
January 2019

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Recommended Citation

Barton, Sarah Anne (2019) "Close Only Counts in Horseshoes, Hand Grenades, and . . . Mental Health?: The Systematic Inadequacy of State *Olmstead* Plans Outside the Courtroom," *Liberty University Law Review*. Vol. 13 : Iss. 2 , Article 6.

Available at: https://digitalcommons.liberty.edu/lu_law_review/vol13/iss2/6

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NOTE

CLOSE ONLY COUNTS IN HORSESHOES, HAND GRENADES, AND . . . MENTAL HEALTH?: THE SYSTEMATIC INADEQUACY OF STATE OLMSTEAD PLANS OUTSIDE THE COURTROOM

Sarah Anne Barton[†]

*For a substantial minority. . .
deinstitutionalization has been a psychiatric
Titanic. Their lives are virtually devoid of
“dignity” or “integrity of body, mind, and
spirit.” “Self-determination” often means
merely that the person has a choice of soup
kitchens. The “least restrictive setting”
frequently turns out to be a cardboard box,
a jail cell, or a terror-filled existence plagued
by both real and imaginary enemies. Dr. E.
Fuller Torrey¹*

ABSTRACT

In the 1960s and 1970s, mental health reform reached its peak, resulting in the closure of state mental institutions and the sending of patients to community-based treatment programs. This was largely an attempt to integrate them into the community and keep them from being denied a normal life. Forty years later, this reform is still inspiring the closure of state

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1. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 609 (1999) (quoting E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA’S MENTAL ILLNESS CRISIS* 11 (1997)).

institutions and the discharge of patients. However, these closures are better in theory than in practice.

Since the original reforms, Title II of the Americans with Disabilities Act has required that states not “unduly institutionalize” patients and that such undue institutionalization constitutes a form of discrimination. Faced with Georgia’s failure to comply in *Olmstead v. L.C.*, the Supreme Court explained that if a state wanted to defend itself by claiming that compliance constitutes a “fundamental alteration” of its program, it would have to present the Court with what would become known as an “*Olmstead* plan.” Effective *Olmstead* plans are a demonstration of a state’s “comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings[] and a waiting list that move[s] at a reasonable pace not controlled by the state’s endeavors to keep its institutions fully populated.”² While this standard may be effective in some situations for shielding states from liability, it is not effective for keeping mentally ill individuals off the streets and providing them with proper healthcare. States do not always have sufficient funding or resources to provide the community treatment programs mandated by mental health legislation, and institutions do not have the capacity to house or treat newly-released patients. In other situations, *Olmstead* plans meet only the bare minimum required without regard to whether the plan is continuously effective.

While federal oversight seems an attractive option, it implicates another concern—federalism. While still being firmly counterbalanced by the desire to ensure access to healthcare in the least restrictive environment possible, the issue of state autonomy cannot be ignored. These twin concerns divided the Court in *Olmstead* and continue to strictly limit the Court and Congress in their efforts to protect the mentally ill. In response to that struggle, this Note will first explore the history of mental health reform. Then, it will examine the state of mental health post-*Olmstead*, including a survey of various state *Olmstead* plans. Finally, it will address the issue of state autonomy and suggest ways for states to improve their *Olmstead* plans to improve access to care and keep the mentally ill from homelessness.

I. INTRODUCTION

Upon her visit to North Carolina in 1848, Dorothea Dix was shocked and disturbed by the state’s treatment of mentally ill residents, finding most of

2. *Id.* at 605-06.

them cut off from medical care and living in poorhouses and jails.³ She petitioned the North Carolina legislature for \$100,000 and berated them for not using their “God-like influence” to lessen the suffering of the mentally ill.⁴ The state legislature granted Dorothea Dix a small portion of her request, leading to the construction of what was originally the Asylum for the Insane. The Asylum later came to be known as Dorothea Dix Hospital (Dix), a refuge and treatment center for the mentally ill.⁵

Nearly 170 years later, this institution that sought to honor its namesake is a thing of the past as a result of Governor Mike Easley’s 2001 proposed reform package.⁶ In 2010, Dix stopped admitting patients and started transferring most of its patients to small state hospitals.⁷ By 2012, Dix had rid itself of its last few patients.⁸ Dix’s closure was in response to decades of mental health and Medicare reforms throughout the country.⁹ This reform reached its peak in the 1960s and 1970s when the Community Mental Health Act attempted to legislate the deinstitutionalization of mentally ill patients through the widespread closure of state psychiatric institutions.¹⁰ The goal of this legislation was to shift the focus from large mental institutions to community-based treatment, integrating the mentally ill into the community and treating them as productive members of society while still providing them with the care they need.¹¹

While the cause seemed noble, mass deinstitutionalization proved to be a better idea in theory than in practice. The North Carolina healthcare system was unprepared for such a massive transition of patients from mental health

3. See Meredith Malburne, *Dorothea Dix’s Advocacy for the Mentally Ill in North Carolina*, DOCUMENTING THE AMERICAN SOUTH, <http://docsouth.unc.edu/highlights/dix.html> (last visited Feb. 5, 2018).

4. *Id.*; Josh Shaffer, *Don’t Let Dix Hill’s Mentally Ill Patients Be Forgotten*, NEWS & OBSERVER (May 5, 2015), <http://www.newsobserver.com/news/local/news-columns-blogs/josh-shaffer/article20275470.html>.

5. Malburne, *supra* note 3; Shaffer, *supra* note 4.

6. Bob Geary, *Closing of Dorothea Dix Hospital Marks Failure of State Reforms*, INDY WEEK (Dec. 8, 2010), <https://www.indyweek.com/indyweek/closing-of-dorothea-dix-hospital-marks-failure-of-state-reforms/Content?oid=1866209>.

7. *Id.*

8. Shaffer, *supra* note 4.

9. Lindsey Brunson, *North Carolinians Seeking Mental Health Care Might Encounter Problems*, DAILY TAR HEEL (Jan. 30, 2015), <http://www.dailytarheel.com/article/2015/01/north-carolinians-seeking-mental-health-care-might-encounter-problems>.

10. See *infra* Section II.B.

11. *Id.*

institutions into regular institutions and the community. Dix served as “a safety net and a relief valve” for the mental health system, ensuring sufficient treatment and shelter for the mentally ill.¹² Its closure has created a shortage of and desperate need for beds, especially considering that the community-based programs promised by Governor Easley’s 2001 reform package were never realized.¹³ This shortage of beds and community-based programs resulted in homelessness and untreated illness for many former patients.¹⁴

Mental health reform, while well-meaning, has produced many unintended consequences, one of which is a higher incidence of mental health-related emergency room admissions.¹⁵ In 2010, approximately 10% of emergency room visits in the state were mental health-related, and the mentally ill were admitted twice as often as those without mental disorders.¹⁶ Once patients reach the emergency room, it takes an average of 88.9 hours (a little over 3.5 days) for admittance to a state hospital.¹⁷

North Carolina’s system is just one example of mental health reform gone wrong. Other states such as Florida, Oklahoma, and New Jersey have all struggled in recent years to conform to legislation supporting deinstitutionalization and community-based treatment programs,¹⁸ especially with the most recent addition, the Americans with Disabilities Act (ADA).¹⁹ This struggle has been both alleviated and exacerbated by case law attempting to interpret these laws, culminating in the landmark United States Supreme Court case *Olmstead v. L.C. ex rel. Zimring*. *Olmstead* interpreted the fundamental alteration defense set out in the ADA as applied to the requirement that states provide treatment to the mentally ill in the most integrated setting appropriate, requiring them to produce comprehensive, effectively working plans to back up their claims.²⁰ However, while the

12. Geary, *supra* note 6.

13. *Id.*

14. For example, a friend of mine, who wishes to remain anonymous, shared her story with me. Her aunt was a patient at Dix and was forced to live on the streets after its closure. Her family was never notified of her discharge and did not find out about it until later. At this point, the aunt had already been homeless for a month or two.

15. Shaffer, *supra* note 4.

16. Brunson, *supra* note 9.

17. Shaffer, *supra* note 4.

18. *Shortage of Psychiatric Hospital Beds (IMD Exclusion) in Florida, Oklahoma, New Jersey and North Carolina*, MENTAL ILLNESS POL’Y ORG., <https://mentalillnesspolicy.org/imd/hospital-bed-shortage-4-states.html> (last visited Dec. 26, 2017).

19. *See infra* Section II.E.

20. *See infra* Section II.E.2.

standard laid out by the *Olmstead* Court may be sufficient to protect the states legally, it is not sufficient to protect the mentally ill in those states. Favorable outcomes for states in cases such as *Arc of Washington State v. Braddock* evidence this insufficiency.

Ideally, as Justice Thomas explained in his *Olmstead* dissent, the implementation of deinstitutionalization and community-based treatment programs should be left to the states.²¹ To do otherwise would completely violate basic concepts of federalism and infringe on state autonomy. There is no one-size-fits-all federal solution to mental health disparities. The states have different needs, and each state legislature should know better than the federal legislature what is a reasonable solution for its own government and people.

Ultimately, states should model their *Olmstead* plans after states with successful mental health programs. What theoretically works as an affirmative defense in court is not what works in reality. States like Vermont and New Hampshire, which have successfully closed mental institutions while still maintaining low levels of homelessness and providing patients with community-based treatment programs, should be the gold standard for states in the preparation of their *Olmstead* plans. Ideally, state governments should not settle for mediocrity, shielding themselves from liability, but should actively attempt to provide worthwhile services for the mentally ill. Improvements can be made to state mental health systems through *Olmstead* plans that provide for incentive programs for private mental health care providers, and other similar initiatives. Given the utmost deference and autonomy, the states should make their *Olmstead* plans as comprehensive as possible, looking to other states, their citizens, and private entities for resources, ideas, and suggestions.

II. THE RISE OF LEGISLATION REGARDING MENTAL HEALTH

Caring for the mentally ill was largely within the province of individual states rather than the federal government until the end of World War II.²² However, the end of World War II brought heightened federal attention to mental illness, especially within the armed forces.²³ An exponential increase in advocacy from suffering soldiers, their families, and mental health clinicians sparked this new awareness.²⁴ Faced with this newfound knowledge

21. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 624 (1999).

22. ELLEN HERMAN, *THE ROMANCE OF AMERICAN PSYCHOLOGY: POLITICAL CULTURE IN THE AGE OF EXPERTS* 242 (1996).

23. *Id.* at 241.

24. *Id.* at 245.

of mental illness and post-war concerns about military efficacy and national security, the federal government enacted what would within decades become a long string of mental health legislation.²⁵

A. The National Mental Health Act of 1946

In response to increased advocacy and lobbying, Congress passed the National Mental Health Act (NMHA) in 1946.²⁶ The NMHA elevated mental health to the same priority status as other areas of healthcare, attempting to spur scientific research and find methods of prevention, diagnosis, and treatment.²⁷ The passage of the NMHA also caused a shift from palliative care for those with mental illness to preventive care to promote mental health.²⁸ Most notably, the NMHA authorized and provided funding for the National Institute of Mental Health (NIMH), which was to serve as the federal government's vehicle in executing the provisions of the NMHA.²⁹ While the NIMH was not established until 1949, it became foundational in furthering mental health programs, characterized by their preventive and community-oriented nature.³⁰ By the 1960s, the NMHA and NIMH had effectively laid the groundwork for further research and legislation by providing a solid base of behavioral research clinical studies.³¹

B. The Community Mental Health Act

By the mid-1960s, the United States was home to 414 long-stay mental hospitals, housing 558,000 patients.³² Appalled by the isolation he saw in these facilities and spurred by his love for his own disabled sister,³³ President Kennedy signed the Community Mental Health Act (CMHA).³⁴ The CMHA incentivized state legislators to deinstitutionalize mental patients, therefore

25. *Id.* at 241.

26. *Id.* at 245-46.

27. National Mental Health Act, Pub. L. No. 79-487, 60 Stat. 421 (1946).

28. HERMAN, *supra* note 22, at 246.

29. National Mental Health Act § 11.

30. HERMAN, *supra* note 22, at 247-48.

31. *Id.* at 249.

32. CARL A. TAUBE, NAT'L CTR. FOR HEALTH STAT., PHS PUB. NO. 1000, SERIES 12 NO. 1, CHARACTERISTICS OF PATIENTS IN MENTAL HOSPITALS (1965).

33. Brian Prioleau, *Reflecting on JFK's Legacy of Community-Based Care*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/jfk's-legacy-community-based-care> (last updated Apr. 19, 2016).

34. Milton L. Mack, Jr., *Involuntary Treatment for the Twenty-First Century*, 21 QUINNIAC PROB. L.J. 294, 296 (2008).

shifting the cost of their care from the states to the federal government.³⁵ The federal government offering funding to the states with which they would create community-based treatment centers created a shift from federal to state oversight.³⁶ President Kennedy envisioned a system in which the federal government would not dictate how the states should respond, but would simply provide sufficient funds for the states to create their own community-based treatment centers.³⁷ This was an attractive option for state legislators, but its effect was essentially to cut states' mental health budgets and almost obliterate inpatient treatment.³⁸

While the CMHA made great strides in proliferating the use of psychiatric medications and encouraging the social and occupational integration of the mentally ill into society, it did not meet its goal of ensuring that the mentally ill received adequate community-based treatment.³⁹ Because of the decrease in funding for the states, there was a 2.5% decrease in the number of psychiatrists per community center.⁴⁰ Due to the inadequacy of government-funded care, the burden of caring for the mentally ill fell on family members and society in general.⁴¹ However, society was ill-equipped to handle this burden, evidenced by an increase in incarceration of the mentally ill and treatment in facilities such as nursing homes that were not tailored to meet their needs.⁴²

C. *The Mental Health Systems Act of 1980*

In response to this lack of funding, President Carter signed the Mental Health Systems Act (MHSA) in 1980.⁴³ Rather than giving each state a block grant to use as it wished, the federal government under the MHSA granted each community mental health center an amount proportionate to its costs

35. *Id.* at 297.

36. Community Mental Health Act, Pub. L. No. 88-164, 77 Stat. 282 (1963); Megan Honingford, *Efforts at Mental Healthcare and Substance Abuse Treatment Reform*, 22 ANNALS HEALTH L. ADVANCE DIRECTIVE 152, 155 (2012).

37. Prioleau, *supra* note 33.

38. Honingford, *supra* note 36, at 155.

39. Samantha M. Behbahani et al., *The Patient Protection and Affordable Care Act: Will Parity for Mental Health Care Truly Be Achieved in the 21st Century?*, 10 INTERCULTURAL HUM. RTS. L. REV. 153, 155-56 (2015).

40. *Id.*

41. *Id.* at 156.

42. *Id.*

43. Mental Health Systems Act, Pub. L. 96-398, 94 Stat. 1564 (1980).

of operation.⁴⁴ This amount would decrease in percentage, eventually phasing out by the end of the center's eighth year of operation.⁴⁵ Similarly, if a center did not use all of its funding in the previous year, the funding it received for the next year would be reduced by that amount.⁴⁶ The MHSA seemed a promising option that would have had great impact on innovation in the treatment of mental health and other underserved populations.⁴⁷ However, with Ronald Reagan's presidency came the unfortunate repeal of much mental health legislation and drastic cuts in mental health-allocated funding.⁴⁸

D. The Omnibus Budget Reconciliation Act and Its Repeal of Previous Legislation

Ronald Reagan's presidency brought deep cuts to federal funding of healthcare related services, including those that mental health law had spent decades attempting to build.⁴⁹ Rather than giving the states funding based on the needs of their community mental health centers, the Omnibus Budget Reconciliation Act (OBRA) gave the states block grants.⁵⁰ Federal funding was to be split between mental health and substance abuse programs—35% to mental health, 35% to substance abuse, and the remaining 30% left to the state's discretion.⁵¹ Instead of giving the grants to the states directly for community-based treatment programs, they were given to the states as an amorphous block grant, once again allowing the states to house the mentally ill in nursing homes and other facilities ill-equipped to treat them.⁵² This had the effect of essentially re-segregating the mentally ill into large facilities, the exact outcome the federal government attempted to avoid by enacting mental health legislation.⁵³

44. *Id.* § 201.

45. *Id.*

46. *Id.*

47. Lois A. Weithorn, *Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1469 (2005).

48. *Id.*

49. Omnibus Budget Reconciliation Act, Pub. L. No. 97-35, 95 Stat. 357 (1981).

50. SPECIAL COMMITTEE ON AGING, 97TH CONG., INFORMATIONAL PAPER ON OMNIBUS BUDGET RECONCILIATION ACT OF 1981 11 (Comm. Print 1981).

51. *Id.*

52. Daniel Yohanna, *Deinstitutionalization of People with Mental Illness: Causes and Consequences*, 15 AM. MED. ASS'N J. ETHICS 886, 888 (2013).

53. *Id.*

E. *The Americans with Disabilities Act*

By 1990, an estimated 43,000,000 Americans lived with some form of physical or mental disability.⁵⁴ Recognizing the historical segregation of the mentally ill and outright discrimination against those with mental and physical disabilities, Congress passed the Americans with Disabilities Act (ADA).⁵⁵ The ADA had a fourfold purpose: (1) to eliminate discrimination against those with disabilities, (2) to provide clear standards to promote the elimination of this discrimination, (3) to centralize enforcement of the ADA, and (4) to invoke congressional authority through its Fourteenth Amendment and commerce powers.⁵⁶

Since the ADA's passage, the concept of discrimination against the mentally ill has been linked to compliance with the CMHA's community-based treatment plan. While the ADA did not address community-based mental health treatment centers directly, they have since been absorbed into Title II's requirement that public entities provide services in the most integrated setting appropriate. As a common theme of subsequent case law, advocacy groups, families, and mentally ill individuals have sued and continue to sue states for discrimination under the ADA, namely violation of the ADA's integration mandate, in failing to comply with some variation on the CMHA's community-based treatment plan.⁵⁷

1. An Overview of Title II

After the integration mandate was drafted, the Attorney General was instructed to issue regulations for its implementation.⁵⁸ One such regulation, modeled after § 504 of the Rehabilitation Act of 1973, became known as the "integration regulation" and stated that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."⁵⁹ Title II defines a "public entity" as "any State or local government" or "any department,

54. Americans with Disabilities Act, Pub. L. No. 101-336, 104 Stat. 327 (1990).

55. *Id.*

56. *Id.*

57. See *Steimel v. Wernert*, 823 F.3d 902 (7th Cir. 2016); *Amundson ex rel. Amundson v. Wis. Dep't of Health Servs.*, 721 F.3d 871 (7th Cir. 2013); *Frederick L. v. Dep't of Pub. Welfare of Pa.*, 422 F.3d 151 (3rd Cir. 2005); *Sciarrillo ex rel. St. Amand v. Christie*, No. 13-034478, 2013 WL 6586569 (D.N.J. Dec. 13, 2013); *Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184 (E.D.N.Y. 2009); *M.D. ex rel. Davidson v. Dep't of Developmental Servs.*, 985 N.E.2d 863 (Mass. App. Ct. 2013).

58. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 591 (1999).

59. *Id.* at 592 (quoting 28 C.F.R. § 35.130(d) (1998)).

agency, [or] special purpose district.”⁶⁰ “Qualified individual with a disability” means

an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.⁶¹

The preamble defines the “most integrated setting appropriate to the needs of qualified individuals with disabilities” as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”⁶²

In implementing these regulations, the Attorney General determined that unjustifiably limiting the exposure of mentally ill patients to the community was a form of discrimination and that the states had an obligation to counter the discrimination as much as possible.⁶³ In determining whether the states meet this obligation, courts will simply balance several interests, including the cost of housing the patients in a community-based facility, the state's mental health budget and the range of services provided to others with mental disabilities, and the state's obligation to equitably distribute those services.⁶⁴

The *Olmstead* Court interpreted this mandate to require the states to release patients from an institution into community-based treatment if three conditions are met: (1) state mental health professionals have cleared the patient for release to the community program, (2) this transition is “not opposed by the affected individual,” and (3) “the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.”⁶⁵ The last condition is the fundamental alteration defense, which will be discussed in more detail later on.

60. *Id.* at 590 (alteration in original) (quoting 42 U.S.C. § 12131(1)(A), (B)).

61. *Id.* (quoting 42 U.S.C. § 12132).

62. *Id.* at 592 (quoting 28 C.F.R. pt. 35, App. A 450 (1998)).

63. *Id.* at 596-97.

64. *Olmstead*, 527 U.S. at 597.

65. Megan Chambers, Comment, *Integration as Discrimination against People with Disabilities?*, 46 CAL. W.L. REV. 177, 181 (1999) (quoting *Olmstead*, 527 U.S. at 587).

Title II also incorporates § 504 of the Rehabilitation Act for purposes of redress.⁶⁶ Section 504 is the crux of the Title II integration mandate that recipients of federal funds must use them to “administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.”⁶⁷ Courts have been repeatedly left with the task of determining what the “most integrated setting appropriate” means, whether states have complied with this amorphous standard, and whether failure to comply amounts to discrimination.⁶⁸

2. *The Fundamental Alteration Defense as Applied to Olmstead Plans*

The last of the three conditions of the integration mandate makes up the fundamental alteration defense introduced by the Supreme Court in its *Olmstead* opinion.⁶⁹ The Court explained that the state did not have to accommodate Title II if it could prove that “the modifications would fundamentally alter the nature of the services, program, or activity.”⁷⁰ The Court also explained that a state may raise the fundamental alteration defense if the state meets the criteria of what is now called an “*Olmstead* plan.”⁷¹ The state must present the court with “a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated.”⁷²

The fundamental alteration defense is inherently an affirmative defense.⁷³ Initially, the plaintiff has the burden of proving the existence of “a reasonable modification that would address the disability, and to show that the defendant is in violation of the integration mandate.”⁷⁴ If the plaintiff proves

66. *Brown v. District of Columbia*, 322 F.R.D. 51, 53 (D.D.C. 2017).

67. *Id.*; 28 C.F.R. § 41.51 (1973).

68. See *Steimel v. Wernert*, 823 F.3d 902 (7th Cir. 2016); *Amundson ex rel. Amundson v. Wis. Dep’t of Health Servs.*, 721 F.3d 871 (7th Cir. 2013); *Frederick L. v. Dep’t of Pub. Welfare of Pa.*, 422 F.3d 151 (3rd Cir. 2005); *Sciarrillo ex rel. St. Amand v. Christie*, No. 13-034478, 2013 WL 6586569 (D.N.J. Dec. 13, 2013); *Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184 (E.D.N.Y. 2009); *M.D. ex rel. Davidson v. Dep’t of Developmental Servs.*, 985 N.E.2d 863 (Mass. App. Ct. 2013).

69. Darian B. Taylor, Annotation, *Unjustified Institutionalization of Individuals with Disabilities as Violation of Federal Antidiscrimination Provisions—Post-Olmstead Cases*, 90 A.L.R. Fed. 2d 1, § 2 (2014).

70. *Id.*

71. *Id.*

72. *Id.* (quoting *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999)).

73. *Id.*

74. *Id.*

this, the defendant then has the burden of proving that the relief requested by the plaintiff was not reasonable and would be unduly burdensome or would require some fundamental alteration of the state's program, considering economic resources and the state's obligation to other institutionalized mentally ill individuals.⁷⁵

While the requirements seem clear, courts disagree as to the implementation of the defense. Courts are generally unclear as to whether failure to plead the defense in response to an *Olmstead* claim completely waives the defense as well as whether a formalized *Olmstead* plan is required before the court will consider the other elements of the defense.⁷⁶ In a formalized plan's place, courts will consider evidence of success of a currently implemented plan and budget restrictions.⁷⁷ However, cost is not the only consideration.⁷⁸ If the state has shown no evidence of working toward deinstitutionalization, cost is a nonissue.⁷⁹ However, if the state has proven that it is reasonably working toward deinstitutionalization, cost and budgetary restrictions are the court's main mode of analysis.⁸⁰

III. *OLMSTEAD'S* REVOLUTIONARY EFFECTS ON THE COURTS' TREATMENT OF PSYCHIATRIC RIGHTS CASES

The landmark Supreme Court case of *Olmstead* addressed the issue of discrimination as a basis for lawsuits against the state.⁸¹ Throughout its majority, concurring, and dissenting opinions, *Olmstead* discussed a number of topics regarding the ADA's effects on community-based treatment programs.⁸² Relevant here are the Supreme Court's interpretation of the term "discrimination" and the states' available defenses against these allegations.⁸³

In May 1992, L.C., a woman suffering from schizophrenia, voluntarily admitted herself to the psychiatric unit at Georgia Regional Hospital (GRH).⁸⁴ GRH confined her there until May 1993, when her condition

75. Taylor, *supra* note 69, § 2.

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

82. *Id.*

83. *Id.*

84. *Id.* at 593.

stabilized.⁸⁵ Her treatment team at GRH determined that it would be appropriate to release her for treatment by one of Georgia's community-based programs.⁸⁶ However, she was not released until February 1996.⁸⁷

In February 1995, E.W., also an intellectually disabled woman, voluntarily admitted herself to the psychiatric unit at GRH.⁸⁸ GRH confined E.W. for only a month before planning to release her to a homeless shelter.⁸⁹ After an administrative complaint filed by her attorney, GRH decided otherwise.⁹⁰ By 1996, GRH cleared her for release to a community-based program but remained at GRH until 1997, only being released after the district court's judgment.⁹¹

Initially, L.C. filed suit in the Northern District of Georgia in May 1995, alleging that "the State's failure to place her in a community-based program . . . violated, *inter alia*, Title II of the ADA."⁹² She requested that she be placed in a community-based program "with the ultimate goal of integrating her into the mainstream of society."⁹³ Soon thereafter, E.W. intervened under the same claim.⁹⁴

The State countered, claiming that lack of funding, not discrimination "by reason of" the plaintiffs' disabilities, was the reason for its failure to place the plaintiffs in community-based treatment.⁹⁵ The State claimed that, even though it should have transferred L.C. and E.W. into a community-based program, court intervention requiring it to place them now "would 'fundamentally alter' the State's activity."⁹⁶ However, the district court rejected this argument, opining that the State could provide care through existing state programs at less cost than it could at an institution.⁹⁷ Thus, the court granted partial summary judgment to both plaintiffs.⁹⁸ The court held

85. *Id.*

86. *Id.*

87. *Olmstead*, 527 U.S. at 593.

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.* at 593-94.

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

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.* at 594-95.

98. *Id.* at 594.

that unnecessarily keeping the patients segregated in a psychiatric hospital constituted discrimination per se and was a violation of Title II of the ADA.⁹⁹

While the Eleventh Circuit affirmed the district court's judgment, it also held that the State's inadequate funding claim should have been considered. The court remanded the issue to the district court for its reassessment.¹⁰⁰ The Eleventh Circuit recognized inadequate funding as a plausible defense, explaining that Title II required reasonable modifications but not fundamental alterations of a state's Medicaid program.¹⁰¹ Requiring a state to provide community-based treatment to a patient despite inadequate funding would in fact constitute a fundamental alteration.¹⁰² According to the court, the legislature clearly intended to provide for a cost defense "in the most limited of circumstances."¹⁰³ However, because the Eleventh Circuit's view of the defense was so limited, it required that the State prove that requiring it to expend the additional funds would be "so unreasonable *given the demands of the State's mental health budget* that it would fundamentally alter the service [the State] provides."¹⁰⁴ The Supreme Court then granted certiorari.¹⁰⁵

A. *The Supreme Court's Fundamental Alteration Requirements*

The Supreme Court affirmed the Eleventh Circuit as to the issue of discrimination but disagreed with the Eleventh Circuit that inadequate funding was sufficient to constitute an effective fundamental alteration defense.¹⁰⁶ As explained in Justice Ginsburg's majority opinion, unjustified isolation by reason of disability does constitute discrimination per se, but the Eleventh Circuit's instructions on remand to the district court were too restrictive.¹⁰⁷ Rather than just comparing the cost of community-based programs with institutionalization, the district court should also consider the resources to which the state has access, the resources provided by the state to others with disabilities, and the state's obligation regarding those services.¹⁰⁸

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

100. *Id.* 595-96.

101. *Id.* at 595.

102. *Id.*

103. *Id.*

104. *Id.* (alteration in original) (emphasis added).

105. *Olmstead*, 527 U.S. at 596.

106. *Id.* at 597.

107. *Id.*

108. *Id.*

The Court first addressed the issue of whether discrimination by reason of disability includes undue institutionalization.¹⁰⁹ While the State claimed that the term “discrimination” meant the “uneven treatment of similarly situated individuals,” the Court disagreed.¹¹⁰ It concluded that the ADA includes such segregation in its definition of discrimination.¹¹¹ However, in an attempt to mitigate this harsh determination, the Court emphasized that nothing in the ADA mandates the closure of all state mental institutions, contrary to earlier legislation.¹¹² Also, states may use their own mental health professionals in examining whether a patient is fit for release into a community-based program, and patients may decline such release if they so desire.¹¹³

The Court then turned to the issue of the existence of a cost-based defense for the State.¹¹⁴ The Court interpreted the Attorney General’s Title II regulations to require the State to make “reasonable modifications” in attempting to avoid discrimination, but would allow them to resist if they could show that the changes would make “fundamental alterations” in the services the State provides.¹¹⁵ The Eleventh Circuit’s standard requiring only that the State compare the cost between institutionalized treatment and community-based treatment is insufficient and is such a high standard that it would rarely, if ever, allow a state to prevail.¹¹⁶ The Supreme Court determined that a far more sensible solution would be to allow the State to argue that immediate relief for the plaintiffs is inequitable.¹¹⁷

The Court even went so far as to give an example of what the ideal fundamental alteration defense would look like.¹¹⁸ As a preliminary matter, the State would have already met the reasonable modifications standard.¹¹⁹ This would be accomplished by a showing that the State had a “comprehensive, effectively working plan” for placing patients in community-based programs and “a waiting list that moved at a reasonable pace.”¹²⁰ If a state could meet the reasonable modifications standard, the

109. *Id.*

110. *Id.* at 598.

111. *Olmstead*, 527 U.S. at 600.

112. *Id.* at 601-02.

113. *Id.* at 602.

114. *Id.* at 603.

115. *Id.*

116. *Id.*

117. *Olmstead*, 527 U.S. at 604.

118. *Id.* at 605-06.

119. *Id.*

120. *Id.*

Supreme Court explained, it could bring a defense of fundamental alteration knowing that a court would have no reason not to grant it.¹²¹

Ultimately, the Court reiterated the requirement that states must provide mentally ill patients with community-based treatment programs in circumstances where (1) the patients have been cleared for release from institutionalization by state mental health professionals and (2) it is practical for the state after meeting the reasonable modifications standard.¹²²

B. Possible Issues with This Approach

Justice Kennedy's concurrence and Justice Thomas's dissent more substantially analyze the policy issues and implications arising from the application of a discrimination *per se* rule and allowance of the fundamental alteration defense.

Citing statistics supporting early legislation attempting to incentivize deinstitutionalization, Justice Kennedy also recognized its "dark side."¹²³ He opined that "deinstitutionalization has been a psychiatric *Titanic*."¹²⁴ He also explained that mental health legislation has incentivized states to force patients out of mental institutions without providing sufficient care afterward, resulting in a lack of supervision and assistance and in some cases homelessness.¹²⁵ Kennedy reiterated the importance of granting deference to the decisions of the State's treatment providers and policymakers.¹²⁶ He was concerned about the effects such federal involvement would have on federalism, and, while he still agreed with the majority's decision, he was hesitant about allowing federal judicial review over what should probably be a state political matter.¹²⁷

Next, Kennedy addressed the issue of considering undue institutionalization as discrimination *per se*.¹²⁸ Contrary to the majority, he believed that discrimination should be given its ordinary meaning as claimed by the State rather than the meaning the majority claims was attributed to it by the statute.¹²⁹ However, contrary to Justice Thomas's dissent, Kennedy

121. *Id.* at 606.

122. *Id.* at 607.

123. *Olmstead*, 527 U.S. at 609 (Kennedy, J., concurring).

124. *Id.*

125. *Id.* at 610.

126. *Id.*

127. *Id.*

128. *Id.* at 611.

129. *Olmstead*, 527 U.S. at 611 (Kennedy, J., concurring).

believed that the ordinary meaning of discrimination yielded the same result as the majority.¹³⁰

Further, Kennedy addressed the issue of what was required of the State.¹³¹ He emphasized that states without community-based treatment programs already in place are not required to create these programs, a seemingly novel idea since the advent of mental health legislation and its accompanying case law.¹³² However, also showing his hesitance to involve the judiciary in these state-based programs, Kennedy explained that the judgment of whether states must create programs is largely a political one.¹³³

Rather than explicitly addressing the issue of a defense available to the State, Kennedy advocated for narrowing the ability of plaintiffs to bring discrimination claims.¹³⁴ He recognized that discrimination is a rather broad term and that plaintiffs bringing a claim of discrimination must prove that “a comparable or similarly situated group received differential treatment.”¹³⁵ He also explained that cases of discrimination should be decided case-by-case to ensure that all institutionalization is not labeled discrimination *per se*.¹³⁶ However, he agreed with the majority that, with the facts of this case, the plaintiffs did have a claim for discrimination that should be explored further.¹³⁷

In contrast, Justice Thomas’s dissent first focused on the definition of discrimination that should be applied. He opined that discrimination should be given its traditional meaning, not a statutory meaning separate from ordinary use, and that “[t]emporary exclusion from community placement” does not constitute discrimination.¹³⁸ Discrimination requires differential treatment of “similarly situated persons” in different groups.¹³⁹ Supporting this definition, he said that case law interpreting § 504 of the Rehabilitation Act uses the traditional definition of discrimination.¹⁴⁰

Also, the version of the term “discrimination” used in the statute has always been limited to discrimination “by reason of [the patient’s] handicap,”

130. *Id.* at 611.

131. *Id.* at 612.

132. *Id.*

133. *Id.* at 612-13.

134. *Id.* at 613.

135. *Olmstead*, 527 U.S. at 613 (Kennedy, J., concurring).

136. *Id.* at 614.

137. *Id.* at 614-15.

138. *Id.* at 616 (Thomas, J., dissenting).

139. *Id.* at 617.

140. *Id.* at 618.

and avoiding discrimination does not always require the type of affirmative act required by the majority.¹⁴¹ In support of this assertion, Thomas mentioned two specific cases. In *Alexander v. Choate*, the Court held “that § 504 does ‘not . . . guarantee [individuals with disabilities] equal results from the provision of state Medicaid.’”¹⁴² Similarly, in *Traynor v. Turnage*, the Court held that, while the goal of the Rehabilitation Act was to provide “evenhanded treatment” in comparison to those without disabilities, the Act does not require that “any benefit extended to one category of [individuals with disabilities] also be extended to all other categories of [individuals with disabilities].”¹⁴³

Thomas also expressed concern about the effects such an approach would have on federalism.¹⁴⁴ He explained that the affirmative defense offered by the majority was of little consequence, especially since the State would have to defend itself in court anytime an individual disagreed with the State’s decision regarding placement.¹⁴⁵ Thomas suggested that the states should be the ones to make this decision, consistent with their “historical role as the dominant authority” in the area of public services for disabled individuals.¹⁴⁶

Applying his preferred definition of discrimination to this case, Thomas concluded that the plaintiffs were not discriminated against.¹⁴⁷ He explained that the proximate causation element (that plaintiffs be discriminated against “by reason of [their] disabilities”) required by the statute was not satisfied.¹⁴⁸ Further, he claimed that discrimination is not possible here because those without disabilities are not eligible for community placement, and therefore, the disability was not the proximate cause of the denial of community placement.¹⁴⁹ Instead, the proximate cause of the denial of community placement was the State’s limited resources.¹⁵⁰

141. *Olmstead*, 527 U.S. at 619 (Thomas, J., dissenting) (quoting *Se. Cmty. Coll. v. Davis*, 442 U.S. 397, 405, 410 (1979)).

142. *Id.* (quoting *Alexander v. Choate*, 469 U.S. 287, 304 (1985)).

143. *Id.* at 619-20 (quoting *Traynor v. Turnage*, 485 U.S. 535, 548-49 (1988)).

144. *Id.* at 624.

145. *Id.* at 625.

146. *Id.*

147. *Olmstead*, 527 U.S. at 626 (Thomas, J., dissenting).

148. *Id.* (alteration in original) (quoting 42 U.S.C.S. § 12132).

149. *Id.*

150. *Id.*

IV. THE DISCONNECT BETWEEN COURT ENFORCEMENT OF *OLMSTEAD* AND THE STATE OF MENTAL HEALTH

An influx of lawsuits followed *Olmstead* for the next couple of decades, ending in court orders for enforcement, settlements, and the drawing up of new *Olmstead* plans. However, this generally did not result in improvements within state mental health programs. To the contrary, it left many individuals with mental illness without access to mental health, especially those living in rural areas, and left many more homeless. This disconnect between court enforcement and the reality of living with mental illness cannot be ignored.

A. Court Enforcement of *Olmstead* Plans

Arc of Washington State v. Braddock showcases an instance when a state has met the requirements for the fundamental alteration defense. In this case, the state of Washington devised a plan that split its funding between large institutions and small, privately operated residences.¹⁵¹ Further, Washington instituted a waiver program, called the Home and Community-Based Services waiver (HCBS), providing non-institutional alternatives for qualified persons and thereby promoting integration.¹⁵² However, the issue was the limitation of HCBS to 9,977 individuals, which a special interest group known as the Arc of Washington State (the Arc) contended was in direct violation of the ADA.¹⁵³ The Arc argued that, in order to comply, the State must accept everyone who qualifies and prefers the community-based treatment program.¹⁵⁴ The district court disagreed and granted summary judgment to the State.¹⁵⁵

The Ninth Circuit explained that the Medicaid statute actually contemplated situations in which a state might choose to limit its community-based treatment program to a certain number of individuals as long as that number was greater than 200.¹⁵⁶ In fact, the regulations implementing the Medicaid statute require that states limit the number of participants in the program.¹⁵⁷ Conversely, the ADA requires that “no qualified individual . . . be excluded from participation.”¹⁵⁸ The *Olmstead*

151. *Arc of Wash. State Inc. v. Braddock*, 427 F.3d 615, 617 (9th Cir. 2005).

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.* at 618 (citing 42 U.S.C. § 1396n(c)).

157. *Arc of Wash. State*, 427 F.3d at 618 (citing 42 C.F.R. 441.303(f)(6)).

158. *Id.* (quoting 42 U.S.C. § 12132).

integration mandate accompanies this, requiring the states to make reasonable modifications to avoid disability-based discrimination.¹⁵⁹ *Olmstead* allowed for the fundamental alteration defense and that the court “will not tinker with” comprehensive programs that the State has proven are effective.¹⁶⁰ Ultimately, the Ninth Circuit determined that the limitation on the waiver program hinged on whether requiring expansion of the program would be a reasonable modification or a fundamental alteration.¹⁶¹

According to the court here, the Ninth Circuit had already essentially answered its own question. It had consistently held that “[s]o long as states are genuinely and effectively in the process of deinstitutionalizing disabled persons ‘with an even hand,’” it would not interfere.¹⁶² The Ninth Circuit therefore focused on Washington’s deinstitutionalization plan and whether it was acceptable, meaning that its disruption would amount to a fundamental alteration.¹⁶³

The Ninth Circuit here concluded that Washington’s deinstitutionalization efforts were “genuine, comprehensive and reasonable.”¹⁶⁴ It based this conclusion on the fact that the program provided care to approximately 10,000 disabled persons, the program was currently full and took a new participant each time a slot opened up, and all Medicaid-eligible disabled individuals had the opportunity to participate when a spot became available.¹⁶⁵ Not only did Washington have an acceptable comprehensive plan, but the HCBS program had previously been responsive to the State’s requests to increase capacity of the program and the State had more than doubled its budget for community-based programs in the last seven years while declining the budget for institutional programs.¹⁶⁶ This evidenced that Washington was not neglecting participants of the HCBS program when compared to other programs.¹⁶⁷

The Ninth Circuit consistently held to a broader view of the *Olmstead* mandate. As it explained in *Sanchez v. Johnson*,

When there is evidence that a State has in place a comprehensive deinstitutionalization scheme, which, in light of existing

159. *Id.*

160. *Id.* at 618-19 (quoting *Sanchez v. Johnson*, 416 F.3d 1051, 1067-68 (9th Cir. 2005)).

161. *Id.* at 619.

162. *Id.* at 620 (quoting *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 605-06 (1999)).

163. *Arc of Wash. State*, 427 F.3d at 620.

164. *Id.* at 621.

165. *Id.*

166. *Id.*

167. *Id.*

budgetary constraints and the competing demands of other services that the State provides, including the maintenance of institutional care facilities . . . is “effectively working,” . . . the courts will not tinker with that scheme. *Olmstead* does not require the immediate, state-wide deinstitutionalization of all eligible developmentally disabled persons, nor that a State’s plan be always and in all cases successful. . . . (“It is reasonable for the State to ask someone to wait until a community placement is available.”).¹⁶⁸

Ultimately, the Ninth Circuit held that, although forced expansion could at some point be a reasonable modification required by Title II, it amounted to a fundamental alteration in this case.¹⁶⁹ In addition to all the characteristics mentioned above, the HCBS program “significantly reduced the size of the state’s institutionalized population.”¹⁷⁰ Because of the program’s outstanding record of compliance with the ADA and state requirements in this case, the forced expansion of the Medicaid waiver program would have constituted a fundamental alteration and would therefore not be required by the ADA.¹⁷¹ Accordingly, the Ninth Circuit affirmed the district court’s decision granting summary judgment for the State.¹⁷²

B. Reality Outside the Courtroom: The Lack of Resources for and Access to Community-Based Treatment Programs

While the courts deliberate over the sufficiency of states’ *Olmstead* plans for legal purposes, the mentally ill live out these plans’ insufficiencies. Closures of state-funded mental hospitals have caused homelessness to skyrocket and deprived many individuals with mental illness of the treatment they need by a number of factors, including reduced access and reduced funding.

1. The Failure of Deinstitutionalization

While many state hospitals were successfully closed down by legislation championing deinstitutionalization, their closure proved to be detrimental to patients forced out of the institutions absent the simultaneous creation of

168. *Id.* (citations omitted) (quoting *Sanchez v. Johnson*, 416 F.3d 1061, 1067-68 (9th Cir. 2005)).

169. *Arc of Wash. State*, 427 F.3d at 621-22.

170. *Id.*

171. *Id.* at 622.

172. *Id.*

community-based treatment centers.¹⁷³ Ironically, mental health budgets have faced chronic disinvestment since the peak of mental health legislation, and such budgets continue this downward spiral.¹⁷⁴ Between the years of 1955 and 2006, the combined state mental health budget dropped from the equivalent of \$261.7 billion to \$30.9 billion.¹⁷⁵ This problem was exacerbated by the 2007 recession, which triggered further cuts to state mental health budgets, drastically reducing the scope of available services.¹⁷⁶ The reduction has led to a sort of informal, accidental institutionalization, and while many organizations attempt to cater to the needs of those who do not receive services from the state, their efforts have proven to be insufficient.¹⁷⁷ Many mentally ill patients essentially end up in a hopeless cycle of short term institutionalization, homelessness, and incarceration.¹⁷⁸

2. Modern Lack of Resources to Comply with the Mandate

The National Alliances on Mental Illness (NAMI) releases a report called “Grading the States” in which each state receives an A through F grade based on the condition of its mental health care system then averages these scores to grade the United States as a whole.¹⁷⁹ NAMI uses sixty-five criteria to determine the grades, including factors such as “access to medicine, housing, [and] family education.”¹⁸⁰ In 2009, 10 years after *Olmstead*’s interpretation of the Title II mandate and fundamental alteration defense, the United States’ national average grade was a D.¹⁸¹ The NAMI noted a correlation with state budget cuts that provided state mental health programs with fewer resources but still required them to push community-based treatment.¹⁸²

Current state mental health services are insufficient from the perspective of the mentally ill as well. The University of California, Davis, conducted a study asking participants about their perceptions of their community’s

173. Bryan Redfern, *To Wait or to Litigate? The Ethical Implications of Utilizing Litigation as a Vehicle for Reforming State Mental Health Care Systems*, 29 GEO. J. LEGAL ETHICS 1279, 1284 (2016).

174. *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. *New Report Card: Nation’s Mental Health Care System*, NAT’L ALLIANCE ON MENTAL ILLNESS (Mar. 11, 2009), <https://www.nami.org/Press-Media/Press-Releases/2009/New-Report-Card-Nation-s-Mental-Health-Care-System>.

180. *Id.*

181. *Id.*

182. *Id.*

mental health services.¹⁸³ Participants stated “that services were not affordable, inappropriate, or located too far away.”¹⁸⁴ Participants also shared concerns that communities were not providing culturally or linguistically appropriate services; that they distrusted mental health institutions; and that they lacked awareness of symptoms and services that were already available.¹⁸⁵

Further, because the federal government provides states with block grants, the state government is responsible for providing much of its own mental health funding. However, instead of shifting their resources from inpatient care to outpatient services, states across the board made budget cuts to mental health services, shifting the responsibility of treating the mentally ill to other facets of the healthcare system, typically public emergency rooms.¹⁸⁶ This shift is especially problematic for rural communities. For example, a study published by the American Journal of Preventive Medicine found that, among rural counties (termed by the study as non-core), “80% lacked a psychiatrist, 61% lacked a psychologist, and 91% lacked a psychiatric [nurse practitioner].”¹⁸⁷

A total of \$4 billion was cut from state mental health budgets between the years 2009 to 2011, leading to the closure of “vitaly needed services,” not just large mental health institutions.¹⁸⁸ Further, federal mental health and substance abuse programs cut their spending as well, evidenced by the Substance Abuse and Mental Health Services Administration (SAMHSA) cutting \$168 million from its spending, including \$83.1 million in grants for substance abuse treatment programs.¹⁸⁹ Ultimately, this led to a shortage of

183. *Building Partnerships: Conversations with Communities about Mental Health Needs and Community Strengths*, UC DAVIS CTR. FOR REDUCING HEALTH DISPARITIES 3 (June 2009), http://www.latinomentalhealthconcilio.org/documents/Building_Partnerships-01.pdf.

184. *Id.* at 8.

185. *Id.*

186. Sarah Kliff, *Seven Facts About America's Mental Health-Care System*, WASH. POST (Dec. 17, 2012), https://www.washingtonpost.com/news/wonk/wp/2012/12/17/seven-facts-about-americas-mental-health-care-system/?utm_term=.8e2b91fa154b.

187. C. Holly A. Andrilla et al., *Geographic Variation in the Supply of Selected Behavioral Health Providers*, 54 AM. J. PREVENTIVE MED. S199, S200 (June 2018), [https://www.ajpmonline.org/article/S0749-3797\(18\)30005-9/pdf](https://www.ajpmonline.org/article/S0749-3797(18)30005-9/pdf).

188. Nicole Fisher, *Mental Health Loses Funding as Government Continues Shutdown*, FORBES (Oct. 10, 2013), <https://www.forbes.com/sites/theapothecary/2013/10/10/mental-health-loses-funding-as-government-continues-shutdown/#14f9ba685690>.

189. *Id.*

beds and available treatment opportunities, leaving patients untreated in emergency rooms, homeless shelters, or prisons.¹⁹⁰

In all areas, cost is a prohibitive factor as well. Recent federal legislation, including the Mental Health Parity and Addiction Act of 2008, requires insurance expansion to ensure the coverage of mental health services.¹⁹¹ However, a majority of those seeking treatment still have out-of-pocket costs between \$100 and \$5,000.¹⁹² Despite legislation, there continues to be significant limitations on mental health coverage.¹⁹³ A SAMHSA survey found that 45% of the mentally ill who remain untreated cited cost as a barrier to receiving mental health treatment.¹⁹⁴

3. Where It Works: The State of Mental Health in Vermont and New Hampshire

While every state struggles to provide effective mental health care to its residents, some states have gone above and beyond a simple attempt to appease the courts, and their efforts have paid off. Two shining examples of that initiative are the mental health systems in Vermont and New Hampshire. Instead of putting together a plan just sufficient enough to shield themselves from liability, these states targeted specific issues in their mental health system.

For example, Vermont's mental health system no longer has waiting lists for opioid addiction treatment.¹⁹⁵ Experts say that part of the reason for such successful treatment and eradication of unnecessary waiting lists is treating patients like individuals, not just as another mentally ill patient using the state's resources.¹⁹⁶ Vermont even went so far as to look outside the direct need of treatment and prevention and to other needs in the individual's life that would prevent them otherwise from getting the help they need, such as lack of childcare and cab fare.¹⁹⁷

Alternatively, although it has not yet come as far as the program in Vermont, New Hampshire is making great strides as well. In planning its

190. *Id.*

191. Kliff, *supra* note 186.

192. *Id.*

193. *Id.*

194. *Id.*

195. Shawne K. Wickham, 'Hub and Spoke': Expect Waiting Lists Amid Overwhelming Need for Addiction Recovery Care, Says Vt. Expert, N.H. UNION LEADER (Oct. 23, 2018), https://www.unionleader.com/news/stigma/hub-and-spoke-expect-waiting-lists-amid-overwhelming-need-for/article_88df0130-d72c-11e8-8793-2b7b0caee7a4.html.

196. *Id.*

197. *Id.*

opioid addiction treatment centers, New Hampshire strategically placed its resources so that no one looking for opioid addiction treatment would have to drive more than an hour to reach a treatment center.¹⁹⁸ This is sharply contrasted with other states, such as Maine, where some patients may have to travel up to three hours to get the treatment they need.¹⁹⁹

V. A PROPOSED SOLUTION: CAREFUL CRAFTING AND CREATIVE INITIATIVES

As things stand, community-based treatment is simply not available to all mentally ill individuals who need it. While a state treatment professional may deem a patient suitable for release to a community-based program, a number of issues may prevent the patient from getting the treatment he needs, therefore making it more reasonable to keep him institutionalized. As previously discussed, many patients cannot afford community-based treatment, leading to the use of emergency rooms that are ill-equipped for the treatment of these individuals. In more extreme situations, the inability to afford community-based treatment also leads to homelessness or incarceration. Also, if proper services are not readily available to newly discharged patients, patients may be better provided for in an institution. Without the proper services provided within a reasonable proximity to the patient's home, patients will remain untreated where they would otherwise be treated if they remained in an institution. These are just a few examples of situations in which a patient may be deemed suitable for community-based treatment, but it would technically discriminate against the patient to require that they be discharged from the institution. A blanket requirement that states strive towards deinstitutionalization may seem like an effective way to curb discrimination against the mentally ill, but it often commits the discrimination it tries so hard to avoid. These concerns find a helpful remedy in an equal balance between concern for state autonomy and concern for civil rights.

A. *The Autonomous State*

One cannot address mental health issues without acknowledging the federal government's excessive interference in public services offered to the mentally ill. Increased state autonomy and minimal federal oversight may be able to remedy these issues. Justices Kennedy and Thomas were correct to be concerned about violations of federalism when the federal government is so heavily involved in mental health. Prior to *Olmstead*, the Supreme Court had

198. *Id.*

199. *Id.*

given states the utmost deference in these areas²⁰⁰ and should continue to do so. As stated in *Bowen v. American Hospital Association*, “[N]othing in [§ 504] authorizes [the Secretary of Health and Human Services (HHS)] to commandeer state agencies [These] agencies are not field offices of the HHS bureaucracy, and they may not be conscripted against their will as the foot soldiers in a federal crusade.”²⁰¹

Ultimately, states should be the dominant authority in providing services to individuals with disabilities. State governments should know better the needs of their own citizens than would the federal government. Allowing the state to be the dominant authority provides more opportunity for individual influence with the governing body. Individuals can more directly affect legislation through lobbying.

B. *Following the Gold Standard*

In crafting their *Olmstead* plans and improving their mental health programs, states should model their plans after states whose plans are working most effectively, while still modifying them to meet the needs of the individuals within their state. This seems like a fairly common-sense solution that most states would already be practicing. However, plan creation generally focuses on factors within the state itself.

For example, the National Association of State Mental Health Program Directors (NASMHPD) created the *Olmstead Risk Assessment and Planning Checklist*.²⁰² The purpose of the checklist is to provide guidance to the states in their compliance with the ADA and *Olmstead*.²⁰³ The checklist purports to take each state through seven categories:

1. The various segregated settings and populations in or at-risk of entering those settings,
2. The state’s capacity for community-based integrated services and housing,
3. Funding mechanisms,
4. Alignment of state policies with Federal mandates,
5. State and local agency involvement,

200. See *Alexander v. Choate*, 469 U.S. 287, 303-06 (1985); *Bowen v. Am. Hosp. Ass’n*, 476 U.S. 610, 642 (1986).

201. *Bowen*, 476 U.S. at 642.

202. *Olmstead Risk Assessment and Planning Checklist*, NAT’L ASS’N OF ST. MENTAL HEALTH PROGRAM DIRECTORS (Sept. 15, 2015), https://www.nasmhpd.org/sites/default/files/Assessment%20%236_Olmstead%20Risk%20Assessment%20and%20Planning%20Checklist.pdf.

203. *Id.* at 2.

6. Stakeholder involvement, and, finally,
7. Goals, benchmarks, timeframes, and outcomes.²⁰⁴

Notably, these checkpoints all have one thing in common: they are all factors that are internal to the state. They look at what resources the state has internally and what the state hopes to accomplish, without ever contemplating resources outside its borders. The practices of other states, whether these practices are contained within an *Olmstead* plan or not, are an invaluable resource for states in crafting their *Olmstead* plans and other facets of their mental health systems.

For example, two such states that plans should emulate are Vermont and Minnesota. Vermont takes a very individualistic look at its mental health program. What its mentally ill citizens really needed was closer treatment centers, cab fare, and childcare in order to attend their sessions.²⁰⁵ Plans should emulate Vermont's strategic placement of centers throughout the state so that no patient should have to travel more than an hour to get treatment. This may be more difficult for larger states, but states may achieve it with proper appropriation of available funding.

Further, Vermont is improving its mental health system by increasing inpatient beds. While counter to typical mental health reform, an individualized analysis shows that, more than anything, Vermont's system is in need of inpatient beds. In April 2018, Vermont directed the University of Vermont Medical Center to use its excess \$21 million revenue from 2017 to build a new facility to increase the state's inpatient capacity.²⁰⁶ A recent study has shown a significant increase in days spent in the ER waiting for an inpatient bed, going up from 4,037 to 5,237 days.²⁰⁷ Ultimately, Vermont's goal is to decrease that time while simultaneously decreasing the costs associated with treating the mentally ill in a setting that is ill-equipped to provide those particular kind of services.²⁰⁸

Alternatively, Minnesota is revolutionizing its mental health system through inpatient services. As of April 2018, Minnesota's legislature proposed a bill that would give local communities grants to create their own

204. *Id.*

205. Wickham, *supra* note 195.

206. Dan D'Ambrosio, *Vermont Directs UVM Medical to Use \$21M to Help Fix 'Mental Health Care Crisis,'* BURLINGTON FREE PRESS (Apr. 18, 2018), <https://www.burlingtonfreepress.com/story/news/2018/04/18/uvm-medical-revenue-21-m-over-target-so-state-gets-direct-those-funds/515474002/>.

207. *Id.*

208. *Id.*

mental health treatment centers and programs.²⁰⁹ Representatives crafting the legislation envision interplay between healthcare professionals, social workers, law enforcement, local churches, and mental health advocates.²¹⁰ Ideally, the combined \$80 million grants would be used to create six mental health crisis centers and three long-term housing facilities.²¹¹ For example, a center in Ramsey County was created through the cooperation of local hospitals, insurers, and advocacy groups.²¹² The center incentivizes the usage of local short-term treatment options rather than long-term hospital treatment. According to Alyssa Conducy, a manager at the Ramsey County center, “Eighty percent of [clients] can get the services they need in the community, not in hospitals.”²¹³

Other states went to extensive lengths to keep their citizens involved in the crafting of an *Olmstead* plan. Minnesota, for example, has created an *Olmstead* plan website.²¹⁴ The website not only explains *Olmstead*, but it also provides citizens with the chronology by which Minnesota’s *Olmstead* plan was developed and contact information for the employees of the Olmstead Implementation Office (OIO).²¹⁵ The website even has a page to allow citizens affected by *Olmstead* to share their stories, including a link to a Minnesota *Olmstead* Plan Facebook page.²¹⁶ The OIO also allows citizens to sit in on their meetings and provides them with the necessary materials to keep them informed about new developments.²¹⁷

209. Bill Salisbury, *People in Mental Health Crises Often End Up in ERs or Jail. An \$80M Plan Is Proposed to Help*, PIONEER PRESS, <https://www.twincities.com/2018/04/15/minnesota-legislature-eye-mental-health-crisis-centers-regional-care-support/> (last updated Apr. 16, 2018).

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

214. MINNESOTA’S OLMSTEAD PLAN, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_home (last visited Feb. 27, 2019).

215. *Id.*

216. *Participate*, MINNESOTA’S OLMSTEAD PLAN, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_participate# (last visited Feb. 27, 2019).

217. *Meetings*, MINNESOTA’S OLMSTEAD PLAN, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_meetings (last visited Feb. 27, 2018).

C. Cooperation with Private Providers Through Parity and Managed Care

Another underutilized resource in *Olmstead* plan creation, compliance, and implementation is private providers. Patients disproportionately use public mental health services,²¹⁸ and including private providers and insurers in *Olmstead* plans may improve the quality and reach of mental health services. Much of the provision of health care services is a balance between public providers and insurers and private providers and insurers. Parity laws and managed care programs, when executed effectively, can fill many areas where *Olmstead* plans have been ineffective in the past, especially in areas regarding access to care, both locationally and financially.

For example, in 1998, Vermont enacted the nation's most comprehensive parity laws then existing.²¹⁹ These laws were passed with objectives such as providing patients with mental health and substance addiction benefits that were equal to those of its physical health counterparts, making services more financially accessible, and preventing discrimination associated with receiving mental health services.²²⁰ However, opinions are mixed as to whether these parity laws were actually effective in improving mental health care.²²¹ While system stakeholders are generally undecided as to whether parity laws actually make any difference in the utilization of services,²²² studies have shown that there is at least a small increase in utilization by those with minor mental health issues,²²³ as well as improvements in other unintended mental health related areas, such as a reduction in traffic fatalities.²²⁴

Another way to partner with private providers is through managed mental health care. While most mental health care is received through public services, most of it is financed through private insurance.²²⁵ Both of these

218. Kavita K. Patel et al., *What Is Necessary to Transform the Quality of Mental Health Care*, 25 HEALTH AFF. 681, 687 (2006).

219. U.S. DEPT. OF HEALTH & HUM. SERVS., SMA 03-3822, EFFECTS OF THE VERMONT MENTAL HEALTH AND SUBSTANCE ABUSE PARITY LAW ix (2003).

220. *Id.* at 16.

221. *Id.*

222. *Id.*

223. Katherine M. Harris et al., *The Effects of State Parity Laws on the Use of Mental Health Care*, 44 MED. CARE 499, 499 (2006).

224. Ioana Popovici et al., *The Effects of Health Insurance Parity Laws for Substance Use Disorder Treatment on Traffic Fatalities: Evidence of Unintended Benefits*, IZA INST. OF LABOR ECON. (Apr. 2017), <http://ftp.iza.org/dp10746.pdf>.

225. Patel, *supra* note 218, at 688.

sectors utilize “carve-out programs.”²²⁶ These carve-out programs allow the state Medicaid program to delegate benefits normally provided by that program to another management entity, which may be private or governmental.²²⁷ While thirty-eight states currently utilize these carve-out services in regular physical medical care, only twenty-four manage any portion of their behavioral health services through a primary carve-out arrangement.²²⁸ While in some states this has only saved state governments small amounts of money, it has increased the usage of outpatient mental health services overall.²²⁹

However, in other states, such as Massachusetts, health plan costs were reduced as much as 30-40% due partly to incentives contractually provided to providers by the state.²³⁰ While these were only small incentives, they still created dramatic changes in mental health and substance abuse spending.²³¹ The largest decreases in spending were in facility care, namely inpatient care and hospitalization.²³² These were the services attempted to be reduced by the most integrated setting appropriate mandate. These services were replaced by less expensive partial hospitalization and outpatient care,²³³ the mandate’s desired outcome. These outcomes were even greater in those with unipolar depression or substance dependence.²³⁴ Expansion of an *Olmstead* plan to include managed care for behavioral health services may be instrumental in achieving the mandate’s goals more quickly.

VII. CONCLUSION

Just as with the closure of Dorothea Dix hospital in North Carolina, state mental hospitals are closing across the country. Mental health reform reached its peak in the 1960s and 1970s, and those effects continue to be felt

226. *Id.*

227. Athena Mandros, *Understanding the Medicaid Behavioral Health Carve-Out Map—Step One in Health Plan Contracting*, OPEN MINDS (Apr. 18, 2017), <https://www.openminds.com/market-intelligence/executive-briefings/understanding-the-medicaid-behavioral-health-carve-out-map-step-one-in-health-plan-contracting/>.

228. *Id.*

229. Patel, *supra* note 218, at 688.

230. Ching-to Albert Ma & Thomas G. McGuire, *Costs and Incentives in a Behavioral Health Carve-Out*, 17 HEALTH AFF. 53, 54 (1998).

231. Haiden A. Huskamp, *How a Managed Behavioral Health Care Carve-Out Plan Affected Spending for Episodes of Treatment*, 49 PSYCHIATRIC SERVS. 1559, 1559 (1998).

232. *Id.* at 1562.

233. *Id.*

234. *Id.*

today. These adverse effects include increased rates of incarceration and homelessness for the mentally ill as well as increased emergency room visits for mental illnesses. Emergency rooms and facilities in other sectors of the healthcare system, correctional facilities, and homeless shelters are ill-equipped to handle mental illness and are incapable of getting mentally ill individuals the services they need in an efficient and timely manner.

Despite these complications, states are still systematically closing their mental institutions. The Title II most integrated setting appropriate requirement attempts to prevent discrimination against the mentally ill by requiring the states to transfer patients from mental institutions to community-based treatment programs if they meet certain criteria. Attempting to give the states more deference, the Supreme Court tailored the fundamental alteration defense to allow states to craft *Olmstead* plans, proving that compliance with Title II would constitute a fundamental alteration in their Medicaid programs.

However, states are not utilizing these *Olmstead* plans to the maximum extent possible. The *Olmstead* Court moved in the right direction but did not completely accomplish its goal. In order to properly meet their goals, states must have as much autonomy as possible and must look outside of their own borders and governments to other states, individuals, and private providers to most effectively comply with Title II. Ultimately, states must answer one question: Are we simply looking to shield ourselves from liability, or do we truly want to provide for our mentally ill citizens?