.

While Kentucky requires its CMHCs to operate a 24/7 crisis hotline, Louisville's crisis hotline has remained insufficiently funded and staffed despite efforts to increase staffing.[36] As a result, many calls to this hotline are directed to out-of-state answering services, where staff may not be familiar with local service providers. It is important for local agencies to answer crisis calls that originate in their area because they are better equipped to refer callers to the appropriate resources. But in Louisville, the rate of calls answered in-state is the lowest of any call center in the Commonwealth.

Hotline staff have also reported delays in answering, which can result in unnecessary admissions to emergency rooms or jails or even deaths. These delays can also lead to potentially unnecessary law enforcement response. For example, one individual reported reaching out to the crisis hotline and waiting on hold for minutes before disconnecting. He proceeded to call 911 for support and law enforcement transported him to the hospital. Another person described past experiences calling the crisis hotline for assistance, only to have police respond. Though he reported believing that crisis services would have helped him avoid hospitalizations, he was hesitant to call due to those experiences. Despite Kentucky's acknowledgement of deficiencies with the crisis hotline in Louisville, a state official reported that there currently was no plan to improve the answer rate, no corrective action plans had been issued, and there were no efforts to review the quality of the crisis hotline's answered calls.

Mobile crisis teams are two-person teams that include a clinician and offer 24/7 "community-based intervention to individuals in need wherever they are."[37] When in place, they can reduce psychiatric hospitalizations, encounters with law enforcement, and incarceration. Kentucky has established a Medicaid billing code for mobile crisis services and, on paper, requires CMHCs to provide 24/7 access to crisis intervention.

Despite this requirement, access to mobile crisis services is limited in Louisville. Medicaid data show that billing for mobile crisis services in Louisville is nearly non-existent for adults with SMI. Among the highest utilizers of psychiatric hospitals, Medicaid billing data showed *no* use of mobile crisis services at any point during a recent three-year period, and little use of other crisis

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[34] *National Guidelines for Behavioral Health Crisis Care*, Substance Abuse and Mental Health Services Administration, *supra* note 31, at 14 (2020).

[35] *Kentucky Mobile Crisis Intervention Services Needs Assessment*, Kentucky Cabinet for Health and Family Services, *supra* note 33, at 53 (quoting *National Guidelines for Behavioral Health Crisis Care*, *supra* note 31, at 39).

[36] The crisis hotline in Louisville includes the National Suicide Prevention Hotline, which is now known as the Suicide and Crisis Lifeline, and other hotlines answered through the CMHC's regional call center. We refer to these hotlines collectively as "crisis hotline" in this report. In July 2022, 988 became the new dialing code for the Suicide and Crisis Lifeline nationwide.

[37] *National Guidelines for Behavioral Health Crisis Care*, Substance Abuse and Mental Health Services Administration, *supra* note 31 at 18.

intervention services.[38] And CMHC reports indicate that only two people with SMI received mobile crisis services in Louisville in Fiscal Year 2022. As one prominent behavioral health provider told us, there is a "huge gap in crisis response, especially mobile crisis response." State officials acknowledge that Louisville critically needs mobile crisis services. For Henry, a talented musician whose band plays in local venues on the weekends, mobile crisis could have kept him in his community. Henry has been hospitalized at least six times since 2019, with each hospitalization lasting between three and seven days. He stated, "I don't think I've been in the hospital for anything that a mobile crisis [team] couldn't handle."

Louisville Metro Government has also recognized the need for mobile crisis services. In the absence of services provided through Kentucky's mental health system, Louisville Metro funded a pilot program, and later expanded it, to make mobile crisis teams available throughout the city part of the day. It recently announced that it would operate twenty-four hours a day as of July 1, 2024. These mobile crisis teams are dispatched through the 911 call center.[39] Kentucky has not been closely involved with the development or implementation of this new program. The program has limited eligibility criteria and is not directly connected to the crisis hotline, and community members have raised concerns about the program's sustainability. Moreover, aside from Louisville Metro's new program, there have been no mobile crisis teams for adults with serious mental illness in Louisville. This means that, at least until recently, for the part of the day when Louisville Metro's program was not operating, there were no mobile crisis teams for adults with serious mental illness in Louisville at all.

In any case, the critical lack of mobile crisis services in Louisville often leads individuals with SMI, their family members, and their mental health providers to turn to law enforcement and EPS when a mental health crisis occurs. For example, 34-year-old Kenneth has had several recent hospitalizations at CSH and local Louisville hospitals. Most recently, he was admitted to CSH after the police came to his house and brought him to EPS in handcuffs, which he said is a scary experience. Kenneth was living in a boarding house with seven roommates. Kenneth told us that when he and his roommates experience mental health crises, the only option they were aware of was to call 911.

Crisis Stabilization and Crisis Respite are non-hospital, community-based settings that offer 24/7 access to mental health and substance use care; they accept walk-ins and provide screening and assessments onsite. Crisis stabilization services "are a cost-efficient alternative"

[38] Indeed, a state report indicated that, of total crisis intervention spending statewide, only four percent was on mobile crisis intervention (MCI) services—which are defined to include crisis lines, mobile crisis teams, and crisis receiving and stabilization facilities—showing "very limited MCI service utilization." *Kentucky Mobile Crisis Needs Assessment*, Kentucky Cabinet for Health and Family Services 16-17 (April 2022), https://perma.cc/J3JA-4LM4. According to another state report, the "'spotty' coverage of behavioral health services" available in Kentucky "is not adequate to serve the needs of Kentuckians in crisis." *Kentucky Community Crisis Co-Response (CCCR) Model Stakeholder Engagement and Research Report*, Kentucky Cabinet for Health and Family Services 59 (June 15, 2023), https://perma.cc/8DA3-6QLD.

[39] Stakeholders have raised concerns that the only option for dispatching a mobile crisis team is through 911, because many community members refuse to call 911 due to fear of the police.

to emergency departments "and can reduce incarceration and hospitalization costs."[40] They can be provided in apartments and other home-like settings.

In Louisville, a behavioral health organization provides residential crisis stabilization services in two small, home-like environments. Combined, they can serve up to 18 people at a time, but this option does not allow for walk-ins or for police drop-off. Although Kentucky allows for this service to be funded through Medicaid, recent Medicaid billing data show that even among the highest utilizers of psychiatric hospitals in Louisville, fewer than 14 percent used residential crisis stabilization services in recent years.

In addition, the Kentucky Cabinet for Health and Family Services has recommended implementing the "Living Room Model"[41] of crisis stabilization, which it says "is designed to reduce mental health emergency room visits" and is "comprised of small units [that] are open to the public, catering to clients who need help due to behavioral health concerns."[42] Louisville Metro Government previously funded a Living Room for about a year, but it closed when that funding ended,[43] leaving no similar service in the Louisville area.

However, as part of its new mobile crisis program, Louisville Metro began funding a 23-hour respite center that can provide crisis respite services to people who are connected to it through the program's mobile crisis response teams, but the center serves a small fraction of those served by the broader program, because it has limited capacity.

State officials, community-based mental health providers, judges, hospital staff, homelessness services providers, police officers, and family members of people with serious mental illness have all identified crisis respite services and expanded crisis stabilization capacity as a central need in Louisville. One provider for homelessness services stated that "what we're lacking is a crisis place, without going to hospital. There's no between." The State has published a related assessment about crisis services statewide, *see* Section C, which provides some information about available services. However, officials did not know of any assessment of the need for crisis stabilization services in Louisville and told us that Kentucky had no plan to ensure coverage of crisis stabilization and practiced little oversight of the crisis stabilization services that are offered.

> "What we're lacking is a crisis place, without going to hospital. There's no in between."
>
> - Employee at Local Shelter

[40] *Kentucky Mobile Crisis Needs Assessment*, Kentucky Cabinet for Health and Family Services 122 (April 2022), https://perma.cc/J3JA-4LM4.

[41] The Living Room Model provides welcoming and voluntary crisis stabilization support in a home-like environment. The services associated with the Living Room model are rooted in the recovery model with a focus on autonomy, respect, hope, and empowerment. The Living Room is often peer-led but can have a combination of peer and clinical staff.

[42] *Kentucky Mobile Crisis Needs Assessment*, Kentucky Cabinet for Health and Family Services 183 (April 2022), https://perma.cc/J3JA-4LM4.

[43] Louisville Metro requested funding from the Commonwealth, but it was not granted.

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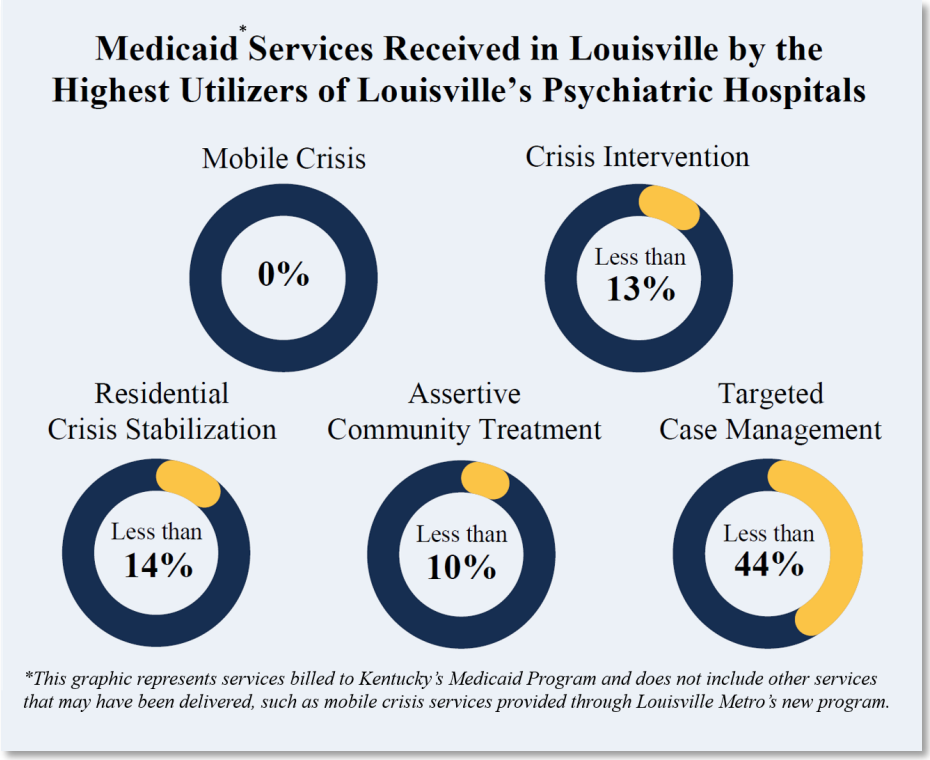
In sum, access to critical crisis services and other community-based services that are known to reduce psychiatric hospitalizations is insufficient in Louisville. As highlighted below, Kentucky's Medicaid billing data during a recent three-year period show that even among the highest utilizers of Louisville's psychiatric hospitals—people who experienced three or more stays, or spent at least 45 cumulative days, in psychiatric hospitals in Louisville over the course of a year—a small percentage received key services in Louisville at any point during a recent three-year period.



7. Kentucky Fails to Ensure that People Are Connected to Needed Community-Based Services After Hospitalization

Discharge planning is the process that should begin soon after admission to identify and connect people to the services and supports that will meet their needs in the community and prevent hospital readmission. Effective discharge planning requires close coordination between hospital staff, community providers, and the individual. In addition, it must be individualized and account for the person's preferences and their ability to access the services. As Kentucky acknowledged in a recent application to SAMHSA, "a well-planned aftercare process is the key to ensuring a successful transition from the psychiatric hospital and other facilities" and "is critical to reducing hospital readmission rates, enhancing community housing tenure, and ultimately improving quality of life."

According to a Kentucky state official, coordination between the hospitals and community providers should be "seamless," but instead it is "not consistent." "I find it extremely difficult to coordinate with anybody in some of the hospitals," said an official from one of Louisville's

community providers. Our review found insufficient coordination between psychiatric hospitals and individuals' existing providers, outside of ensuring an appointment was scheduled at the time of discharge, even though involving community-based providers in discharge planning early leads to better outcomes.

Louisville's CMHC staff are present at CSH at least twice a week to work with the hospital staff and engage patients in discharge planning.[44] But they are not usually included in the hospital's discharge planning meetings and they do not always assess people for needed community-based services before they are discharged. The CMHC does not have a physical presence at other Louisville hospitals, and CMHC staff report that their role in discharge planning is minimal. Though CMHC staff said having a team embedded in each of the hospitals to boost communication would help reduce readmissions, Kentucky has taken no steps to support or encourage a partnership between CMHCs and local hospitals.

Kentucky has the ability to manage discharge planning at local psychiatric hospitals, for instance through its state regulation and licensing and through MCO contracts, which already require the MCOs to participate in the process. Instead, at CSH and other local hospitals that provide in-patient services, discharge plans often involve an office appointment with Louisville's CMHC for follow up one to two weeks after discharge, regardless of whether the person had an immediate housing need or need for intensive in-home services like ACT or medication monitoring immediately upon discharge.

For example, David, who has been hospitalized at least 19 times in the last six years, had multiple discharges where he was sent home in a cab with "follow up with provider" as the outpatient plan. As discussed in Section A.5, in-office appointments are not always a realistic option. And key community providers report that they are not reliably notified when their clients discharge from hospitals, which reduces the amount of time they have to engage the client and can make it difficult to connect with the client altogether. This is because some clients—especially those who are unhoused or unstably housed—are harder to find once they are discharged. In practice, people discharged from psychiatric hospitals in Louisville are not consistently seen by the CMHC or their MCO within the contractually required 7 and 14-day timeframes.

In addition, a lack of sufficient community-based services resulted in individuals being hospitalized longer than necessary and then discharged to inappropriate or substandard settings. At times, individuals remained hospitalized after their records indicate they were ready for discharge. These same individuals were then discharged to shelters, hotels, and other substandard or congregate settings with only an outpatient appointment, despite their need for more intensive community services and more integrated housing. From July to November 2022, 15% of CSH patients were discharged to a shelter, which is a placement associated with frequent readmissions.

[44] Kentucky recognizes the importance of limiting long, repeated stays in psychiatric hospitals. To this end, it hosts recurring meetings to focus on specific people with SMI who have experienced such stays—typically people who are currently in a state hospital and have been there for 90 days or more. These meetings, while commendable, address the individual circumstances of a small number of people. They are not designed to identify or address larger system issues that may be contributing to unnecessary hospitalizations.

B. The Absence of Community-Based Mental Health Services Contributes to Avoidable Law Enforcement Encounters and Incarceration

Law enforcement officers are the primary responders to behavioral health crises in Louisville due to the lack of crisis and other mental health services.[45] As Kentucky acknowledges, such encounters often result in law enforcement officers "taking these individuals into custody (e.g., jail, EDs, or mental health facilities), often due to a lack of more appropriate alternatives and resources to address the needs of the individual."[46] LMPD officers, other first responders, and behavioral health providers report that taking people in crisis to hospitals or jail are the options available after LMPD responds.

Many people experience a combination of law enforcement encounters, hospitalization, and incarceration. One example is Jack, a Louisville man who has been repeatedly admitted to psychiatric hospitals. One of Jack's family members, Kelly, told us that he had eleven hospitalizations in less than eleven months, lasting a total of 114 days, as well as dozens of emergency room visits over the past few years seeking help for mental health crises. Kelly reported that Jack's mental illness has led him to engage in behaviors resulting in dozens of law enforcement encounters and criminal charges. Most of his charges were misdemeanors and violations such as trespassing and disorderly conduct. Kelly told us of her desire for community-based services as a way to avoid hospitalizations and encounters with the criminal justice system.

Like Kelly, people with serious mental illness and their family members, medical and behavioral health providers, and Louisville Metro Government employees, have told us there is nobody they can call when there is a behavioral health crisis, other than the police. Indeed, our investigation of Louisville Metro Government and LMPD, revealed that thousands of calls handled by LMPD each year "could be safely and more effectively resolved through a response by behavioral health professionals, such as a mobile crisis team, or with co-responding behavioral health professionals paired with appropriately selected and trained officers."[47] Louisville Metro Government's new mobile crisis program, while a positive step, is insufficient to meet the need. A source with direct knowledge of the program told us that an overwhelming majority of calls that could be addressed by a behavioral health response are still dispatched to LMPD. Kentucky has acknowledged that "individuals with behavioral health disorders increasingly encounter law enforcement, potentially exposing them to increased trauma,

[45] *Investigation of the Louisville Metro Police Department and Louisville Metro Government*, United States Department of Justice 59, 61 (March 8, 2023), https://perma.cc/DV43-VXD2.

[46] *Kentucky Community Crisis Co-Response (CCCR) Model Stakeholder Engagement and Research Report*, Kentucky Cabinet for Health and Family Services 59 (June 15, 2023), https://perma.cc/8DA3-6QLD.

[47] *Investigation of the Louisville Metro Police Department and Louisville Metro Government*, United States Department of Justice 59-60 (March 8, 2023), https://perma.cc/DV43-VXD2.

In State Fiscal Year 2022,

16%

of people admitted to psychiatric hospitals in Louisville were also held in the local jail.

hospitalization, arrests, and incarceration."[48] In Louisville, this law enforcement contact also exposes people to further potential civil rights violations.[49]

In addition, the lack of community-based services in Louisville and the resulting law enforcement response to behavioral health issues contributes to the avoidable arrest and incarceration of people with serious mental illness. Indeed, state officials told us that some individuals with serious mental illness are incarcerated for minor charges when they would be better served in the mental health system. According to an external investigation commissioned by Louisville Metro Government, Louisville Metro Detention Center (LMDC) "is considered the biggest mental health and detox facility in the Commonwealth."[50] Many people cycle in and out of jail with low-level charges due to mental health needs. A Louisville Metro Detention Center official told us that jail staff "grow up with" people frequently booked into LMDC, who "are doing life on an installment plan." One person is Diego, who was booked in LMDC at least 31 times in two years and held for 39 days; during the same two-year period, he was admitted three times to psychiatric hospitals for 122 days. Over the last several years, the vast majority of his charges were for low-level offenses such as criminal trespassing for refusing to leave a business.

The report of our investigation into LMPD and Louisville Metro Government described one man's experience highlighting this issue. He had an apparent serious mental illness and more than 25 LMPD encounters between March 2020 and January 2022.[51] All of those encounters appeared related to his disability and could have been handled by a behavioral health-focused response. But LMPD arrested him at least 18 times during this period and took him to a psychiatric hospital at least another four. He was admitted to inpatient hospitals at least three times between May 2020 and October 2021, concluding in a stay at Central State Hospital for more than two months. Less than three weeks following his discharge from Central State Hospital, he was arrested by LMPD after refusing to leave a business, and died four days later in LMDC.

He was not the only person with a mental illness who died in LMDC. Another 15 people died there between November 2021 and August 2023, many by suicide or suspected overdose. A Louisville Metro-commissioned investigation found that a contributing cause of deaths at the jail was the "[l]ack of readily available alternatives to jail incarceration for person[s] suffering from

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[48] *Revised Notice of Funding Opportunity, Kentucky Community Crisis Co-Response Grant Program*, Kentucky Cabinet for Health and Family Services 3, https://perma.cc/M9GD-RY9X (last visited Mar. 27, 2024).

[49] *See Investigation of the Louisville Metro Police Department and Louisville Metro Government*, United States Department of Justice (March 8, 2023), at 60-64, https://perma.cc/DV43-VXD2

[50] David J. Beyer, *Investigation into Deaths at Louisville Metro Corrections Department*, Louisville Metro Council 375 (April 10, 2023), https://perma.cc/TBF4-JXFL.

[51] *Investigation of the Louisville Metro Police Department and Louisville Metro Government*, United States Department of Justice 60 (March 8, 2023), https://perma.cc/DV43-VXD2

mental health issues."[52] LMDC officials agree that a lack of alternatives, including ACT and other intensive in-home services, is leading to incarceration at the jail. As one official said, "Does a person need to go to jail? Many times, no. But we don't have a place to send them."

Although some people may be transferred from LMDC to a psychiatric hospital for needed assessments or care, the examples above point to the fact that the criminal justice system and the mental health system in Louisville overlap to a striking extent. In fact, our analysis of LMDC and hospital admissions data revealed that, in State Fiscal Year 2022, at least 637 people were admitted to both LMDC and a psychiatric hospital at least once—16 percent of all people who had a psychiatric hospitalization in Louisville. On average, these people had four admissions to psychiatric hospitals or LMDC that year. Some were admitted as many as 25 times. On average, people who were admitted to both psychiatric hospitals and LMDC spent 54 nights out of the year in institutional settings. While some of these people faced serious charges, the most common charges were nonviolent, low-level offenses: failure to appear for a misdemeanor citation, criminal trespass, probation violation for a misdemeanor offense, and disorderly conduct.

The avoidable incarceration of people with serious mental illness hurts them in other ways, including potentially causing them to lose housing and healthcare and to re-enter psychiatric institutions. Moreover, incarceration can exacerbate individuals' mental illness. As an LMDC official stated, the jail "is a deplorable place to house mental health inmates. . . That the facility and what it has to offer to mental health patients [are] completely contrary to everything that is conducive to therapeutic benefits to mental health patients."[53]

C. Kentucky Does Not Meaningfully Assess the Capacity of Community-Based Services or Ensure the Development of those Services

Kentucky fails to conduct the meaningful evaluation, planning, and implementation needed to understand and address the gaps in its service system for people with serious mental illness and other behavioral health disabilities. None of the senior DBHDID officials we interviewed were aware of any efforts to assess the capacity or need for community services for people with SMI in Kentucky, beyond CMHC contract monitoring and a "general needs assessment" that is completed every two years as part of the application for federal Community Mental Health Services Block Grant funding. DBHDID relies primarily on CMHC data about the services used even though many adults with SMI receive services from other providers. This not only presents an incomplete picture of service utilization, it says nothing about service *needs*. [54]

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[52] David J. Beyer, *Investigation into Deaths at Louisville Metro Corrections Department* 12 (April 10, 2023), https://perma.cc/TBF4-JXFL. The report found that primary causes of these deaths include prior leadership deficiencies, an inadequate facility and staffing, failures in adherence to security protocols, and a deficient medical care program at LMDC.

[53] David J. Beyer, *Investigation into Deaths at Louisville Metro Corrections Department*, Louisville Metro Council 270-79 (April 10, 2023), https://perma.cc/TBF4-JXFL.

[54] DBHDID program administrators monitor CMHC compliance with contract requirements related to specific services. In connection with this, DBHDID receives reports that show the total number of people receiving CMHC services and the client to staff ratios. However, DBHDID does not assess whether the

And although Kentucky's Department of Medicaid Services has access to data about other Medicaid-funded providers, it does not assess whether mental health services are available as needed except where this is required as part of federal reporting. When conducted, these assessments typically focus on select programs, and do not provide a comprehensive view the service system's capacity. For example, Kentucky published a Mobile Crisis Intervention Services Needs Assessment in April 2022, which resulted in some findings regarding deficiencies in the crisis system, including minimal utilization, limited provider awareness, and issues with billing practices. However, state officials acknowledge that it provided insufficient detail. Moreover, the assessment did not even purport to determine the additional crisis services needed in Louisville, and in fact inaccurately reported the availability of crisis services in that county.[55]

Across DBHDID and DMS, we found limited analysis of service capacity. For example, although Kentucky acknowledges the surprisingly low utilization of ACT, we found no meaningful efforts to assess whether the capacity of ACT is sufficient to meet the need in Louisville or statewide, and no plans to expand access to the service. To date, neither State officials nor community providers could identify anyone who conducts a broader analysis of the service system's capacity.

Further, even though multiple state Departments, community providers, and MCOs play a role in the delivery of mental health services, there is no coordinated process that brings these groups together for system planning and acts on that planning. The State reportedly depends on local providers and community leaders to drive this effort, without building the partnerships needed to do so.[56]

Without more information, Kentucky cannot effectively oversee MCOs and community providers, or ensure that people with SMI receive the community-based services needed to avoid hospitalization. Although Kentucky relies on local hospitals to serve the majority of adults who are hospitalized for mental health care in Louisville, senior officials admit they exercise no oversight over local hospitals, do not monitor the frequency of admissions to these facilities, and do not collaborate with them to ensure *Olmstead* compliance. In sum, Kentucky does not appear to monitor the full extent of psychiatric hospitalizations among adults with SMI, nor does it appear to have any measurable goals to reduce the unnecessary reliance on these facilities.

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capacity of these services is sufficient to meet the need, and it does not require regular reporting from the CMHCs about this. Rather, it relies on the CMHCs to elevate concerns. Moreover, while the CMHC responsible for Louisville assesses its own ability to accept referrals, it does not assess the capacity of other providers or the needs of the overall population in the area.

[55] One recent federal funding opportunity should have prompted a comprehensive needs assessment. The Louisville CMHC was selected to participate in a 2-year federal Certified Community Behavioral Health Clinic (CCBHC) demonstration program beginning in 2022. The program was created to provide robust community-based treatment to anyone who requests care for mental health or substance use. As part of the demonstration, Kentucky was required to complete a community needs assessment regarding the availability and accessibility of services, and the cultural, linguistic, and treatment needs of the population, and certify that the selected CCBHCs were ready to implement the model. However, staff charged with overseeing the demonstration report that the assessment completed thus far was based on outdated information and was not as comprehensive as it should have been. Staff have said a more comprehensive needs assessment is planned, but they reported inconsistent timelines for completing it.

In addition, Kentucky does not appear to use data to assess its overall reliance on institutional versus community-based services for people with SMI, or the extent of other potentially harmful outcomes that may stem from gaps in the community system. For instance, Kentucky does not monitor the extent of repeat emergency department visits among adults with SMI, even though senior officials acknowledge this indicates a risk of psychiatric hospitalization. Further, although officials believe reliance on "chaotic" hospital-based emergency departments could be reduced with access to other crisis services, Kentucky does not appear to have established measurable goals related to reducing these visits.

And while Kentucky knows that law enforcement responses to mental health crises may expose individuals to "trauma, hospitalization, arrests, and incarceration,"[56] see Section B, it has not collaborated with local law enforcement to assess the frequency of those encounters among adults with SMI in Louisville. Kentucky also lacks qualitative measures on other outcomes—like people's ability to retain housing and employment and avoid incarceration—which are relevant to understanding whether its service system is meeting people's needs.

D. Kentucky Can Reasonably Modify its System

States must reasonably modify their service systems to avoid discrimination on the basis of disability.[57] Kentucky 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 psychiatric hospitals. Such modifications would allow people with SMI to live and thrive in their own homes and communities instead of entering institutions to access appropriate care.

Kentucky has established many of the community-based services needed to support individuals with serious mental illness in the most integrated setting appropriate to their needs. It already provides a combination of federal and state funding for mobile crisis, crisis intervention, residential crisis stabilization services, ACT, peer support, supportive housing assistance, supported employment, targeted case management, and individualized community support services. However, as demonstrated above, these services are frequently unavailable or inaccessible in Louisville, and Kentucky has not assessed what is needed in Louisville or ensured the development of these services.

Increasing the availability of these vital community-based services would be consistent with Kentucky's own goals and plans. Kentucky has identified a range of services that it should provide to support adults with SMI who are at-risk for institutional care. Services like ACT, peer support, targeted case management, and crisis services are already part of Kentucky's Medicaid State Plan, allowing it to leverage federal Medicaid funds to help pay for them. Kentucky accepted federal funding to expand Medicaid coverage starting in 2014, significantly decreasing the number of uninsured Kentuckians. The federal government reimburses Kentucky for roughly 72 percent of traditional Medicaid recipients' healthcare costs, and 90 percent of the costs for expansion recipients. Further, Kentucky is currently preparing an

[56] *Revised Notice of Funding Opportunity, Kentucky Community Crisis Co-Response Grant Program Kentucky Cabinet for Health and Family Services 3*, https://perma.cc/M9GD-RY9X (last visited Marrch 27, 2024).

[57] *See* 28 C.F.R. § 35.130(b)(7)(i); *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999).

amendment to its State Plan to help fund additional services it found are most needed, including: In-Home Independent Living Supports; Tenancy Supports; Supported Employment and Supported Education; Transportation; Medication Management; Assisted Technology; and Planned Respite for Caregivers. [58] Kentucky is also planning changes aimed at increasing the availability of crisis services.

These are important steps toward expanding access to these services, which Kentucky recognizes are not sufficiently available. However, as with its existing service array, it will be critical both to make services Medicaid reimbursable so that more people can access them, and also to ensure that people who experience repeated crises and hospitalizations actually receive the services they need to break that cycle.

Further, Kentucky has acknowledged that a failure to provide community-based mental health services leads to increased costs. A recent budget request for DBHIDID stated: "Investment in mental health services is critical. Failure to provide adequate mental health services has an economic impact due to the higher cost of care for unnecessary emergency room visits and preventable psychiatric hospitalizations. . . An investment in behavioral health services can decrease costs to other areas of state and local government, and society overall." High-level officials agree that intensive community-based services are cost-effective.

Kentucky could serve adults with serious mental illness in Louisville 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 Kentucky should ensure are available and accessible include mobile crisis, crisis stabilization, ACT, peer support, permanent supportive housing, supported employment, targeted case management, transportation, and individualized community support services.

- **Ensuring that integrated, permanent, affordable housing options are accessible and available in sufficient quantities to prevent unnecessary institutionalization.** This would include adequate funding for permanent supportive housing. Kentucky should evaluate and implement strategies to expand permanent supportive housing for adults with SMI.

- **Ensuring that people are connected to meaningful community-based services during and after hospitalization, in the appropriate intensity to meet their needs and avoid unnecessary hospitalizations.** This would include conducting oversight to

[58] This amendment was developed in response to advocates' concerns, and legislation directing the Cabinet to pursue a solution. Specifically, in May 2021, Kentucky's Legislative Research Commission established a Severe Mental Illness Task Force to assess, among other things, the availability of adequate treatment options and affordable housing for adults with severe mental illness. The Task Force highlighted that Kentucky is not taking full advantage of Medicaid funding for important services such as supported housing and supported employment. Following the Task Force's recommendations, the Legislature passed a joint resolution declaring an emergency, and directing the Kentucky Cabinet for Health and Family Services to apply for Medicaid funding to make these services reimbursable. Governor Beshear signed the Joint Resolution into law on March 30, 2022.

facilitate rapid and comprehensive assessments and discharge planning across all psychiatric hospitals in Louisville, coordination with relevant community providers throughout the discharge planning process, and connection to appropriate community-based services.

- **Ensuring appropriate diversion from psychiatric hospitals, law enforcement contact, and incarceration for people experiencing a mental health crisis or hospitalization.** This would include connecting people who are experiencing a crisis to community-based crisis services to avoid law enforcement contact, hospitalization, and incarceration, whenever appropriate. It would also include connecting people who have experienced crises to longer-term intensive community-based services.

- **Ensuring meaningful assessment, development, and oversight of its mental health service system.** Kentucky should develop a reliable system for assessing the extent of the need, develop a strategy for ensuring it can meet the need, and oversee local providers to ensure these services are provided with sufficient quality and intensity to avoid unnecessary institutionalization. Throughout this process, it should consider input from adults with lived experience in assessing and adjusting its service array.

CONCLUSION

We conclude that there is reasonable cause to believe that Kentucky fails to provide services to Louisvillians with serious mental illness in the most integrated setting appropriate, in violation of the ADA. Because of deficiencies in its community-based service array, and the manner in which Kentucky administers its adult mental health system, it relies unnecessarily on segregated psychiatric hospitals to serve adults with serious mental illness who could be served in their homes and communities.

We look forward to working cooperatively with Kentucky to reach a resolution of our findings. We are required to advise you that if we cannot reach a resolution, the United States may take appropriate action, including bringing 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.