# KEEPING THE MENTALLY ILL OUT OF JAIL: SHERIFFS AS LITIGANTS

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## INTRODUCTION

In March 2014, Congress convened a hearing titled "*Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage*."[1] Cook County Sheriff Tom Dart testified "[s]ince becoming Sheriff in 2006, I have seen an explosion in the percentage of seriously mentally ill individuals housed in the jail."[2] "I usually have about 3,500 mentally ill in my jail in a day."[3] In 2011, Sheriff Dart had announced that he had considered filing a lawsuit against the state for failing to provide services to prevent people with serious mental health problems from ending up in his jail.[4]

The purpose of this paper is to develop a litigation strategy that will help Sheriffs accomplish that goal. The Americans with Disabilities Act (ADA) protects disabled individuals who are at risk of institutionalization.[5] This includes the mentally ill who are at risk of repeated incarceration in jails. They need an advocate to protect their rights under the ADA. Sheriffs and mentally ill inmates share a mutual interest in preventing the endless cycle of incarceration, which makes Sheriffs good candidates to take on the task. As third party litigants, Sheriffs could sue states on behalf of mentally ill inmates to ensure that the inmates receive the services and treatment that are needed to prevent them from returning to jail.

Sheriff Dart and other experts on the panel recommended that the mental health system prioritize treating individuals with the most serious mental illnesses so that the criminal justice system no longer bears the responsibility for their care.[6]

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[1] *Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. On Energy and Commerce,* 113th Cong. (2014) [hereinafter *Hearings*].

[2] *Id.* at 65 (statement of Sheriff Tom Dart).

[3] *Id.* at 152.

[4] *See* Ben Bradley, *Sheriff Dart Considers Suing the State Over Health Issue*, ABC7 EYEWITNESS NEWS (May 22, 2011, 8:14 AM), http://abc7chicago.com/archive/8143042/.

[5] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-01-1167T, LONG-TERM CARE: IMPLICATIONS OF SUPREME COURT'S OLMSTEAD DECISION ARE STILL UNFOLDING 1, 6 (2001) ("The *Olmstead* decision has been widely interpreted to apply to people with varying types of disabilities who are either in institutions or at risk of institutionalization.").

[6] *Hearings, supra* note 1, at 52 (statement of Michael C. Biasotti, Police Chief) ("If I could make one recommendation, it would be to prevent individuals from deteriorating to the point where law enforcement becomes involved. Return care and treatment of the most seriously ill back to the mental health

In many parts of the United States, psychiatric acute and long-term care services are inadequate to meet the needs of people with serious mental illnesses.[7] Many individuals need extended inpatient care to stabilize the symptoms of their illnesses, but public psychiatric hospitals that are equipped for this challenge are virtually non-existent.[8] By default, the criminal justice system has become a substitute for a public psychiatric hospital system that has been dismantled in this country.

The decline in psychiatric care can be traced to the downsizing of public psychiatric hospitals, a process known as "deinstitutionalization," which began in 1955 following the discovery of psychotropic medications.[9] The process accelerated with the enactment of Medicaid in 1965, which provided a means for states to shift costs to the federal government for psychiatric services.[10] States have continued to close psychiatric hospitals to save money and today there are no more than about 40,000 public psychiatric hospital beds left in the United States.[11]

Homeless mentally ill who inhabit city streets and parks are the most visible consequence of deinstitutionalization to the general public. However, few people realize that many of the homeless are talented, bright people who lived full and productive lives before the onset of their psychiatric illnesses.[12] On the other

system. Make the seriously mentally ill first in line for services rather than last. As a law enforcement officer and a father, I know that treatment before tragedy is a far better policy than treatment after tragedy.").

[7] *See* L. ARON ET AL., NAT'L ALLIANCE ON MENTAL ILLNESS, GRADING THE STATES 2009: A REPORT ON AMERICA'S HEALTH CARE SYSTEM FOR ADULTS WITH SERIOUS MENTAL ILLNESS 27, 40 (2009), *available at* http://www2.nami.org/Content/NavigationMenu/Grading_the_States_2009/Findings/NAMI_GTS09_Findings.pdf.

[8] *See* RON HONBERG ET AL., NAT'L ALLIANCE ON MENTAL ILLNESS, STATE MENTAL HEALTH CUTS: A NATIONAL CRISIS 11 (2011), *available at* http://www2.nami.org/Content/NavigationMenu/State_Advocacy/State_Budget_Cuts_Report/NAMIStateBudgetCrisis2011.pdf.

[9] *Hearings, supra* note 1, at 21 (statement of Jeffrey Geller, M.D.).

[10] *Id.* at 23–24 (statement of Jeffrey Geller, M.D.) (Medicaid created an incentive for states to "transfer as many people as the state could from places where states paid dollar for dollar for care and treatment, i.e., state hospitals, to places where states paid only a fraction of the cost for care, i.e., community residences and general hospitals.").

[11] *Id.* at 28 (statement of Jeffrey Geller, M.D.).

[12] *Id.* at 97 (statement of Gunther Stern) ("Homeless people are real people with families like yours and mine, families that care. Greg is someone I met sitting on a park bench near our center. He was shabbily dressed and smelled bad. . . . All this belied the fact that Greg was once a gifted constitutional lawyer who delighted his children with his dry wit. They were in their late teens when he began to show the signs of what would become a profoundly

hand, people who deal with mental illness crises on a regular basis, such as families[13] and law enforcement,[14] are all too aware of the magnitude of the problem. A particularly difficult aspect of the illness, that is unique among neurological disorders, is called anosognosia.[15] It impairs a person's insight and awareness of their illness.[16] Because they do not recognize they have an illness, they often refuse treatment.[17] Refusing treatment frequently results in homelessness[18] and arrests.[19]

The effects of deinstitutionalization were compounded when states redirected the funding that had been used to treat individuals with serious mental illness for different purposes, feigning of a more enlightened approach to mental illness.[20] The

disabling bipolar disorder.").

[13] *Id.* at 11 (statement of Lisa M. Ashley) (testifying that when her son was psychotic, he felt "his head was burning and the voices were screaming at him." She brought her son to emergency rooms three times over a period of eighteen months before his condition was finally fairly stable. Her son waited for long periods of time in emergency rooms before being admitted due to the shortage of psychiatric beds. He waited up to four days in an emergency room for an open bed. On one occasion, her son waited nearly as long in the emergency room (two days) for a psychiatric hospital stay that was not much longer (three days)).

[14] *Id.* at 51 (statement of Michael C. Biasotti, Police Chief) (stating a survey of law enforcement officers "essentially found that we have two mental health systems today, serving two mutually exclusive populations. Community programs serve those who seek and accept treatment. Those who refuse, or are too sick to seek voluntary treatment, become law enforcement responsibilities. Officers in the survey were frustrated that mental health officials seemed unwilling to recognize or take responsibility for this second more symptomatic group. Ignoring them puts patients, the public and police at risk and costs more than keeping care within the mental health system.").

[15] *Id.* at 149 (statement of Jeffrey Geller, M.D.).

[16] *Id.* 104, 149 (statement of Hakeem Rahim & Jeffrey Geller, M.D.) ("During my hospitalization, I accepted my illness and began my arduous road to recovery. I cannot pinpoint what triggered my immediate acceptance, but I am grateful it did not take years for me to obtain insight.").

[17] *See id.* at 97–98 (statement of Gunther Stern) ("[Homeless] people I work with [have] limited or no insight into their illness[,] don't think they need treatment and vehemently refuse treatment when it is offered.") *Id.* at 154 (statement of Michael C. Biasotti, Police Chief) ("[M]y wife and I both pray for the day that our daughter has the insight that Mr. Rahim has . . . because I believe if she had that insight, she could seek . . . care in the community. It has been 20 years . . . and she does not have that insight.").

[18] *Id.* at 97–98 (statement of Gunther Stern) ("[A]lmost all the people I see on the street are there because they have refused treatment, not for rational reasons but because illness has insidiously robbed them of their insight to understand that they have an illness and that treatment can help them.").

[19] *Id.* at 51.

[20] *Id.* at 24 (statement of Jeffrey Geller, M.D.) ("[S]tates could not publically acknowledge they were moving persons with serious mental illness from one location to another to garner more federal dollars. They risked a public uproar.

"medical model" for treating mental illness as a disease was subjugated by the "prevention and recovery" model that is based on a message of hope; that mental health can be achieved with community outreach and access to rehabilitative opportunities, such as education and employment.[21] This approach often involves redirecting funding at the expense of "diagnostically driven" services for people who "have a diagnosis" or are "in crisis."[22]

The commissioner of a department of behavioral services testified,[23] that inpatient capacity for those diagnosed with serious mental illness is not a priority when services are centered on prevention and recovery.[24] "An over emphasis on inpatient beds can drain needed resources away from the very services that prevent people from needing crisis services."[25] "No discussion . . . should focus solely on increasing inpatient beds or lowering the threshold for commitment without addressing the need for a comprehensive, culturally appropriate strategy . . . ."[26]

> [W]hen we focus on those individuals in acute distress who need inpatient care we are taking a snapshot of their illness at only one point in time . . . . [W]e need to reframe our questions to . . . "How

So the states attached their fiscal policy to the progressive thinking of the day. The states proclaimed they were interested in patients' autonomy and self-determination; they sought to treat patients in the most integrated setting; and they were interested in patients' recovery.").

[21] *See id.* at 134 (statement of Arthur Evans, Commissioner of the Philadelphia, PA Department of Behavioral Healthy and Intellectual Disability Services) ("[I]nstead of just an individual focus, we need to focus on community level interventions – increasing understanding of mental health issues, reducing environmental stressors such as violence and trauma, increasing safe and healthy housing, developing employment opportunities, and decreasing misperceptions of mental illness that prevent people from seeking out help when needed.").

[22] *Id.* at 129, 134 ("Prevention and early intervention are more efficient than a singular focus on treatment.").

[23] *Id.* (it must be noted that the opinions of one do not necessarily reflect that of all mental health officials).

[24] *See id.* at 133.

[25] *Id.* (statement of Arthur Evans, Commissioner of the Philadelphia, PA Department of Behavioral Healthy and Intellectual Disability Services).

[26] *Id.* at 139 (statement of Arthur Evans, Commissioner of the Philadelphia, PA Department of Behavioral Healthy and Intellectual Disability Services). *But see id.* at 18 (statement of Jeffrey Geller, M.D. ) ("The threshold for holding somebody in the emergency department awaiting admission keeps creeping up. Many released folks are picked up by the police, processed through courts, sent to the state hospital for a forensic evaluation, further decreasing available beds to the person awaiting a bed in the emergency department.").

can we prevent these acute crises?"[27]

While it may not be intended, these comments suggest that it is simply too late to help those who are already in crisis and a more prudent investment is prevention.

The dimensions of the crisis of untreated mental illness, in terms of human suffering and wasted resources, simply cannot be ignored. A singular focus on prevention and recovery in community mental health programs neglects individuals who need immediate care and psychiatric treatment, such as those who have frequent encounters with the criminal justice system. Judge Steve Leifman described "recidivists" who are often homeless, predominantly diagnosed with schizophrenia, with histories of frequent arrests and periods of incarceration.[28] In a study conducted in Miami-Dade County over a five-year period, ninety-seven individuals accounted "for nearly 2,200 arrests, 27,000 days in jail, and 13,000 days in crisis units, state hospitals, and emergency rooms."[29]

There are opportunities for police (pre-arrest) and the courts (post-arrest) to divert individuals with serious mental illnesses from the criminal justice system. However, after incarceration, jail administrators do not have the discretion to release inmates without a court approval.[30] Thus, the last stop is jail.[31]

As the administrators of jails, Sheriffs have a custodial responsibility to provide protective supervision and medical care.[32] In many cases, people receive mental health care and

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[27] *Id.* at 133–34 (statement of Arthur Evans, Commissioner of the Philadelphia, PA Department of Behavioral Healthy and Intellectual Disability Services).

[28] *Id.* at 80 (statement of Steve Leifman, Eleventh Judicial Circuit Judge in Miami-Dade County, Florida). Sheriff Tom Dart also stated that recidivist offenders are a problem in Cook County jail as well. The Sheriff described a woman with mental illness who had been arrested recently for attempting to steal $20.00 from a person's purse during a church service. Having been arrested over 100 times, her chronic self-mutilation was known to jail personnel, who made special mittens to prevent her from attacking herself with her own finger nails and keep her safe while in custody. The sheriff estimated the costs of her arrests and incarceration to be over $1 million. *Id.* at 65–66.

[29] *Id.* (statement of Steve Leifman, Eleventh Judicial Circuit Judge in Miami-Dade County, Florida).

[30] *Id* .at 155.

[31] *Id.* at 66 ("[W]e are in an unsustainable position. I often refer to the jail as the last car on a long train. Every single day – and at every step before a person comes in to the jail, there is discretion – discretion to arrest, to charge and to set bond.").

[32] *Id.* at 66–67 ("[A]s custodian, I am obligated to care for those individuals.").

treatment in jails that they are unable to access in the community.[33] Consequently, some individuals and families seek incarceration as a means of getting treatment and shelter. Congressman G.K. Butterfield, a member of the Subcommittee, said that when he was a trial judge, families "would call and plead with me as a judge not to release their loved one because they could get better care and treatment in the facility as opposed to the community . . . ."[34] Sheriff Dart testified, "during the cold weather, we have people affirmatively commit offenses so they can come into our housing."[35] "[W]e have people trying to break back in. One threw a planter through a window to crawl back into the jail, and then we had to arrest him."[36]

The costs to taxpayers are substantial.[37] In Miami Dade County, taxpayers pay more than $178,000 per day for 1,200 individuals receiving psychotropic medications in the jail.[38] Sheriffs' offices are responsible for the fiscal management of jails, which are funded by county governments.[39] Consequently, another cost shifting opportunity for states evolved when the responsibility for providing care and treatment for individuals in the criminal justice system was diverted to counties.[40]

When there is no continuity of care for inmates upon release to the community, individuals with serious mental illnesses often return to jail.[41] Sheriffs do not have jurisdiction over inmates in the community, but the state could provide case managers to

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[33] *Id.* at 148.

[34] *Id.* (statement of G.K. Butterfield, Member, Subcomm. on Oversight & Investigations) ("[Y]ou talked about some people [who] believe that jail is the best place for treatment, and you are absolutely correct.").

[35] *Id.* at 143 (statement of Sheriff Tom Dart) ("I talk with the detainees on a regular basis. They will tell me frequently they don't want to leave the jail because it is the best place they can go for treatment, they feel safe, they don't get harmed out in the community, and we have had some where when we release them, they will try to break back into the jail.").

[36] *Id.* at 155 (statement of Sheriff Tom Dart).

[37] *Id.* at 75.

[38] *Id.* at 79–80 (statement of Steve Leifman, Eleventh Judicial Circuit Judge in Miami-Dade County, Florida).

[39] *Id.* at 141 (statement of Sheriff Tom Dart: "It is all county-related money.").

[40] *See, e.g.,* MARCUS NIETO, MENTALLY ILL OFFENDERS IN CALIFORNIA'S CRIMINAL JUSTICE SYSTEM 3–4 (1999).

[41] *See Hearings*, *supra* note 1, at 155–56 ("There are things that we can do that will not be expensive that can help and it be a continuum of care. It could work with people. It won't be 100 percent successful but it can't conceivably be any worse than what we do now.").

coordinate treatment and services for inmates upon release.[42] The initial cost to the state would not be substantial because the jails already have the case and medical histories on file that are needed for case management.[43]

Preventing recidivism among mentally ill offenders would significantly reduce the financial burden on counties[44] and significantly improve the quality of life for thousands of people with serious mental illness.

Deinstitutionalization is still in progress. Congress' intent in passing the Americans with Disabilities Act of 1990 was to prevent individuals with disabilities from being excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, and or be subjected to discrimination by any such entity and provide a legal recourse to redress institutional discrimination.[45] The United States Department of Justice and disability lawyers have brought litigation against the states under the ADA to require states to provide services in the community,[46] which has contributed to further closures of psychiatric hospitals beds and fewer options for individuals with serious mental illnesses.[47]

In summary, the testimony of the hearing witnesses described the decline of the system of care and treatment for individuals

[42] *Id.* (statement of Sheriff Tom Dart) ("There is no place for them, and there is no one to work with them because they need a certain level of case managing to make sure they stay on their med[ication]s . . . ." "Upon leaving the jail . . . someone from a . . . State agency [could] be their case manager who would . . . work with them through housing issues [and help them stay] on their med[ication]s . . . .").

[43] *Id.* at 143, 155 ("I do think this is doable with not great expenditures because we literally have everything about this person in our possession. So if you are trying to think of case plans and diagnosing them and what would be the best strategies . . . ." "[W]e have a full file on them, not only on their criminal background but their mental health needs.").

[44] *Id.* at 143 (statement of Sheriff Tom Dart) ("Why we can't follow them out in simple case management type of fashion, and even if we just break the cycle for a short period of time, we would save tremendous amounts of money.").

[45] 42 U.S.C. § 12101(a)(3–4) (2012).

[46] *Hearings, supra* note 1, at 24–25 (statement of Jeffrey Geller, M.D.) ("The Americans with Disabilities Act of 1990 was used by advocates and the US Justice Department to require states to expand any form of . . . community services they provided to accommodate all individuals in state hospitals who needed that service, arguing that Title II—'no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity'—required this.").

[47] *Id.* at 28.

with serious mental illnesses and the evolution of jails as the new psychiatric institutions for the most seriously mentally ill citizens in this country.

## I. JAILS HAVE BECOME PSYCHIATRIC FACILITIES BY DEFAULT

For three centuries, jails[48] and psychiatric hospitals have shared the custodial responsibly for individuals with serious mental illnesses who are unable to care for themselves and/or present a risk of harm to themselves or others.[49] Beginning in the fifteenth century, public psychiatric hospitals were established as a more humane alternative to confining the non-criminal "poor insane" in jails.[50]

Through time, the bed capacity of hospitals has been insufficient to meet demand[51] and many patients who were not admitted to hospitals were kept in jails.[52]

It is important in this discussion to keep in mind some of the relevant distinctions between psychiatric hospitals and jails. State governments are responsible for funding public psychiatric hospitals, primarily with general revenues and some limited federal reimbursement.[53] State Psychiatric Hospitals are administered by agencies within state governments, generally

[48] E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 1 (2010).

[49] *Id.*

[50] E. FULLER TORREY & JUDY MILLER, THE INVISIBLE PLAGUE: THE RISE OF MENTAL ILLNESS FROM 1750 TO THE PRESENT 10 (2001) ("[In] the fifteenth century . . . Bethlem Hospital emerged as an institution exclusively devoted to treating the insane." King Henry VIII "assigned Bethlem Hospital to the city of London for use by [the] insane poor . . . ." "Bethlem Hospital was [already] referred to simply as Bedlam.").

[51] *See* ALBERT DEUTSCH, THE SHAME OF THE STATES 37 (1948) ("Overcrowding has been a continuing condition of all public mental hospital systems." Prior to deinstitutionalization, state hospitals "were under unceasing pressure to admit more patients even when . . . gravely overcrowded.").

[52] *E.g.,* TORREY & MILLER, *supra* note 50, at 208 (When Worcester Hospital was established in 1833, "[o]ver half of the admissions in the first year came from jails and almshouses . . . . In the latter part of 1834, half of all applications . . . had to be rejected because of overcrowding. In 1835, the hospital began *returning* chronic patients to local jails, exactly the opposite of its intended purpose . . . .").

[53] *See* NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS., THE VITAL ROLE OF STATE PSYCHIATRIC HOSPITALS 8–11 (Joseph Parks & Alan Q. Radke eds., 2014).

referred to as State Mental Health Authorities (SMHAs).[54] To a large extent, SMHAs are able to control the admission and discharge of patients, thereby controlling the hospital census.[55]

In contrast, Sheriffs, who are elected county officials, are responsible for administering the fiscal and operational aspects of jails.[56] Sheriffs have no discretion in the booking and release of inmates.[57] Only courts are authorized to make those decisions. County governments bear the full burden of financing jail operations, but do not control how many inmates are in jail each year.[58]

"Deinstitutionalization" is the term used to describe the closure of state psychiatric hospitals since 1955 when there were nearly 560,000 patients.[59] The number of patients began to decline shortly after psychiatric medications were discovered.[60] The initial rate of decline was a modest 1.5% and by 1965 there were still 475,202 patients.[61] Beginning in 1965, the rate of deinstitutionalization accelerated and by 1980, there were only 137,810 patients.[62] Two significant factors contributed to the decline in available public psychiatric hospital beds. First, the enactment of Medicaid in 1965 enabled states to adopt an important cost-shifting strategy[63] because Medicaid covers services provided in the community, but excludes public psychiatric hospitals.[64] Increased federal funding provided an

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[54] *See id.* at 13–14.

[55] *See, e.g., id.* at 17.

[56] *See* AMERICAN JAILS: PUBLIC POLICY ISSUES 11–12 (Joel A. Thompson & G. Larry Mays eds., 1991).

[57] *See id.* at 6.

[58] ROD MILLER ET AL., AMERICAN CORRECTIONAL ASSOCIATION, ACA GUIDE FOR ADULT LOCAL DETENTION FACILITIES 6 (1993) ("Jails have become one of the largest costs born by local and county governments in the United States; in many jurisdictions, jails are the costliest item in the budget.").

[59] RAEL JEAN ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 20 (1990); DONNA M. NICKITAS ET AL., POLICY AND POLITICS FOR NURSES AND OTHER HEALTH PROFESSIONALS: ADVOCACY AND ACTION 171 (2011).

[60] PAUL S. APPELBAUM, ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE 50 (1994); JOHN D. PRESTON ET AL., CONSUMER'S GUIDE TO PSYCHIATRIC DRUGS 29–30 (2009).

[61] HISTORY AND HEALTH POLICY IN THE UNITED STATES 232 (Rosemary A. Stevens et al. eds, 2006); Richard G. Frank et al., *Medicaid And Mental Health: Be Careful What You Ask For*, 22 HEALTH AFF. 101, 107 (2003).

[62] APPELBAUM, *supra* note 60, at 50.

[63] Frank et al., *supra* note 61, at 101, 106.

[64] Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent*

incentive for states to move patients out of hospitals.[65] Second, the enactment of strict state civil commitment laws provided a means of restricting the number of patients who were admitted to hospitals.[66] Today there are no more than 43,000 beds[67] available despite the fact that there is a need for many more.[68] Implementation of the Americans with Disabilities Act of 1990[69] has also contributed to deinstitutionalization. Disability advocates have been successful in requiring states to provide community based services via litigation brought on behalf of individuals with mental disorders residing in nursing homes,[70] board and care facilities,[71] as well as psychiatric hospitals.[72] Those lawsuits have resulted in the closure of additional state psychiatric hospital beds.[73]

It is unlikely that the mental disability attorneys who typically bring lawsuits to enforce the right to community treatment for people with mental illnesses, who are institutionalized, would bring cases on behalf of people in the criminal justice system. Disability lawyers "historically have imposed a strict orthodoxy of analysis geared to separating out 'criminal' mental health law from 'civil' mental health law."[74] It is based on their fear that

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*Mentally Ill,* 29 AM. J.L. & MED. 159, 162 (2003).

[65] Frank et al., *supra* note 61, at 103, 105.

[66] *See* APPELBAUM, *supra* note 60, at 50.

[67] Ray Sanchez & Rose Arce, *Mental Health Advocates: Shortage of Beds Could Mean More Violence,* CNN (Nov. 20, 2013, 9:39 PM), http://www.cnn.com/2013/11/20/us/psychiatric-beds-shortage/.

[68] *Cf.* Bauke Koekkoek et al., *"Difficult Patients" in Mental Health Care: A Review*, 57 PSYCHIATRIC SERVICES 795, 799 (2006) ("Recent studies have stressed that the psychiatric hospital increasingly becomes a last resort for very specialized care or treatment of more disturbed difficult patients.").

[69] 42 U.S.C. § 12101.

[70] Williams v. Quinn, Dkt No. 1:05-cv-04673, at 4 (N.D. Ill. Sept. 29, 2010) (Consent Decree), *available at* http://www.clearinghouse.net/chDocs/public/PB-IL-0005-0025.pdf.

[71] United States v. New York, Dkt No. 1:13-cv-04165, at 1–3 (E.D.N.Y. July 23, 2013) (Stipulation and Order of Settlement), *available at* http://www.clearinghouse.net/chDocs/public/PB-NY-0013-0036.pdf.

[72] Disability Rights New Jersey, Inc. v. Velez, Dkt No. 3:05-cv-01784, at 2 (D. N.J. July 29, 2009) (Settlement Agreement), *available at* http://www.clearinghouse.net/chDocs/public/PB-NJ-0003-0003.pdf.

[73] *Id.* at 25 (providing that the "[state] will consider whether and to what extent State Hospital units can be closed . . . ."); *see* Beth Fitzgerald, *Hagedorn Closing Raises Concerns About Future of Elderly Patients*, NJ SPOTLIGHT (Jan. 6, 2012), http://www.njspotlight.com/stories/12/0106/0111/ ("In her statement, Velez noted that the state's decision to close Hagedorn [Psychiatric Hospital] is consistent with the 1999 Olmstead decision of the U.S. Supreme Court . . . .").

[74] Michael L. Perlin, *"For the Misdemeanor Outlaw": The Impact of the ADA*

application of the ADA to individuals in the criminal justice system will stigmatize the individuals they represent in the community. One author described it as the "fear of fusion."[75]

Therefore, disabled people who are at risk of institutionalization in jail need an advocate to enforce their rights under the ADA.

## II. SHERIFFS AS LITIGANTS ON BEHALF OF MENTALLY ILL INMATES

Congress provided a right to enforce the ADA in federal court to "any person alleging discrimination on the basis of disability" under Title II of the ADA.[76] However, some individuals with serious mental illnesses may not have the capacity to bring a suit on their own behalf, since litigation is a complex process that requires many skills, including the ability to understand the process and the capacity for decision-making. Serious mental illnesses can cause neurocognitive deficits that affect memory, attention, executive function, and insight.[77] For example, impaired decision-making capacity may affect a person's ability to grasp the meaning of information provided to them, recognize its relevance for their own situation, apply the information in reasoning a decision, and express a meaningful choice.[78]

An individual whose decision-making capacity is seriously impaired may be deemed legally incompetent.[79] However, it would be impractical to pursue guardianship for each individual who needs treatment to prevent repeated incarcerated.

While "[o]rdinarily, one may not claim standing . . . to vindicate the constitutional rights of some third party[,]"[80] there are third party exceptions to the rule, such as when courts are inaccessible to the injured party for reasons such as mental capacity or other disability.[81]

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*on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. 193, 195 (2000).

[75] *Id.*

[76] 42 U.S.C. § 12133 (2012).

[77] *See* E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A MANUAL FOR FAMILIES, PATIENTS, AND PROVIDERS 124–25 (5th ed. 2006).

[78] THOMAS GRISSO & PAUL S. APPELBAUM, ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS 101 (1998).

[79] *See id.* at 11.

[80] Barrows v. Jackson, 346 U.S. 249, 255 (1953).

[81] Whitmore v. Arkansas, 495 U.S. 149, 163 (1990).

Sheriffs could represent the interests of mentally ill inmates under the theory of "next friend" standing, which has been accepted since the 17th century.[82] It has been used primarily by parties seeking habeas corpus "on behalf of detained prisoners who are unable, usually because of mental incompetence or inaccessibility, to seek relief themselves."[83]

In *Whitmore v. Arkansas*,[84] the United States Supreme Court "discussed the concept of 'next friend' standing at length[]" for the first time in a case in which a death row inmate sought habeas corpus on behalf of another inmate.[85] Because the claim was not based on the federal habeas corpus statute,[86] the Court addressed established criteria for "next friend" standing outside the statute.[87]

The Court identified two prerequisites.[88] "First, a 'next friend' must provide an adequate explanation—such as inaccessibility, mental incompetence, or other disability—why the real party in interest cannot appear on his own behalf to prosecute the action."[89] "Second, the 'next friend' must be truly dedicated to the best interests of the person on whose behalf he seeks to litigate . . . [and] must have some significant relationship with the real party in interest."[90] "The burden is on the 'next friend' clearly to establish the propriety of his status and thereby justify the jurisdiction of the court."[91]

The Court recognized that although "next party" standing is sought typically for habeas corpus, courts have granted "next party" status in other cases, such as prosecuting a personal injury case on behalf of a minor.[92] Ultimately, the court did not address

[82] *Id.* at 161–62 ("[T]he English Habeas Corpus Act of 1679 authorized complaints to be filed by 'any one on . . . behalf' of detained persons . . . .").

[83] *Id.* at 162.

[84] *Id.* at 161–62.

[85] *Id.* at 153–54.

[86] 28 U.S.C. § 2242 (2012).

[87] *Whitmore*, 495 U.S. at 162–64.

[88] *Id.* at 163–64.

[89] *Id.* at 163 (citing Wilson v. Lane, 870 F.2d 1250, 1253 (7th Cir. 1989)).

[90] *Id.* at 163–64 (citing Davis v. Austin, 492 F. Supp. 273, 275–76 (N.D. Ga. 1980)).

[91] *Id.* at 164 (citing Smith *ex rel.* Missouri Pub. Defender Comm'n v. Armontrout, 812 F.2d 1050, 1053 (8th Cir. 1987)).

[92] *Id.* at 163 n.4 (stating "[s]ome courts have permitted 'next friends' to prosecute actions outside the habeas corpus context on behalf of infants, other minors, and adult mental incompetents. *See, e.g.*, Garnett v. Garnett, 114 Mass. 379 (1874) ('next friend' may bring action for divorce on behalf of an insane person); Campbell v. Campbell, 242 Ala. 141, 5 So.2d 401 (1941) (same);

"whether a 'next friend' may ever invoke the jurisdiction of a federal court absent congressional authorization . . . ."[93]

Thus, the Court left the door open for Sheriffs to bring cases on behalf of inmates and prosecute their rights under the Americans with Disabilities Act. However, as a third party, a Sheriff would have the burden of establishing that he is pursuing the action in the best interests of the inmates who have mental illness and are frequently incarcerated in their jails.[94]

### *A. First Prerequisite: Seriously Mentally Ill Individuals in the Criminal Justice System Lack the Capacity to Bring an Action in Court to Protect Their Own Rights*

There is ample evidence that many people with serious mental illnesses in the criminal justice system lack these skills.[95]

For example, there are individuals in jail awaiting trial because their capacity to understand a criminal proceeding is in question.[96] A person who is incapable of understanding the legal process for defending himself against a criminal charge would not be capable of prosecuting his rights in a civil claim under the ADA. This is the case for a growing number of people with mental illness in the criminal justice system.

There are so many defendants waiting in jails for psychiatric evaluations that lawsuits are frequently filed to protect inmates' rights "to be free from incarceration absent a criminal conviction[] and to receive restorative treatment when they are being incarcerated due to mental incompetence."[97] In a recent case the district court noted that "[t]he average in-jail waiting times now range from two weeks at the low end to almost two months on the high end." [98]

Competency evaluations are typically performed in psychiatric hospitals' "forensic beds," which are reserved for individuals with

Blumenthal v. Craig, 81 F. 320, 321–322 (CA3 1897) ('next friend' was admitted by court to prosecute personal injury action on behalf of the plaintiff, who was a minor); Baltimore & Ohio R. Co. v. Fitzpatrick, 36 Md. 619 (1872) (same).").

[93] *Id.* at 164.

[94] *See id.* at 163–64.

[95] Trueblood et al. v. Washington State Dep't of Soc. & Health Services, Dkt No. 2:14-cv-01178, at 2 (Order Granting Plaintiffs' Motion for Summary Judgment), *available at* http://old.seattletimes.com/ABPub/2014/12/23/2025296701.pdf.

[96] *See, e.g., id.*

[97] *Id.*

[98] *Id.*

psychiatric conditions who are involved in the criminal justice system, including jail inmates who require psychiatric evaluations to determine if they are competent to stand trial.[99] "Civil beds" are reserved for patients who are hospitalized for treatment.[100] The number of forensic beds has increased significantly to accommodate the growing number of inmates in need of competency determinations.[101] The increasing number of jail inmates awaiting competency evaluations is evidence that a significant population of inmates with mental illness lack the capacity to initiate litigation on their own behalf.

Studies of jail inmates with mental disorders provide further evidence that many inmates with mental illnesses have limited capacity to function well enough to initiate litigation on their own behalf. In a 2007 study of inmates in an urban county jail, 95% of inmates had overt psychotic symptoms in jail.[102] Among the inmates in the study, 32% had been in the acute psychiatric inpatient unit in the jail and 44% were in a lockdown area[103] for seventy-two hours or more.[104]

A 2002 Bureau of Justice Statistics report estimated that "227,200 jail inmates reported having impaired functioning, most commonly a learning impairment (22%), such as dyslexia or attention deficit disorder, or having been enrolled in special education classes."[105] "About 8% of jail inmates said they had a mental health condition that kept them from participating fully

[99] *See id.* at 4.

[100] *See id.*

[101] William H. Fisher et al., *The Changing Role of the State Psychiatric Hospital,* HEALTH AFFAIRS, http://content.healthaffairs.org/content/28/3/676.full.html (last visited Mar. 4, 2015).

[102] H. Richard Lamb et al., *Treatment Prospects for Persons with Severe Mental Illness in an Urban County Jail*, 58 PSYCHIATRIC SERVICES 782, 785 (2007).

[103] *Id.* at 784 ("The lockdown area is a highly staffed, highly structured area for people whom the mental health staff believe need acute psychiatric hospitalization. It [is] used only when there [are] no available beds in the acute inpatient unit . . . . Persons with mental illness were sent to the lockdown area for the same criteria used for admission to the jail's acute inpatient unit. . . . [T]hey are judged to be a danger to self or others (or both) or were unable to use food, clothing, or shelter as provided by the sheriffs. Each person in this unit [is] checked at least once every 15 minutes and [is] often housed alone in a single cell for safety reasons.").

[104] *Id.*

[105] LAURA M. MARUSCHAK, U.S. DEP'T OF JUSTICE, MEDICAL PROBLEMS OF JAIL INMATES 1 (2006).

in school, work, or other activities."[106]

In addition, being homeless prior to arrest and incarceration is common for individuals with mental illness.[107] The Brief Instrumental Functioning Scale has been used specifically to assess skills that are important to the daily functioning of people who are homeless.[108] These skills include taking medications as prescribed by a physician, filling out an application for benefits such as food stamps, keeping track of or budgeting their money, using city buses to get where they want to go, setting up job interviews by telephone, and finding an attorney to help them with a legal problem.[109] The absence of such skills, particularly finding an attorney to help them with a legal problem, is evidence that the "real party in interest cannot appear on his own behalf to prosecute the action[]"[110] to protect their rights under the ADA.

In *Pennsylvania Psychiatric Association*, the circuit court articulated the challenges that people with mental illnesses face in litigation.[111] "[T]he stigmatization . . . may blunt mental health patients' incentive to pursue litigation [and] their impaired condition may prevent them from being able to assert their claims . . . . [F]ear of stigmatization, coupled with their potential incapacity to pursue legal remedies, operates as a powerful deterrent to bringing suit."[112]

"Anosognosia" is a neurological term that is used to describe impaired insight or lack of awareness of one's illness and is

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[106] *Id.*

[107] Nancy Wolff et al., *Profiling Mentally Disordered Inmates: A Case Study in New Jersey*, 11 J. CORRECTIONAL HEALTH CARE 5, 16 (2004) (stating that arrests and incarceration are more likely for individuals with mental illness, who were homeless within six months of or at the time of, arrest, than people who do not have a mental illness).

[108] *See* Greer Sullivan et al., *Validation of the Brief Instrumental Functioning Scale in a Homeless Population*, 52 PSYCHIATRIC SERVICES 1097, 1098 (2001).

[109] *Id.* ("The BIFS items ask respondents whether they can perform six activities entirely by themselves: take medications as prescribed by a physician, fill out an application for benefits such as food stamps, keep track of or budget their money, use city buses to get where they want to go, set up a job interview by telephone, and find an attorney to help them with a legal problem. Respondents answer that they can do the activity by themselves, that they need help, or that they do not know whether they can do the activity by themselves. The BIFS is scored by assigning one point for each activity that respondents report being able to do by themselves. Items checked 'don't know' are considered to be activities with which the respondent would need help.").

[110] Whitmore v. Arkansas, 495 U.S. 149, 163 (1990).

[111] Pennsylvania Psychiatric Soc'y v. Green Spring Health Servs., 280 F.3d 278, 290 (3d Cir. 2000).

[112] *Id.*

common in people with serious mental illnesses.[113] Studies have shown that lack of insight is related to treatment non-compliance.[114] People who lack insight into their illness and do not believe they are ill would not pursue a lawsuit to secure the treatment they do not believe that they need.

Finally, although the Attorney General has authority to enforce Title II on behalf of disabled individuals,[115] it is unlikely this would happen. In the twenty-five years since the ADA was passed, the Department of Justice has only filed a little over fifty lawsuits under Title II "*Olmstead*" cases and none have addressed the issues here.[116] This is further evidence that individuals, who are at risk of incarceration due to mental illness, need the help of a third party "next friend" to enforce their right to treatment under the ADA.

### *B. Second Prerequisite: Dedication to the Best Interests of the Real Party in the Action*

Sheriffs are well suited to act as "next friend." Preventing repeated incarceration is the best interest of both the inmates and the Sheriffs. In 2012, the American Jail Association adopted a resolution stating that it "feels strongly that the jail setting is not the proper therapeutic milieu for effective, long-term

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[113] E. FULLER TORREY, SCHIZOPHRENIA AND MANIC-DEPRESSIVE DISORDER 27 (1994) ("Approximately half of all people with schizophrenia have only limited insight [into their illness] and do not realize or acknowledge that they are sick. This is not surprising, since the brain, the organ we use to think about ourselves and assess our needs, is the same organ that is affected in schizophrenia and bipolar disorder."); Celso Arango & Xavier Amador, *Lessons Learned About Poor Insight,* 37 SCHIZOPHRENIA BULL. 27, 27 (2011) ("If after months and years of evidence, the person still does not believe she or he is ill, what we are often dealing with [is] a cognitive deficit: anosognosia (AH-no-sog-NO-sia). The term anosognosia was coined by the Hungarian-born neurologist Babinski who, when working in Paris at the turn of the last century, described patients with neurological deficits such as hemiparesis, who were completely unaware of the deficits. And perhaps more importantly, most studies of nonadherence and partial adherence to treatment find that the best predictor is unawareness of illness or poor insight.").

[114] *See* Stephen R. Marder et al., *A Study of Medication Refusal by Involuntary Psychiatric Patients*, 35 HOSP. & COMMUNITY PSYCHIATRY 724, 725 (1984).

[115] 42 U.S.C. § 12134 (2012); Megan Flynn, *Olmstead Plans Revisited: Lessons Learned from the U.N. Convention on the Rights of Persons with Disabilities*, 28 L. & INEQ. 407, 412 (2010).

[116] *Information and Technical Assistance on the Americans with Disabilities Act*, ADA.GOV, http://www.ada.gov/olmstead/olmstead_enforcement.htm (listing the over fifty cases litigated since the enactment).

treatment of mental illness and recognizes that steps by State and local governments can improve the response to people with mental illness who come into contact with the criminal justice system[.]"[117]

They have a close relationship with the people who are frequently in and out of their jails. As custodians, they are responsible for providing food, shelter, and medical care, as well as ensuring that their inmates are safe. For many persons with mental illnesses, "jails have become one of the predominant settings for providing acute psychiatric inpatient treatment."[118]

Sheriffs and their deputies develop bonds with people with mental illness in their custody. Speaking about a young woman who overdosed after being released, a sheriff explained, "'[w]hen [my deputies] are dealing with someone who says, I'm going to kill myself if I leave here, and ultimately does, that takes a toll.'"[119]

Nicholas Kristof, a human rights columnist for the New York Times visited the Cook County jail, which he described as "[the] largest mental health center in America . . . ."[120] In a column entitled *Inside a Mental Hospital Called Jail* Kristof wrote "[i]n the jail here, some prisoners sit on their beds all day long, lost in their delusions, oblivious to their surroundings, hearing voices, sometimes talking back to them."[121] After interviewing Cook County Sheriff Thomas Dart, Mr. Kristof wrote, "*The first person to say that this system is barbaric is their jailer*."[122] Yet Sheriffs have no way to prevent the repeated incarceration of inmates with serious mental illnesses.

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[117] AM. JAIL ASS'N, RESOLUTIONS OF THE AMERICAN JAIL ASSOCIATION 20 (2014), *available at* http://www.americanjail.org/wp-content/uploads/2014/03/Resolutions-08_25_14.pdf.

[118] Lamb et al., *supra* note 102, at 786.

[119] Alicia Freese, *Sheriffs "Watch" Psychiatric Patients in Emergency Rooms*, VTDIGGER.ORG (Dec. 6, 2014, 12:17 AM), http://vtdigger.org/2013/12/06/sheriffs-watch-psychiatric-patients-emergency-rooms/.

[120] Nicholas Kristof, Op-Ed., *Inside a Mental Hospital Called Jail,* N.Y. TIMES (Feb. 8, 2014), http://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html?_r=0.

[121] *Id.*

[122] *Id.* (emphasis added).

## III. MENTALLY ILL INMATES AT RISK OF INSTITUTIONALIZATION IN JAIL ARE PROTECTED BY THE AMERICANS WITH DISABILITIES ACT

In 1990, Congress passed the ADA in response to society's historical practice of isolating, segregating and excluding individuals with disabilities and the need to eliminate these practices in the delivery of services, programs and other opportunities provided by states and other public entities.[123] In enacting the ADA, Congress found in part, that discrimination against disabled citizens persists in critical areas, such as institutionalization.[124] Title II of the ADA protects "qualified individual[s] with a disability" who meet the "essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity."[125] Congress directed the Attorney General to develop regulations consistent with the prohibition against discrimination, including the ADA's "integration mandate."[126] The Attorney General promulgated an "integration regulation" which provides that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[127]

In 1999, the Supreme Court interpreted the "integration regulation" in the seminal case, *Olmstead v. L.C. by Zimring*,[128] as it applied to two patients with mental disorders who were institutionalized in a psychiatric hospital, but wanted the state to provide services in a community setting.[129] The Court held that under the "integration regulations" of Title II, states must provide community-based services to disabled people who are institutionalized if a state's professionals determine that the person "'meets the essential eligibility requirements' for

[123] 42 U.S.C. § 12101 (2012) (stating Congress' intent "to provide a clear and comprehensive national mandate [to eliminate] discrimination against individuals with [physical and mental] disabilities . . . .").

[124] *Id.* § 12101(a)(3).

[125] *Id.* § 12131(2).

[126] *Id.* § 12134.

[127] 28 C.F.R. § 35.130(d) (2014).

[128] 527 U.S. 581, 593–94 (1999) (stating that two women with disabilities who were confined in an institution, wanted to be treated in a community setting. Their physicians agreed, but they had to wait until the state could provide a community placement. The women alleged that the state discriminated by not providing services in the least restrictive setting.).

[129] *Id.*

habilitation in a community-based program[,]" provided the person does not oppose leaving the institution to live in the community.[130] However, the Court decided that states are relieved of obligations under the integration mandate if providing community-based services would fundamentally alter a state's services and programs.[131]

The term "institution" is not defined in the ADA or its implementing regulations.[132] However, at least one court has held that prisons are covered under the ADA,[133] so it follows that jails would be covered as well. Unlike the *Olmstead* plaintiffs who needed services to move from an institution to the community,[134] people with mental illnesses, who are at risk of incarceration due to their illnesses, are already in the community and need services to avoid being institutionalized in jail.[135] The issue is whether the integration mandate applies to disabled people who are not in institutions, but need services to prevent being institutionalized. Courts have held that disabled people who are at risk of institutionalization are entitled to protection under the ADA.[136]

The Americans with Disabilities Act prohibits discrimination against individuals who have a qualifying disability as defined in the Act, which includes, an "impairment that substantially limits one or more major life activities . . . ."[137] "[M]ajor life activities include, but are not limited to, caring for oneself, performing

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130 *Id.* at 602, 607.

131 *See id.* at 597.

132 *See* 42 U.S.C. §§ 12101–213 (2012); 28 C.F.R. § 35.104 (2014) (omitting a definition for the word "institution").

133 Perlin, *supra* note 74, at 221–22 (citing Pennsylvania Dep't of Corr. v. Yeskey, 524 U.S. 206, 209 (1998)).

134 *Olmstead*, 527 U.S. at 594.

135 *See* Deborah Dennis et al., *Best Practices for Increasing Access to SSI and SSDI on Exit From Criminal Justice Settings*, 65 PSYCHIATRIC SERVICES 1081, 1081 (2014) ("Upon release, the lack of treatment and [income], inability to work, and few options for housing mean that many individuals quickly become homeless and recidivism is likely.").

136 *E.g.*, M.R. v. Dreyfus, 697 F.3d 706, 720 (9th Cir. 2012) (remanding a case for entry of a preliminary injunction where "reduced access to personal care services [would] place [plaintiffs] at serious risk of institutionalization." This decision was in part due to plaintiffs' ADA claims.); Fisher v. Okla. Health Care Auth., 335 F.3d 1175, 1178, 1181–82, 1186 (10th Cir. 2003) (stating *Olmstead* does require present institutionalization to bring an ADA claim and that plaintiffs' argument that a five-prescription cap would result in nursing home institutionalization presented a potential ADA claim).

137 42 U.S.C. § 12102(1) ("The term 'disability' means, with respect to an individual . . . a physical or mental impairment that substantially limits one or more major life activities of such individual . . . .").

manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working."[138] Even if medication ameliorates the limitation imposed by the impairment, the individual still qualifies as disabled under the Act.[139] Schizophrenia and manic depression are characterized by symptoms that substantially impair one or more of the listed major life activities, thus individuals with these diseases are qualified for the ADA's protections.[140]

### A. *Establishing Eligibility For Services Under the ADA*

In addition to being a disabled person as defined in the regulations, a person must meet three requirements to be eligible for protection under the ADA: 1) the services must be provided in the most integrated setting appropriate to the individual's needs;[141] 2) an individual must be eligible for services provided by the public entity;[142] and 3) the provision of services must not fundamentally alter the nature of a state program.[143]

### B. *First Requirement: Most Integrated Setting*

*Olmstead* established that it is appropriate to apply the "integration mandate" when an individual is seeking services that will allow him/her to leave an institution.[144] Here the question is whether the integration mandate is applicable when an individual is in the community, but needs services to prevent being institutionalized. The Tenth Circuit, in *Fisher v.*

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[138] *Id.* §12102(2)(A).

[139] *Id.* §12102(4)(E)(i)(I).

[140] E. FULLER TORREY & MICHAEL B. KNABLE, SURVIVING MANIC DEPRESSION: A MANUAL ON BIPOLAR DISORDER FOR PATIENTS, FAMILIES, AND PROVIDERS 47, 49 (2002) (listing symptoms of mania to include decreased need for sleep, pressure to keep talking, flight of ideas or subjective experience that thoughts are racing, and distractibility. Symptoms of depression include insomnia or hypersomnia nearly every day, and decrease in appetite nearly every day.); TORREY, *supra* note 77, at 64 (citing criteria for schizophrenia to include: "deterioration of functioning . . . in such areas as work skills, social relations, and self-care.").

[141] 28 C.F.R. § 35.130(d).

[142] *See* 28 C.F.R. § 34.104(a)(1)–(2).

[143] 28 C.F.R. § 35.130(b)(7).

[144] *See* Henry Claypool, *Olmstead's Role in Community Integration for People with Disabilities Under Medicaid: 15 Years After the Supreme Court's Olmstead Decision*, KAISER FAM. FOUND. (June 18, 2014), http://kff.org/report-section/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-issue-brief/.

*Oklahoma*[145] was the first court to address this issue. The court held

> there is nothing in the plain language of the regulations that limits protection to persons who are currently institutionalized. The integration regulation simply states that public entities are to provide "services, programs, and activities in the most integrated setting appropriate" for a qualified person with disabilities. Those protections would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation. Second, while it is true that the plaintiffs in *Olmstead* were institutionalized at the time they brought their claim, nothing in the *Olmstead* decision supports a conclusion that institutionalization is a prerequisite to enforcement of the ADA's integration requirements.[146]

*Cota v. Maxwell-Jolly* was a "risk of institutionalization" case that was settled before the court issued a decision.[147] However, the Department of Justice filed an *amicus curiae* brief, as it did in the *Olmstead* case.[148] In *Olmstead*, the Supreme Court relied upon an argument in the Attorney General's brief "[b]ecause the Department is the agency directed by Congress to issue Title II regulations . . . ."[149] In the *Cota* brief, the Attorney General wrote "individuals with disabilities who reside in community placements should be permitted to bring integration claims under the ADA to prevent their unnecessary institutionalization."[150] The Attorney General argued that not only does the integration mandate apply when a person is at risk of institutionalization, but the risk need not be imminent.[151] In this case, the purpose of

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[145] Fisher v. Okla. Health Care Auth., 335 F.3d 1175, 1177–78 (10th Cir. 2003) (challenging the state's change to its Medicaid program that would limit the number of prescriptions that would be covered each month, arguing it would put plaintiffs at risk of institutionalization).

[146] *Id.* at 1181 (internal citation omitted).

[147] *See Olmstead: Community Integration for Everyone*, ADA.GOV, http://www.ada.gov/olmstead_cases_list2.htm (last visited Feb. 12, 2015).

[148] *See id.*

[149] Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 582–83 (1999).

[150] Brief for the United States as Amicus Curiae Supporting Plaintiffs-Appellees at 24, Cota v. Maxwell-Jolly (No. 10-15635), *available at* www.ada.gov/olmstead/documents/cota_brief.pdf.

[151] *Id.* at 26. ("For some individuals, the denial of services could result in immediate institutionalization. For others, it could lead to their eventual institutionalization over time. In both cases, the unnecessary institutionalization of such individuals violates the integration mandate of the

the litigation would be to require states to provide services to mentally disabled people at risk of being incarcerated,[152] an extremely restrictive form of institutionalization. In a report on the status of the ADA, the Government Accountability Office took the same position.[153] Applying this reasoning, individuals with mental illness in the community, who qualify for Medicaid services, are entitled to services to prevent them from being institutionalized in jails.

### *C. Second Requirement: Eligible for Receipt of Services Provided by a Public Entity*

Individuals must meet the eligibility requirements for the services that are provided by the public entity, which in this case are State Mental Health Agencies (SMHAs).[154] SMHAs "are the single state government agency responsible for planning and operating state public mental health systems[,]"[155] and are the public entities that provide services for people with serious mental illnesses.[156] In 2013, the two largest sources of SMHA funding were Medicaid (48%) and state general funds (42%).[157]

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ADA.").

[152] *See* THE SENTENCING PROJECT, MENTALLY ILL OFFENDERS IN THE CRIMINAL JUSTICE SYSTEM: AN ANALYSIS AND PRESCRIPTION 3–5 (2002), *available at* http://www.sentencingproject.org/doc/publications/sl_mentallyilloffenders.pdf, (illustrating that states' lack of treatment of mentally ill is leading to incarceration).

[153] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 5, at 1 (ADA "applicability to people with physical as well as mental disabilities, to those in nursing homes and other institutional settings in addition to psychiatric hospitals, and to those who live in the community and are at risk of institutionalization."). "The breadth of the disabled population to whom *Olmstead* may eventually apply is uncertain. Much is unknown about the widely varying population of people with disabilities, the settings in which they are receiving services, and the extent to which their conditions would put them at risk of institutionalization." *Id.* at 6. "The *Olmstead* decision has been widely interpreted to apply to people with varying types of disabilities who are either in institutions or at risk of institutionalization." *Id.*

[154] *See* JODI HANNA & CHRISTINE CURLEY, WIS. COAL. FOR ADVOCACY, AMERICANS WITH DISABILITIES ACT: TITLE II-GOVERNMENT PROGRAMS AND SERVICES, 319–20 (2009), *available at* http://www.disabilityrightswi.org/wp-content/uploads/2008/09/ada-title-2.PDF; NASMHPD RESEARCH INSTITUTE, INC., STATE MENTAL HEALTH AGENCY REVENUES 5 (2014), *available at* http://www.nasmhpd.org/docs/TAC%20Assessment%20PDF%20Report/Assessment%209%20-%20Revenues.pdf.

[155] NASMHPD RESEARCH INSTITUTE, INC., *supra* note 154, at 5.

[156] *Id.*

[157] *Id.* at 10.

Medicaid provides a broad array of services, including medication and case management services.[158] Medicaid is a state administered joint federal and state funded system for providing health care to indigent citizens.[159] To be eligible for Medicaid, a person must meet the requirements for financial need and categorical need, which includes disabled individuals.[160] States are required to provide basic services, which include medication and health care. Case management services are optional; although most states have opted-in.[161]

To be eligible for state services that are funded exclusively by state general funds, the criteria in the federal definition of "adults with a serious mental illness" must be met at a minimum.[162] State funded services include programs for those who are not eligible for Medicaid,[163] services that Medicaid does not cover, and state hospitals.[164] The priority population for purposes of the federal definition of serious mental illness includes people who are frequently incarcerated due to a serious mental illness.[165] Federal Community Mental Health Services (CMHS) Block Grants[166] accounted for only one percent of SMHA funding in 2013.[167] Block Grant eligibility is limited to "adults with a serious mental illness[,]" as defined by CMHS.[168] States

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[158] Frank et al., *supra* note 61, at 105 ("Medicaid pays for a broad array of treatments for mental disorders: mandatory services such as prescription drugs, physician services, inpatient care, nursing home care, and laboratory services, plus a large number of optional services that most states choose to pay for. These services typically include psychologists' services, case management, clinic services, personal care, and rehabilitation. When properly bundled, these services include most of the components of existing evidence-based mental health treatments.").

[159] *See id.* at 103, 107.

[160] *See Eligibility*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html (last visited Feb. 26, 2015).

[161] *Medicaid Benefits: Targeted Case Management*, KAISER FAM. FOUND., http://kff.org/medicaid/state-indicator/targeted-case-management/ (last visited Mar. 3, 2015) (showing that Delaware and Indiana are the only states that do not provide case management under Medicaid).

[162] *See* Thomas Insel, *Director's Blog: Getting Serious About Mental Illnesses*, NIH (July 31, 2013), http://www.nimh.nih.gov/about/director/2013/getting-serious-about-mental-illnesses.shtml.

[163] Frank et al., *supra* note 61, at 107.

[164] NASMHPD RESEARCH INSTITUTE, INC., *supra* note 154, at 13.

[165] Definition of Adults With a Serious Mental Illness, 58 Fed. Reg. 29,425 (May 20, 1993).

[166] NASMHPD RESEARCH INSTITUTE, INC., *supra* note 154, at 10.

[167] *Id.* at 18.

[168] MAJOR FEDERAL PROGRAMS SUPPORTING AND FINANCING MENTAL HEALTH

use the funds for a broad array of services, including case management, crisis services, residential support services and assertive community treatment.[169] Finally, a few states have constitutional provisions that refer to caring for the mentally ill, which courts could interpret as conferring a constitutional right to community-based treatment for citizens with mental illnesses.[170]

### *D. Third Requirement: Fundamental Alteration*

The ADA requires a public entity to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."[171] In *Fisher v. Oklahoma*,[172] the court established some principles that can be applied to the facts of individual cases. "If every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed."[173] A state's fiscal problems cannot be used as a fundamental alteration defense.[174]

The success of a fundamental alteration defense will depend on the nature of the community services that individuals need to remain safely in the community. A factor that should be considered in the fundamental alteration analysis is the states' obligations to care for individuals with serious mental illness who are vulnerable to homelessness and incarceration. The preamble to the federal regulation defining serious mental illness states that:

> [s]tates need to continue to set priorities to assure that the most . . . seriously mentally ill adults are given priority for services. In the case of adults, the most seriously mentally ill

CARE 23 (2003).

[169] *See* NASMHPD RESEARCH INSTITUTE, INC., *supra* note 154, at 41–42.

[170] *See* Antony B. Klapper, Comment, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739, 819 (1993).

[171] 28 C.F.R. § 35.130(b)(7) (2014).

[172] Fisher v. Okla. Health Care Auth., 335 F.3d 1175, 1177 (10th Cir. 2003) (involving a challenge to the state's plan to reduce coverage of prescriptions under a Medicaid program).

[173] *Id.* at 1183.

[174] *Id.* at 1182–83.

population is largely comprised of persons with schizophrenia and major mood disorders. *Attention should also be given to those individuals . . . whose disorders have resulted in homelessness or inappropriate involvement in the criminal justice system*.[175]

At least one state, Oklahoma, has put individuals at risk of incarceration in the high priority population for services.[176] Specifically, "[p]ersons at risk of institutional placement or homelessness (e.g., mental health, jail, prison, etc.) due to symptoms and behaviors resulting from a serious emotional disturbance or any mental illness. This includes adults being released from jail/prison . . . ."[177]

## CONCLUSION

The repeated incarceration of the mentally ill is an enormous burden, both in terms of human suffering and economic costs.[178] Sheriffs' offices are responsible for the fiscal management of jails, which are funded exclusively by county governments.[179] Sheriffs must provide food, shelter, medical treatment, and medications for inmates with mental illnesses,[180] but have no way to ensure that they receive appropriate services when they leave the jail.[181] Thus, the cost of treatment is effectively shifted from the state agencies that are responsible for providing mental health services in the community, to jails that have no other option when an inmate needs care and treatment.[182]

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[175] Substance Abuse and Mental Health Services Administration, 58 Fed. Reg. 29423 (May 20, 1993) (emphasis added).

[176] *See* ELIGIBILITY AND TARGET POPULATION MATRIX 4 (2010), *available at* www.odmhsas.org/01FY11EligPopMatrixapprovedFINAL05282010.doc.

[177] *Id.*

[178] *See* Marisa Elena Domino et al., *Cost Shifting to Jails After a Change to Managed Mental Health Care*, 39 HEALTH SERVICES RES. 1379, 1391 (2004) ("Costs of the psychiatric unit of the jail were substantially higher ($1,756/month for users) than nonpsychiatric costs ($670 /month for users) . . . .").

[179] *See* BRIAN ALBERT, STATE PRISONERS IN COUNTY JAILS 3 (2010), *available at* http://www.naco.org/newsroom/pubs/Documents/Health,%20Human%20Services%20and%20Justice/State%20Prisoners%20in%20County%20Jails%20Updated.pdf.

[180] *See, e.g., My Family Member Has Been Arrested—What Do I Do?* ALAMEDA COUNTY SHERIFF'S OFF., https://www.alamedacountysheriff.org/dc_mentalhealth.php (last visited Mar. 16, 2015).

[181] *See* TREATMENT ADVOCACY CTR., THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 18 (2014).

[182] *See* MILLER ET AL., *supra* note 58, at 6.

Congress passed the ADA in response to society's historical practice of isolating, segregating and excluding individuals with disabilities.[183] When services are not available to mentally ill inmates upon release from jail, homelessness, and repeated incarceration is common.[184] Individuals with disabilities who are at risk of institutionalization are protected under the Americans with Disabilities Act.[185]

The litigation strategy presented in this paper is designed to achieve a goal that will benefit both Sheriffs and mentally ill inmates—ensuring that treatment and services are available in the community to prevent the cycle of repeated incarceration.

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[183] 42 U.S.C. § 12101 (2012).
[184] Dennis et al., *supra* note 135, at 1081.
[185] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 5, at 130.