

Diversion, Not Discrimination:

How Implementing the Americans with Disabilities Act Can Help
Reduce the Number of People with Mental Illness in Jails

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July 2017

This report was created with support from the John D. and Catherine T. MacArthur Foundation as part of its *Safety and Justice Challenge* initiative, which seeks to address over-incarceration by changing the way America thinks about and uses jails. Core to the Challenge is a competition designed to support efforts to improve local criminal justice systems in jurisdictions across the country that are working to safely reduce over-reliance on jails, with a particular focus on addressing the disproportionate impact of over-incarceration on low-income individuals, communities of color, and persons with mental illnesses and substance abuse disorders.

More information is available at:

www.safetyandjusticechallenge.org

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Introduction and Summary

Across the nation, local justice systems frequently encounter people with mental illness. Police are regularly called to intervene with individuals who are regarded as being in mental health crises. Police often transport some of these individuals to hospitals. In other instances, people with mental illness are arrested for behaviors associated with their disabilities, including administrative offenses (such as failures to appear in court), which could generate warrants. Those arrested often end up in jails, where they represent a significant portion of the inmate population.

Within jails, inmates with mental illness tend to fare poorly, and they spend longer periods of time incarcerated than similarly charged individuals who do not have mental illness. While in jail, they require special attention, and their care can be especially costly. For all of these reasons, people with mental illness are an important population for *Safety and Justice Challenge (SJC)* sites to target in their efforts to reduce the number of people incarcerated in local jails.

This paper discusses why people with mental illness are over-represented in local justice systems and how the Americans with Disabilities Act (ADA)—which has far-reaching requirements for public services provided by state, county, and local entities—can be used to strengthen diversion efforts and reduce jail populations. Knowledge of and compliance with the requirements of the ADA are crucial for those managing correctional and criminal justice programs and mental health service delivery systems, i.e., the people at the center of the work of the *SJC*. In addition to the benefits of operating programs that conform to the requirements of federal law, proven positive policy outcomes occur when justice-involved individuals with mental illness have access to an array of effective community services. Accordingly, while the specific strategies adopted will vary depending on local circumstances, understanding the obligations the ADA imposes on public entities—including local mental health, criminal justice, and correctional programs—and the opportunities that arise when those obligations are addressed will assist sites in achieving the *SJC* goals.

The Americans with Disabilities Act can be used to strengthen diversion efforts and reduce jail populations.

Background: Deinstitutionalization

There is a long and shameful history of discrimination against people with disabilities, resulting in their exclusion from mainstream society. That exclusion reinforced stereotypes that people with disabilities were incapable—or even unworthy—of being full members of our communities.

Locking people with mental illness away in institutions, sometimes for decades, was a common and particularly stark form of such exclusion. These often-massive state hospitals, originally meant to be safe places where people with mental illness could live in a humane environment, once held over 500,000 people nationwide. The hospitals were anything but humane, however, and patients were subjected to abusive practices, relegated to squalid living conditions, and afforded little hope of leaving.

In reaction, a disability rights movement emerged in the 1970s that challenged the conditions of state hospitals and the need for people with mental illness to be locked away from society. Advocates brought lawsuits challenging the process by which individuals were committed as well as treatment and living conditions at hospitals. These suits resulted in landmark court decisions establishing requirements now embedded as standard practice, including courts needing a basis beyond a psychiatric diagnosis before an involuntary commitment can occur (e.g., “danger to self or others”); a right to legal representation and due process; and a right to adequate treatment and the least restrictive conditions while a hospital patient.

These decisions, along with the development of new anti-psychotic medications and a disability rights movement growing in power and influence, spurred what is referred to as deinstitutionalization. As a result, hundreds of thousands of people who had been held on “back wards” of state psychiatric hospitals were discharged to various community settings. This process peaked during the 1980s and continues on a smaller scale to this day. Many people were discharged to group homes, then considered a state-of-the-art model, while others were discharged to nursing homes, board and care homes, or to their families.

¹ See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563 (1975) (holding that a state cannot constitutionally confine a non-dangerous person with a mental disability who is able to live safely in the community); *Welsch v. Likins*, 373 F. Supp. 487, 499 (D. Minn. 1974), *aff'd*, 525 F.2d 987 (8th Cir. 1975) (constitutional right to adequate treatment for individuals with mental disabilities who are civilly committed); *N.Y. State Ass'n for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973) (constitutional right to protection from harm in state institutions); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) (constitutional right to treatment for people with mental disabilities committed to state institutions).

Is Deinstitutionalization the Problem?

Deinstitutionalization is often identified as the reason there are so many people with mental illness in America's jails and prisons—so many, that today these facilities are sometimes cynically characterized as the nation's largest psychiatric institutions. But, for a number of reasons, that is not a complete or accurate story.

First, deinstitutionalization, as a policy or program, was supposed to be linked to and coordinated with the development of a comprehensive network of community mental health programs² that were intended to replace hospital care and allow people with mental illness to live successfully in their communities. America failed to deliver on that promise—not because it lacked the ability to do so, but rather because lawmakers lacked the political will to fund and ensure the availability of much-needed services in localities nationwide, including outpatient treatment, residential and crisis services, and case management that coordinated between the mental health system and law enforcement and courts.³ At its core, the disproportionate involvement of people with mental illness in the criminal justice system (from police contact through incarceration) reflects the broken promise that community services would replace hospitalization. Deinstitutionalization was never meant to abandon people with mental illness or require them and their families to rely on their own devices for treatment and housing.

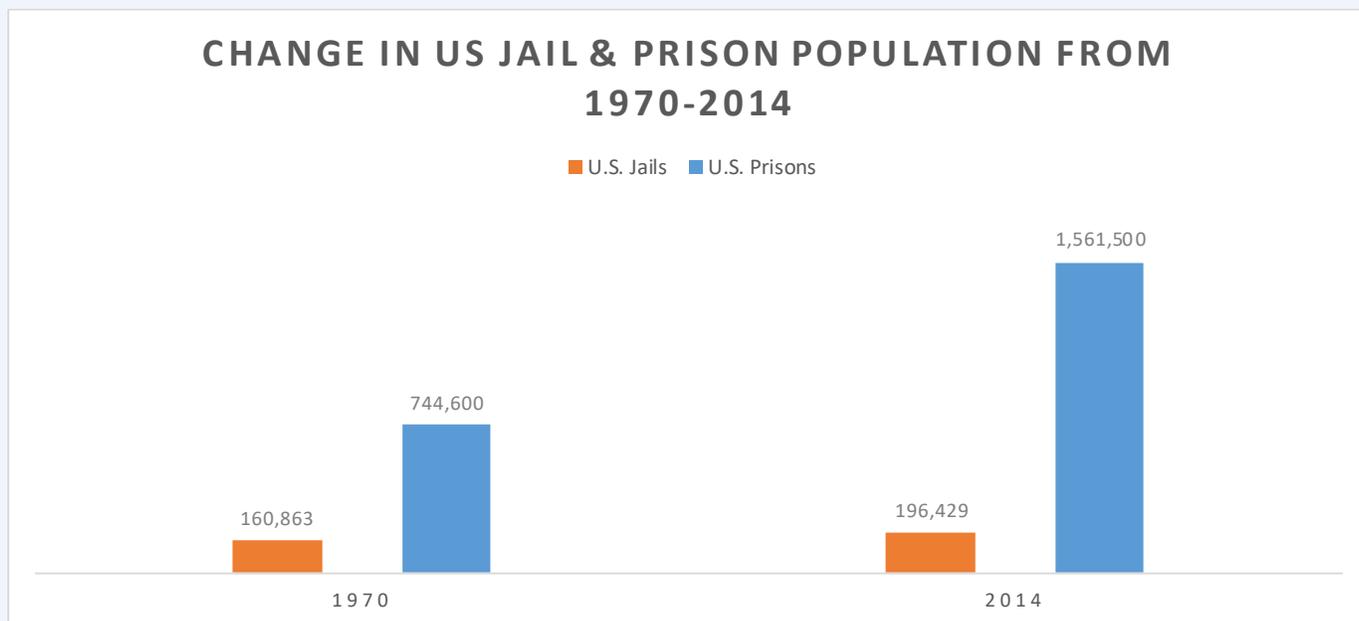
At the state level, despite the assurances of officials that “the money will follow the people,” states pocketed the savings from closing or downsizing their psychiatric institutions and redirected those funds to other uses. State spending on mental health services actually declined in the era of deinstitutionalization.⁴ In short, only fragments of what was intended to be a comprehensive system of community mental health services materialized.

² See Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 *Cardozo L. Rev.* 1, 16 (2012).

³ Mental Health Systems Act, Pub. L. No. 96-398, 94 Stat. 1564 (1980) (repealed 1981).

⁴ From 1981-2005, as adjusted for both population growth and inflation, state spending on mental health services declined 0.2 percent per year. Bogira, *Starvation Diet: Coping with Shrinking Budgets in Publicly Funded Mental Health Services*, *Health Affairs*, May/June 2009 at 667 (Available at <http://content.healthaffairs.org/content/28/3/667,full>).

Figure 1:



Along with the broken promise of deinstitutionalization, other developments have contributed to the disproportionate arrest and incarceration of people with serious mental illness. In the 1980s, homelessness became a feature of American society, fueled in part by reductions in federal spending on rental subsidies and affordable housing. Changes in urban real estate markets eliminated many of the rental rooms in city centers where low-income people with mental illness lived. An increasing focus on law and order, as well as the launching of the war on drugs, resulted in more people—including more people with mental illness—being incarcerated and for longer periods of time. During 1970–2014, the U.S. jail population grew from 160,863⁵ to 744,600,⁶ and the prison population increased from 196,429⁷ to 1,561,500 (Fig. 1).⁸ A high proportion of people with mental illness in jail are charged with drug offenses.

⁵ U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *Census Of Jails, 1978, Volume 1: Data For Individual Jails In The Northeast* at 2 (1981).

⁶ U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *Correctional Populations in the United States*, 2015 2

⁷ U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *Prisoners 1925-81* 2 (1982).

⁸ BUREAU OF JUSTICE STATISTICS, *supra* note 5, at 2

Correctional Facilities vs. Treatment

There is broad agreement that far too many people with mental illness are being arrested and incarcerated. There is also growing awareness that incarceration can be incredibly harmful to people with mental illness and is extremely wasteful of public resources. Hence, diverting people with mental illness from the criminal justice system is an important and urgent goal that falls squarely within the purview of the *Safety and Justice Challenge*.

Unfortunately, the recognition that far too many people with mental illness are locked up in correctional settings is sometimes linked to the assertion that they should be locked up somewhere else, namely, in psychiatric hospitals. This argument is being advanced by stakeholders unfamiliar with the untapped capacity of the community mental health system, and by groups with self-interest in expanding the number of hospital beds and hospital-like crisis beds (such as the psychiatric hospital industry). While particular communities may, or may not, need additional psychiatric beds, that is not the key issue when it comes to avoiding the arrest or incarceration of people with mental illness. Most people with mental illness who are incarcerated in the nation's jails are charged with less serious offenses. This may include off-putting behaviors associated with untreated mental illness, such as disorderly conduct, "crimes of survival" while homeless, offenses associated with co-occurring substance use, or administrative offenses (such as failing to appear for a hearing or technically violating probation or parole). Most do not need hospital care to address their condition, but they do need housing and appropriate community mental health services. Viewing hospitals as the appropriate place for people with mental illness who are arrested and incarcerated sets up a false choice between one institution and another and, in many ways, echoes a perspective from decades ago when people with mental illness were considered incapable of living as a part of mainstream society.

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Although people with mental illness, like people without mental illness, sometimes commit crimes, the behavior leading to their involvement with the criminal justice system is most often the result of not receiving community services—clinical, housing, or vocational—that address their needs resulting from a disability. While they may receive some level of mental health services as inmates, incarceration does not remedy the underlying causes of their criminal conduct. Furthermore, jails are the antithesis of a therapeutic environment for these individuals. People with mental illness often deteriorate in jail, even to the point of requiring psychiatric hospitalization, thereby contributing to the misconception that a lack of hospital beds is the underlying cause of their criminal justice contact.

The Americans with Disabilities Act

The most significant legal change affecting persons with mental illness, since the era of deinstitutionalization, is the 1990 enactment of the Americans with Disabilities Act. The ADA, and the reforms it has driven, hold great promise for people with mental illness who are involved with the criminal justice system, including the development of effective options for diversion that can significantly reduce police contact with people with mental illness and the number of people with mental illness in jail. In many ways, the ADA and the reforms it is generating are finally making real the promise of an effective community mental health system that was envisioned decades ago.

ADA is a landmark civil rights legislation that goes far beyond the basic constitutional protections that govern corrections and mental health systems.⁹ Like earlier civil rights legislation, the ADA seeks to end discrimination and segregation, and to level the playing field for a mistreated and disadvantaged minority.

Congress enacted the ADA based on a recognition that “historically, society has tended to isolate and segregate individuals with [physical or mental] disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.”¹⁰

Congress found that discrimination against people with disabilities occurs “in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services.”¹¹ The ADA mandates an end to such discrimination, stating that “the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.”¹²

⁹ U.S. Const. amends. VIII, XIV; *see, e.g.*, Prison Rape Elimination Act of 2003, Pub. L. No. 108-79, 117 Stat. 972 (2003) (increased protections against sexual assault in prisons). A discussion of the significant body of case law establishing the standards for constitutionally adequate health/mental health services in correctional facilities is beyond the scope of this paper.

¹⁰ 42 U.S.C. § 12101(a)(2).

¹¹ *Id.* § 12101(a)(3).

¹² *Id.* § 12101(a)(7).

Of the ADA’s several parts, one—Title II—applies to states, counties, cities, and similar public entities. The U.S. Supreme Court has made clear that Title II applies to all activities of such entities, including law enforcement, corrections, and the provision of services to people with mental illness. Furthermore, the ADA applies not only to services directly provided by these entities, but also to services provided by the private sector through contracts with or funding from states, counties or cities.

The broad reach of the ADA means that it applies when states, counties, and cities address the challenges presented by people with mental illness who become, or are at risk of becoming, enmeshed in the criminal justice system. In other words, the ADA speaks directly to issues at the core of the *Safety and Justice Challenge*, including by favoring the delivery of mental health treatment in community settings instead of in institutions such as hospitals and jails.

Many of the specific obligations of the ADA are detailed in regulations promulgated by the U.S. Department of Justice (DOJ). In enacting Title II of the ADA, Congress directed the U.S. Attorney General to issue regulations addressing a wide range of public activities and provided guidance to the Attorney General regarding their content. Included in these regulations disseminated by the Attorney General in 1991 is the “Integration Mandate,” which requires public entities to “administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”¹³ The regulations define *the most integrated setting* as one—in contrast to institutions that isolate people with mental illness—that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.”¹⁴ Additional guidance by the DOJ indicates that the most integrated setting is the one that allows a person with a disability to live as much as possible like people without disabilities.¹⁵

The obligations imposed by the ADA, including its proscription against needless institutionalization, apply to the activities of:

- psychiatric hospitals that are operated by a state, county, or city or that are part of the public system;
- community mental health programs of a state, county, or city or that are part of the public system;
- the Medicaid program (which includes not only federal but also state and sometimes local matching funds);
- the police, the courts, probation and parole agencies, and other law enforcement agencies; and
- correctional facilities, including jails.

¹³ 28 C.F.R. § 35.130(d) (2016).

¹⁴ 28 C.F.R. Pt. 35, App. A (2016).

¹⁵ U.S. DEPT. OF JUSTICE, CIVIL RIGHTS DIVISION, *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.* (June 22, 2011) https://ada.gov/olmstead/q&a_olmstead.htm (defining “Integration Mandate”)

The ADA's Integration Mandate has been pivotal in shifting mental health systems from outdated programs that segregate people from the social mainstream to service models that allow these individuals to routinely interact with members of their communities, including in ordinary contexts such as with neighbors (e.g., through access to rental subsidies and scattered-site supportive housing) and co-workers (e.g., through supported mainstream employment). As mundane as this may all seem, it represents a sea change for mental health systems that in many ways had replicated the segregation of the old state hospitals under the guise of "community-based programs" by, for example, the frequent use of group homes and sheltered workshops.

A basic purpose of the ADA is to prevent, and not simply to correct, discrimination. Thus, the Integration Mandate is focused not only on ending needless institutionalization when it occurs, but also stopping it from happening in the first place. Jails are, without question, one form of institutionalization that affects thousands of individuals with mental illness. The ADA and its Integration Mandate speak to the needless institutionalization of people with mental illness in jails.

The *Olmstead* Decision

Among people with disabilities, their advocates and allies, and many officials and providers in public mental health systems, the ADA was heralded as a game-changer. Understanding the unfulfilled promise of the community mental health movement, they regarded the ADA as a long-awaited vehicle for leveraging needed change. As can be expected with any civil rights legislation, however, there has been resistance in some quarters, and courts have had to elaborate and enforce the ADA's requirements.

One such lawsuit—relating to two Georgia women, Lois Curtis and Elaine Wilson—emerged as the landmark Supreme Court case of *Olmstead v. L.C.*, which has become the impetus for nationwide reform of public policy affecting people with mental illness.¹⁶ The *Olmstead* plaintiffs were similar to many people served through public mental health systems—and also many people who come to be incarcerated in jails. They had longstanding mental disabilities and, for many years, cycled in and out of state-operated psychiatric hospitals. The core of their legal complaint was that they were not being afforded appropriate services in the community and, as a result, were being subjected to repeated and needless institutionalization in violation of the ADA. The state argued that the ADA did not require it to provide the plaintiffs with community-based rather than institutional services.

¹⁶ Tommy Olmstead, who was Georgia's Commissioner of Human Resources at the time, was the named defendant and the person whose name has come to be associated with the case. Because the *Olmstead* decision so clearly affirmed the ADA's Integration Mandate and its application to people with mental illness, the terms "*Olmstead*" and "ADA" sometimes are used interchangeably in mental health advocacy.

In 1999, the Supreme Court ruled for the plaintiffs, finding that “unjustified institutional isolation of persons with disabilities is a form of discrimination” prohibited by the ADA and that people such as Ms. Curtis and Ms. Wilson have a right to receive the community services they need to live outside of an institution.¹⁷ The Court, however, also recognized certain defenses that a public entity could assert when sued for needless institutionalization or segregation. The public entity can defend on the grounds that the changes sought are too expensive (even when taking into account the cost savings from avoided institutional care) or would represent a “fundamental alteration” of public systems, that is, change the essential purpose of those systems. As a practical matter, the facts rarely support such defenses when they are asserted.

The Supreme Court decision led to the development of “*Olmstead* plans” by many states, that is, their blueprints for implementing *Olmstead*’s Integration Mandate. It was recognized that the changes required by the decision could not be made overnight, but instead would require careful planning and address multiple systems serving various disability populations. Many states developed *Olmstead* plans that prioritized the sizable number of people with serious mental illness who were being needlessly segregated, and identified actions to be taken to afford these individuals the opportunity to be served in community settings. The scope, detail, and degree of implementation of *Olmstead* plans vary greatly from state to state.

¹⁷ *Olmstead v. L.C.*, 527 U.S. 581, 600 (1999).

“Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, **institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions** that persons so isolated are incapable or unworthy of participating in community life.. Second, **confinement in an institution severely diminishes the everyday life activities of individuals**, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

United States Supreme Court in
Olmstead v. L.C., 527 U.S. 581, 600-601 (1999)

Although also covered by the ADA and *Olmstead*, and representing sizable numbers of people, few *Olmstead* plans include individuals who, as a result of not receiving appropriate community services, come to be caught up in the criminal justice system and incarcerated in jail. In some states, criminal justice stakeholders were included in the formulation of *Olmstead* plans, but most states focused more narrowly on individuals in psychiatric institutions or institutions for people with developmental disabilities.

States periodically review and update their *Olmstead* plans. If a state’s plan does not address justice-involved individuals, this oversight can be corrected when it is reviewed. If there is no scheduled review, or the review is far off, state officials can be asked to schedule a review for the purpose of considering the *Olmstead* issues raised by justice-involved individuals and the actions that should be taken to prevent the needless arrest and incarceration of people with mental illness.

Dramatic Reforms in Service Systems

The primary way in which the ADA aligns with the core goals of the *Safety and Justice Challenge* is its focus on avoiding institutionalization, rather than on improving conditions in institutional settings. Put another way, earlier civil rights efforts relating to institutions tended to respond to the question: “What is wrong with this institution?” Today’s *Olmstead*-driven efforts focus on the questions: “Why are people in this institution?” and “Could their institutionalization have been avoided?”¹⁸

Below, we summarize how *Olmstead* advocacy has responded to the question of why people are institutionalized, resulting in public systems developing an array of new housing and service alternatives within the community. We then discuss how this same question—and the reforms that have developed in response—can be integrated into the strategies of *SJC* sites and with the Sequential Intercept Model¹⁹ to create diversion options for people with mental illness who are headed toward incarceration as well as release options for those already in jail.

In the last 10 years or so, disability advocates such as the Bazelon Center, as well as DOJ, have brought ground-breaking lawsuits nationwide that challenge the unwarranted institutionalization and segregation of people with mental illness. In addition, DOJ has issued investigation reports or entered into agreements concerning the treatment of people with mental illness by law enforcement or corrections institutions.²⁰

Some of the lawsuits have addressed statewide systems affecting people with mental illness or cities’ policing practices, and some have been more narrow, for instance, focusing on people consigned to privately owned facilities that operate as a part of the public mental health system.²¹

To provide a sense of the capacity of *Olmstead* to spur broad reform, we highlight two important statewide lawsuits, *U.S. v. Georgia* and *U.S. v. Delaware*. These cases are very similar; both emanated from DOJ investigations of systems that were found to unnecessarily institutionalize people with mental illnesses, such as schizophrenia, bipolar disorder, or major depressive disorder.²²

¹⁸ See Bagenstos, *supra* note 2, at 34.

¹⁹ See generally, Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCHIATRIC SERVICES 544 (2006).

²⁰ For more information about DOJ’s *Olmstead*-related work, including guidance and technical assistance on a range of integration issues, visit www.ada.gov/olmstead.

²¹ Examples are *O’Toole v. Cuomo*, No. 13-4166 (E.D.N.Y.), which addresses residents of privately owned adult homes in New York City, and *Williams v. Quinn*, No. 05-4673 (N.D. Ill.), which addresses residents of privately owned psychiatric nursing homes, or “Institutions for Mental Diseases” (IMDs) in Chicago.

²² *U.S. v. Georgia* also includes a developmental/intellectual disability component, which is not discussed here.

They both resulted in settlement agreements. The Georgia agreement went into effect in 2010²³ and the Delaware agreement in 2011²⁴—long enough ago that their impact has become evident.²⁵ And beyond the obvious differences in the size and character of the two states, the agreements allow an understanding of how *Olmstead* can play out in a state that has not expanded Medicaid eligibility under the Affordable Care Act (Georgia), and a state that has expanded eligibility (Delaware).

Responding to the question of why people with mental illness are unnecessarily institutionalized, both the Georgia and Delaware agreements require a significant expansion in community services to prevent people from being institutionalized and to enable those in institutions to be released to the community. These community services are designed to allow people who have been institutionalized or who are at risk of institutionalization to live ordinary lives in the community. Although neither agreement requires the state to reduce the size of its institutions, the availability of community alternatives has enabled each state to do so (as is discussed later).

The agreements in Georgia and Delaware focus on the needs of people with serious and persistent mental illness who:

- Have been hospitalized in state psychiatric facilities;²⁶
- Are at risk of hospitalization or re-hospitalization;
- Have been seen in emergency rooms;
- Are chronically homeless; and/or
- Have criminal justice involvement:
 - Georgia’s agreement prioritizes people with serious mental illness being released from jails or prisons.
 - Delaware’s agreement prioritizes people who have been arrested, incarcerated, or had other encounters with the criminal justice system due to conduct related to their serious mental illness.

²³ *U.S. v. Georgia*, No. 10-249 (N.D. Ga. Oct. 19, 2010). The Bazelon Center represented a broad coalition of Georgia stakeholders and helped draft the settlement agreement in this case.

²⁴ *U.S. v. Delaware*, No. 11-591 (D. Del. July 15, 2011).

²⁵ After slightly over five years of settlement implementation, Delaware was found to be in compliance with the requirements of its settlement agreement, and the case was closed in October 2016.

²⁶ In the case of Delaware, in other psychiatric hospitals with state funding as well.

In order to prevent unnecessary institutionalization, both agreements identify a set of community services that must be developed statewide, including diversion services such as the following, each of which must operate 24 hours per day, 7 days per week:

- A crisis hotline;
- Mobile crisis services capable of having face-to-face contact with an individual in crisis within about one hour;
- Crisis walk-in centers;
- Crisis apartments staffed by peers or paraprofessionals; and
- Crisis stabilization services providing intensive, short-term crisis interventions.

The agreements in Georgia and Delaware require the development of community services known to be effective in enabling people with serious mental illness to live successfully as a part of the community. These include:

- Assertive Community Treatment (ACT), which provides intensive, mobile, and ongoing support by multidisciplinary teams, including mental health peers;
- Intensive Case Management;
- Peer Support Services;
- Supportive Housing, including apartments scattered within the community's ordinary housing stock; and
- Supported Employment that provides ongoing assistance to enable individuals to hold jobs in the mainstream workforce.

The expansion of this set of services, coupled with other commitments to realign practices in accordance with *Olmstead*, has enabled Georgia and Delaware to make important advances. These include reducing their reliance on institutional facilities and better integrating individuals with mental illness into their communities.

The changes in these states have not been limited to their mental health programs.

- Both Georgia and Delaware have developed state-funded housing programs that augment programs funded through the Department of Housing and Urban Development (HUD) and expand the overall number of people receiving housing subsidies. Both states created new rental vouchers for individuals receiving housing under their settlement agreements. Georgia may provide supportive housing for up to 9,000 individuals with serious mental illness who would otherwise be living in segregated facilities or homeless. Delaware has funded supported housing for almost 800 individuals. In both states, the expansion of supportive housing for people with serious mental illness required collaboration between the states' department of mental health and the states' housing agency.
- In both states, the relationship between the mental health and vocational service agencies was strengthened to facilitate compliance with the supported employment requirements of the agreements, including through development of memoranda of understanding.
- Delaware capitalized upon opportunities through Medicaid to secure additional federal dollars to pay for services required by its settlement agreement, as well as other *Olmstead*-oriented services, such as in-home personal care services, community transition services, and non-medical transportation.
- The Delaware agreement requires training for state and local law enforcement personnel on accessing the state's new system of mental health crisis services. In addition, the state's mental health agency provides ongoing consultation to police departments and the courts regarding interactions with people who have mental illness. In Georgia, the settlement agreement has fostered collaboration between Assertive Community Treatment providers and the sheriffs who run the local jails.

As was mentioned earlier, neither agreement required that state psychiatric hospitals be downsized; indeed, because the agreements focused on why people are in psychiatric institutions—rather than what is wrong with these institutions—the agreements make only passing reference to state hospitals. Nevertheless, Georgia's and Delaware's development of the specific services identified in the agreements enabled both states to dramatically reduce the number of beds in their state hospitals. In the five years since it began implementing its agreement, Georgia found that it could close three of its state hospitals. Delaware reduced the number of civil (i.e., non-forensic) beds in its single state hospital by 35 percent in less than four years of implementation of its settlement agreement.

In both states, hospital readmission rates of people receiving the intensive community mental health services required by the settlement agreements have been low. In addition, the arrest rate of people receiving Assertive Community Treatment—individuals with very significant mental health issues and often co-occurring substance use living in their own apartments—also has been low (in Delaware about 1 percent).²⁷

Data from both states (and from all other *Olmstead* settlements involving people with serious mental illness) confirms that the community services of the type required by the Georgia and Delaware settlements, do, in fact, significantly improve the ability of people with mental illness to live successfully outside of institutions, to the point that substantial reductions in institutional beds are achieved.

Translating *Olmstead* Advances to Reductions in Jail Population

Georgia’s and Delaware’s reforms have important implications for *SJC* sites. The people with serious mental illness who are being successfully served with Assertive Community Treatment, supportive housing, and other “*Olmstead* services” (identified on page 16, above) have profiles and needs very similar to the people with mental illness who get incarcerated in jails. The biggest difference is that the people who get arrested and jailed generally lack access to the right kind of community mental health services, including services that persistently reach out to and engage them. Because the needs of the people with mental illness who are being successfully served with “*Olmstead* services” and those who enter local criminal justice systems are more alike than different, providing access for justice-involved individuals to the robust array of “*Olmstead* services” should result in a significant reduction in the number of people with mental illness who are incarcerated in jail.

Deploying “*Olmstead* services” to divert people with mental illness from arrest and incarceration is not only good policy, it also advances jurisdictions’ compliance with the ADA. The people with serious mental illness who are justice-involved qualify for the protections of the ADA, just as do the beneficiaries of the *Olmstead* settlements discussed above. They have impairments due to their mental health condition that qualify as disabilities under the ADA. And the mental health and criminal justice systems that are responsible for their needless (because it is avoidable, if they are provided effective services) arrest and incarceration are public systems covered by the ADA. Moreover, the activities of each of the entities that operate within those systems, whether state or local, public or private, are covered by and hence subject to the ADA.

²⁷ Tenth Report of the Court Monitor on Progress Towards Compliance with the Agreement: *U.S. v. Delaware* at 40, *U.J. v. Delaware*, No. 11-591 (D. Del. Sept. 19, 2016).

This reality can give *SJC* sites leverage in arguing for changed practices in both the mental health and the criminal justice systems. *SJC* sites can use to their advantage the facts that:

- In the *Olmstead* decision, the Supreme Court found that “[u]njustified placement or retention of persons [with disabilities] in institutions ... constitutes a form of discrimination ... prohibited by the ADA.”²⁸ The avoidable incarceration in jail of people with mental illness is a form of “unjustified” institutionalization.
- Jails (as well as the police) have become a de facto part of the mental health system, which is under an obligation to serve people in community, rather than institutional, settings.²⁹
- The mental health and the criminal justice systems operate in ways that needlessly segregate people with mental illness in jails, away from mainstream society.
- Both the mental health system and the criminal justice system operate in ways that have a discriminatory impact on people with mental illness. Although people with serious mental illness represent only about 4.2 percent of adults in the United States,³⁰ they account for about 10 percent of police interactions³¹ and about 20 percent of jail inmates—14.5 percent of male inmates and 31 percent of female inmates.³² Furthermore, people with mental illness are incarcerated in jail longer than people without mental illness charged with the same crimes.³³ While in jail, people with mental illness are disproportionately charged with disciplinary offenses³⁴ and disproportionately placed in solitary confinement.³⁵

²⁸ *Olmstead v. L.C.*, 527 U.S. 581, 596 (1999).

²⁹ See, e.g., AM. CIVIL LIBERTIES UNION OF S. CAL. & THE BAZELON CTR. FOR MENTAL HEALTH LAW, *A Way Forward: Diverting People With Mental Illness From Inhumane and Expensive Jails Into Community-Based Treatment That Works* (2014); Matt Ford, *America's Largest Mental Hospital Is a Jail*, THE ATLANTIC (June 9, 2015), <http://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/>.

³⁰ NAT'L INST. OF MENTAL HEALTH, *Serious Mental Illness (SMI) Among U.S. Adults*, <http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml>.

³¹ David Cloud & Chelsea Davis, *First Do No Harm: Advancing Public Health in Policing Practices* (2015), <http://archive.vera.org/sites/default/files/resources/downloads/public-health-and-policing.pdf>.

³² Henry J. Steadman, Ph.D. Fred C. Osher, M.D. Pamela Clark Robbins, B.A. Brian Case, B.A. Steven Samuels, Ph.D. *Prevalence of Serious Mental Illness Among Jail Inmates*, PSYCHIATRIC SERVICES. June 2009. Vol. 60 No. 6

³³ U.S. DEP'T OF JUSTICE, U.S. BUREAU OF JUSTICE STATISTICS, *Mental Health Problems Of Prison And Jail Inmates* 8 (2006), <http://bjs.gov/content/pub/pdf/mhppji.pdf>.

³⁴ U.S. DEP'T OF JUSTICE, *Report And Recommendations Concerning The Use Of Restrictive Housing* 84 (2016), <https://www.justice.gov/dag/file/815551/download>.

³⁵ *Id.*

- Overwhelmingly, people with mental illness incarcerated in jails do not present significant public safety risks, especially if provided “*Olmstead* services.” The offenses with which they are charged are commonly low-level, nonviolent offenses. Sometimes, their charges reflect their difficulty, without effective treatment or help, in complying with the directives of police officers, the requirements of parole or probation officers, or the rules of residential facilities.
- Substantial federal dollars are available to fund community mental health services for the justice-involved population, including through the Medicaid and SSI programs. Federal funds provided through existing block grant programs, such as the mental health block grant³⁶ and HUD block grants³⁷ can also be used to fund community services for the justice-involved population. In addition, state and local dollars that are now supporting the criminal justice system’s response to unaddressed mental health issues (from police involvement through incarceration in local jails) could be more appropriately used to address homelessness and other risk factors that contribute to this problem.
- There is widespread recognition that many, if not most, episodes of incarceration of people with mental illness serve no meaningful criminal justice purpose and that diverting people with mental illness from the criminal justice to the mental health system is both feasible and cost effective.³⁸

For all of these reasons, *SJC* sites can make a compelling case for the community services needed at each Sequential Intercept point³⁹ to divert people with mental illness from incarceration in jail. The ADA affords special and additional leverage for *SJC* sites in securing the community services needed to reduce the number of people with mental illness in jail.

³⁶ See COUNCIL OF STATE GOV’TS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 85 (2002), <https://www.opensocietyfoundations.org/sites/default/files/Consensus%2520Project%2520Report.pdf>.

³⁷ See *id.* at 111.

³⁸ See generally Kideuk Kim et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System* (2015).

³⁹ The Sequential Intercept Map developed by Policy Research Associates is attached as Appendix A to this paper.

Overcoming Challenges

While *Olmstead* and the services that have been implemented in *Olmstead* settlements hold great promise for reducing the involvement of people with serious mental illness in local justice systems, there are some distinct challenges to be overcome. Among them:

Decision-Making

To use “*Olmstead* services” to accomplish the diversion of people with mental illness, multiple players within the mental health and criminal justice systems must act toward a common goal.

Collaboration within the mental health system toward the goal of serving people in community rather than institutional settings is common, if not universal. Often, systems rely on a case manager and a primary clinician to identify and organize the services the person with mental illness will receive. Best practice is for the person’s case manager and primary clinician to actively engage the person, the person’s natural supports (such as family members), and existing and potential service providers to identify and develop a plan to enable the individual to live successfully in the community. An appropriate plan not only meets the person’s clinical needs through treatment, but also includes skill-building training, housing and social services, resolution of legal problems, and help provided by the person’s natural supports. An Assertive Community Treatment team operates in this way. The community mental health system is responsible for securing appropriate services for the person, including for accessing hospital services as needed.

SJC sites in communities where the public mental health system has developed effective processes for organizing services for people with mental illness can try to harness these processes in the service of diversion. Where the public mental health system is less organized and more fragmented, there may be multiple providers whose activities are not coordinated and even sometimes at cross purposes. Engaging the players in such a system in the service of diversion will be more challenging. Fortunately, even in such systems, the process for expanding “*Olmstead* services,” or accessing them on behalf of specific individuals is usually pretty well-defined. Furthermore, as was explained earlier, these systems have obligations under the ADA and *Olmstead* to serve people in ways that prevent unnecessary institutionalization.

Similar issues exist on the criminal justice side. There may be multiple players who influence whether a person with mental illness is diverted—a police officer, a prosecutor, a public defender, a probation or parole officer, a magistrate, or a judge might be involved. Usually there are fewer players at the earlier Sequential Intercept points. Getting all of these players on the same page can be a challenge that *SJC* sites can address. A well-defined diversion protocol is useful for coordinating the priorities and practices of these players, consistent with the requirements of the ADA and *Olmstead*. Such a protocol would identify who is appropriate for diversion (i.e., the characteristics of such people, including their criminal background and the availability of community mental health services), the processes or mechanisms that will be used to effect diversion, and in what instances and how the criminal justice system will receive information about the progress of the person diverted.

Additionally, at each Sequential Intercept stage, there may be barriers to diverting the individual from the criminal justice system. Police who encounter an individual whose mental health condition has resulted in low-level criminal conduct may—or may not—have the discretion about whether to arrest or instead to engage the mental health system. An outstanding warrant—for instance, for failure to appear—may be a limiting factor. Similarly, jail administrators may lack discretion to divert or release an individual to the community mental health system. Judges may be overloaded and hence slow to act, or may lack faith in the capacity of the mental health system to provide needed services.

To fully capitalize on the ADA as a vehicle for reducing incarceration in jails, all decision makers will need to understand their shared obligations and how their activities can align for timely diversion.

In January 2017, the Department of Justice issued written guidance to assist state and local criminal justice systems in complying with the requirements of Title II of the ADA, including *Olmstead* and the Integration Mandate.

The guidance, titled “**Examples and Resources to Support Criminal Justice Entities in Compliance with Title II of the Americans with Disabilities Act,**” explains how the ADA and *Olmstead* apply to the criminal justice system, including examples. The guidance also offers recommendations for training of personnel, review of policies and procedures, and collaboration among the criminal justice and disability service systems, as well as links to additional resources.

The document can be found at: www.ada.gov/cjta.html

Making the Business Case for Diversion

It is important that *SJC* sites be positioned to make the *Olmstead* case for expanding diversion services. It is also important that sites be prepared to make the business case for diversion, including the case for reallocating public funds to pay for services not (or not yet) covered by Medicaid, as well as housing costs.

Central to making the business case is understanding what savings can be anticipated, and from what budgets, if diversion efforts are expanded. One area where opportunities exist for savings is in local jail budgets. If a diversion system can reduce the number of people with mental illness in a given jail enough so that a floor or unit can be closed or re-purposed, such a reduction would generate significant savings in the jail budget. Fewer jail staff would be required, less medical care would be needed, and fewer specialized cells would need to be maintained. This process is similar to that long used successfully by mental health systems, which have become adept at achieving savings generated from reducing the number of individuals in a particular institution. It may be challenging to introduce the idea of such calculations in the context of criminal justice institutions or to get the data needed to predict cost savings from reducing the number of people with mental illness in a jail. But with proper planning and implementation, savings can be achieved and applied to diversion-related costs.

The cost of serving someone in a psychiatric setting tends to be high, averaging \$69,000 per patient annually. The cost of serving an individual with mental illness in a jail can often be higher, however, since those costs at times can far exceed the amount incurred when incarcerating people without disabilities. On average, however, it is likely that the cost of jailing an inmate with mental illness is not as high as the cost of institutionalizing an individual in a psychiatric setting. The corresponding savings, therefore, from “deinstitutionalizing” people with mental illness who would otherwise be in jail is likely to be less than savings that are generated from more traditional *Olmstead* “deinstitutionalization” efforts. There also may be fewer public dollars to shift from correctional institutions to community services.

On the other hand, psychiatric hospitalization costs are largely contained within the facility. Incarceration in jail is associated with a range of additional costs within other elements of the criminal justice system, including police costs and costs associated with processing an individual through the judicial process. Thus, in making the business case for diversion, sites should identify the full range of expenses associated with criminal justice contact and determine the potential for shifting public resources to invest in diversion efforts.

Also important for the business case is a projection of how much of the cost of diversion can be funded through existing state or federal funding and/or through modifications to the state’s Medicaid program. Data from *Olmstead* settlement agreements focusing upon reforms of mental health systems can help *SJC* sites shape projections about the potential for using state and federal dollars to reduce jail use in the service of the ADA.

The community mental health services that have been shown to be effective in keeping people with mental illness out of institutions can be funded in large part with federal funds through the Medicaid program. Even if a *SJC* site is in a state that has not participated in the expansion of Medicaid eligibility made possible through the Affordable Care Act, it is likely that a significant number of people with mental illness who are jailed already qualify for Medicaid (including as a result of their being eligible for disability benefits under the SSI or SSDI programs), although they may not be enrolled in the Medicaid program or their coverage may have been terminated while in jail. Furthermore, regardless of whether a state has pursued the ACA's Medicaid expansion, there are opportunities to broaden Medicaid's menu of covered services to include those effective in preventing arrest and incarceration, as well as to facilitate release from jail.

As a general matter—and without litigation—*SJC* sites can advance the same arguments for these changes that have been made in the *Olmstead* cases discussed earlier, including the shared obligations of state, county, and local authorities under the ADA. Depending upon the particular political landscapes in which *SJC* sites operate and the scope of Medicaid coverage already in place for the community mental health services needed by justice-involved populations, leveraging new services may be a complicated or a relatively straightforward endeavor. A good deal depends upon the progress that has already been made in re-tooling community mental health and its funding, and which key decision-makers (in state, county, and local government, including the criminal justice, mental health, Medicaid, and other systems) are committed to diversion and jail reduction.

Sharing Accountability for Diversion

Public mental health systems are underfunded. While most overwhelmingly embrace the core principles of deinstitutionalization and community mental health, their funding has lagged behind what is required to comprehensively serve all those in need. Many have the elements of an effective community system, but services such as Assertive Community Treatment and supported housing are in short supply and are reserved for frequent users of psychiatric hospitals.

Resource-strained mental health systems have tended to target their most costly community services on those who are most expensive to those systems, aiming in particular to reduce admissions and re-admissions to psychiatric hospitals. Often, this tendency results in mental health systems placing too little priority on people with mental illness who are—or who are at high risk of becoming—justice-involved. While a jurisdiction may incur substantial costs due to the justice-involved population, including because such persons frequently appear in emergency rooms, those costs may not be borne by the mental health system itself. Thus, although people with mental illness may be homeless, have substance use disorders, or be jail recidivists, the mental health system may not place a priority on engaging with them or providing them services.

For its part, the criminal justice system recognizes that it could generate substantial savings if the mental health system stepped up to the plate and effectively served the justice-involved population. But, it is rare that the criminal justice system is willing to invest in an expansion of services by the mental health system.

Historically, both systems have tended to be driven by their own bureaucratic imperatives, with admissions to psychiatric hospitals being regarded as a mental health matter, incarceration as a criminal justice matter, and so on. The ADA, however, does not make such distinctions.

To successfully divert individuals with mental illness from arrest and incarceration, there must be shared accountability for the outcome by both the mental health and criminal justice systems. The public mental health systems—notably, local community mental health programs—will need to assume greater responsibility for individuals at elevated risk of arrest and incarceration. To the extent that these individuals have not been afforded priority for services, that limitation will need to be softened or reversed. But reducing the number of people with mental illness who are incarcerated cannot be accomplished by mental health systems alone. *SJC* sites will need to understand how the criminal justice system itself affects the trajectory from police encounter to incarceration to release, as part of the larger law enforcement process.

SJC sites have the opportunity to use the ADA as leverage to align practices across systems to reduce both initial contact of people with mental illness with law enforcement, as well as their penetration within the system once initial contact is made. The status quo is not accidental. There is an uncomfortable history of mental health systems allowing—and perhaps, in some respects, benefitting from—large numbers of people with mental illness becoming the responsibility of other public systems, including local justice systems. There is also an uncomfortable history of these other systems allowing this to happen and sustaining this practice to this day. While a reduction in the number of individuals with mental illness who are incarcerated is a goal of the *SJC*, as well as of the ADA, it is reasonable to expect that changes in practice or resource allocations in the service of this goal may be met with resistance at various levels. Careful data collection, thoughtful evaluation of current practices and the factors that sustain them, and rigorous planning of reforms are necessary antidotes. They, as well as open and constructive dialogue between the mental health and criminal justice systems, are essential for securing shared responsibility and improved outcomes.

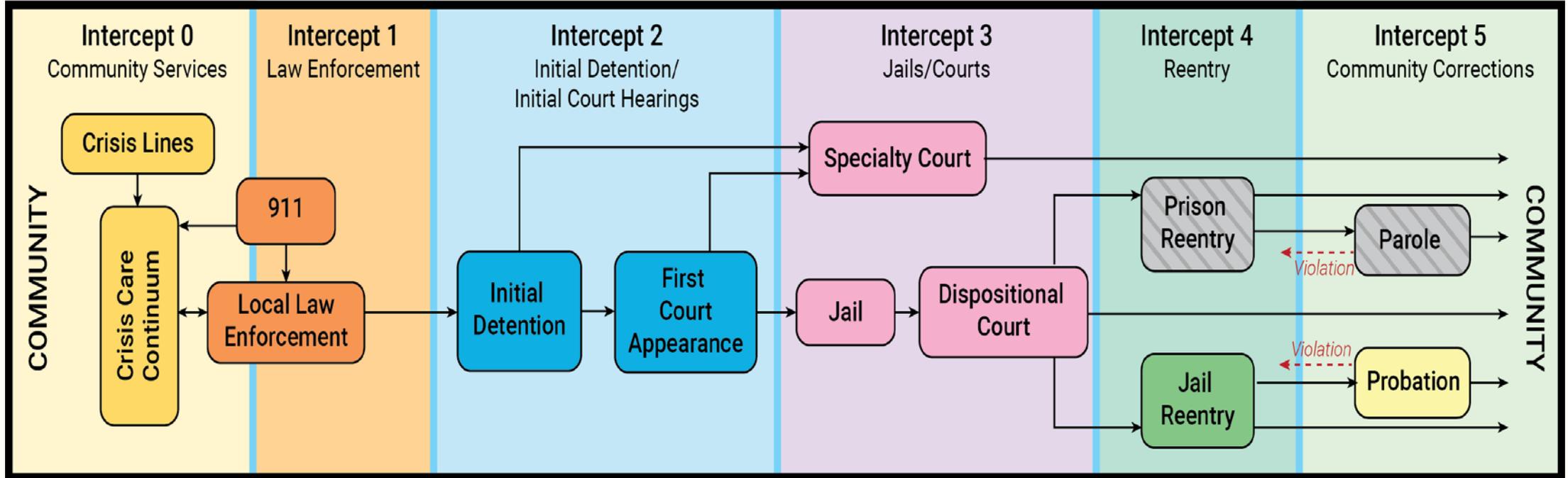
This report provides a framework for how *SJC* sites, as well as other localities, can apply the ADA and *Olmstead* to reduce the high number of individuals with mental illness who become involved with police, jails, and other elements of local justice systems. These legal requirements are important and as yet under-utilized levers that can spur significant reforms in public systems to divert at-risk individuals through the Sequential Intercept model and reduce their vulnerabilities for future criminal justice contact. **Building upon the success of the ADA and *Olmstead* in reducing institutional confinement of individuals within public mental health systems, *SJC* sites can demonstrate how local systems can promote similar improvements to reduce their jail populations and to use public resources in ways that help, rather than harm, citizens who have mental illness. The Bazelon Center for Mental Health Law strongly endorses these goals and will work in partnership with *SJC* sites to ensure that local justice systems no longer bear the consequences of the nation's neglect of people who have mental illness.**

Key ADA and *Olmstead* Compliance Questions

1. Are all elements of the criminal justice system – police, corrections, courts, prosecutors, and defenders – working collaboratively and with the mental health system to avoid needless incarceration in jail?
2. What is the typical profile of the people with mental illness whose incarceration could and should be avoided?
3. What mechanisms need to exist to accomplish their diversion?
4. Does your jurisdiction have, or is it developing, the full array of community mental health services, including mobile teams, Assertive Community Treatment, and supported housing, known to reduce criminal justice involvement by people with mental illness (see list of such services on page 16 of this paper)?
5. What provider network will your jurisdiction need to create or strengthen to ensure appropriate community-based alternatives to incarceration?
6. Are community mental health or housing providers permitted to refuse services to individuals because they have been arrested or incarcerated?
7. Has your jurisdiction identified all possible sources of funding for housing and other community-based services, including maximizing Medicaid funding?

Sequential Intercept Model as Our Behavioral Health Strategy Framework

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Supported by the John D. and Catherine T. MacArthur Foundation