

***Olmstead at 20:***  
***Using the Vision of***

***Olmstead***

***to Decriminalize  
Mental Illness***



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## The *Olmstead* Decision at 20

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA). The ADA established a mandate to public entities to ensure that people with disabilities live in the least restrictive, most integrated settings possible. The 1999 U.S. Supreme Court's *Olmstead* decision affirmed this civil right.

Since that decision 20 years ago, many states have implemented policies, programs, and new housing options to serve people in the most integrated setting appropriate to their needs. A significant number of states have been sued or entered into settlement agreements that have forced new resources and opportunities for community integration into state systems. While progress has been slow, the increased attention *Olmstead* has brought to individuals with mental illness and other disabilities who are unnecessarily segregated (or at risk of becoming so) in settings such as psychiatric hospitals, nursing homes, and large board and care facilities, has resulted in many more people with mental illness living in integrated, community-based settings.<sup>1,2</sup>

Today, as we survey the landscape on this important anniversary, and recommit ourselves to continuing to implement *Olmstead* principles in every state, it is time to address a restrictive and segregated setting in addition to nursing homes, board and care facilities, and psychiatric hospitals. Twenty years after *Olmstead*, a disproportionate number of people with mental illness are incarcerated in jails and prisons, segregated from society for offenses that could well have been prevented had they had access

to appropriate community-based services and supports. This problem deserves but has not yet received the attention or resources that *Olmstead* enforcement has brought to other forms of institutionalization.

In March 2019, the Technical Assistance Collaborative, Inc. (TAC) convened top thinkers from around the United States to examine the criminalization of persons with mental illness, focusing on *Olmstead* as a framework for reform. Based on insights from that group, this brief applies key elements of *Olmstead* law to the challenge of reducing the vastly disproportionate number of people with mental illness in the U.S. criminal justice system. If you are a policymaker – or if you represent a public entity at any level – we encourage you to 1) launch initiatives that minimize preventable interactions with the criminal justice system, and 2) fully incorporate such measures into the *Olmstead* planning efforts of your state or county to meet their legal obligations.<sup>3</sup> We hope that other interested stakeholders, such as advocates and civil rights groups, will also find this framework of use when engaged in *Olmstead* planning and advocacy efforts.

## Mental Illness and the Criminal Justice System

Mental illness itself is not predictive of criminal behavior, and research suggests that crime rates for people with mental illness are similar to those of the general population. Most individuals with stable mental illness do not present an increased risk of violence.<sup>4</sup> As with the general population, there are people with mental illness who might commit criminal acts irrespective of their mental illness, or possess criminogenic needs in addition to a mental illness that increase the risk of criminal

1 United States Senate Health, Education, Labor, and Pensions Committee (2013). [Separate and unequal: States fail to fulfill the community living promise of the Americans with Disabilities Act.](#)

2 United States Department of Justice (2019). [Department of Justice celebrates 20th anniversary of the Olmstead Supreme Court decision protecting the rights of Americans with disabilities.](#)

3 While this brief focuses on individuals with mental illness, many of the issues discussed are applicable to the circumstances that people with other disabilities experience, too.

4 Rueve, M., & Welton, R. (2008). Violence and mental illness. *Psychiatry*, 5(5), 34-46.

behavior.<sup>5</sup> The risk factors that predict crime among people with serious mental illness are the same risk factors that predict crime among people without serious mental illness.<sup>6</sup>

Yet jails and prisons are often wryly described by both mental health and law enforcement professionals as our nation's largest psychiatric facilities.<sup>7</sup> And, indeed many studies have solidly established that a disproportionate number of people with mental illness both encounter law enforcement, and go on to serve time in correctional settings. To get an overview of the challenge, consider these findings:

- Sixty-four percent of jail inmates interviewed in 2002 had either current symptoms or recent history of a mental health condition, with some 17 percent of male jail inmates meeting the threshold of a serious mental illness.<sup>8,9</sup> In a Bureau of Justice Statistics survey conducted between February 2011 and May 2012, about 14 percent of state and federal prisoners and 26 percent of jail inmates reported having experiences in the 30 days prior to the survey that met the threshold for serious psychological distress – an incidence five times higher than in the general U.S. population (5 percent).<sup>10</sup>
- The prevalence of co-occurring substance use disorders among incarcerated persons with mental illness is significant. The Bureau of Justice Statistics found that about 74 percent of state prisoners and 76 percent of local jail inmates with a mental health

condition met criteria for substance dependence or abuse, and that over one-third of inmates who had mental health conditions had used drugs at the time of the offense.<sup>11</sup>

- A significant number of inmates with mental illness have prior histories of homelessness, foster care, or living in institutional settings. State prisoners (13 percent) and local jail inmates (17 percent) who had a mental health condition were twice as likely as their counterparts without a mental health condition to have been homeless in the year before their incarceration.<sup>12</sup>
- Overall, state prisoners who had a mental health condition reported a mean maximum sentence that was five months longer than state prisoners without a mental health condition (146 months compared to 141 months). The mean time state prisoners who had a mental health condition expected to serve was four months longer than state prisoners without a mental health condition (93 months compared to 89 months).<sup>13</sup>
- Inmates with mental health conditions are less likely to receive early release due to disciplinary actions related to behavioral problems while incarcerated.<sup>14</sup>

## Lack of Services and System Coordination

There is consensus among behavioral health professionals, consumers, family members, and other stakeholders that a range of mental health and substance use services should be available

5 Council of State Governments Justice Center (2017). [Supporting people with serious mental illnesses and reducing their risk of contact with the criminal justice system: A primer for psychiatrists](#). New York, NY: The Council of State Governments Justice Center.

6 Lurigio, A. (2011). [People with serious mental illness in the criminal justice system: Causes, consequences, and correctives](#). *The Prison Journal* Supplement to 91(3) 66S–86S.

7 Mental health service systems typically provide more “bed-days” of residential services to people with serious mental illness than do jails and prisons.

8 James, D. & Glaze, L. (2006). [Mental health problems of prison and jail inmates](#). Bureau of Justice Statistics Special Report (Pub no NCJ 213600). Washington, D.C.: Bureau of Justice Statistics.

9 Steadman, H., Osher, F., Robbins, P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6):761–765.

10 Bronson, J., & Berzofsky, M. (2017). [Indicators of mental health problems reported by prisoners and jail inmates, 2011–12](#). Bureau of Justice Statistics Special Report. Washington, D.C.: Bureau of Justice Statistics.

11 James, D. & Glaze, L. (2006). [Mental health problems of prison and jail inmates](#). Bureau of Justice Statistics Special Report (Pub no NCJ 213600). Washington, D.C.: Bureau of Justice Statistics.

12 [Ibid.](#)

13 [Ibid.](#)

14 Krelstein, M. (2002). The role of mental health in the inmate disciplinary process: A national survey. *Journal of the American Academy of Psychiatry & the Law*, 30(4): 488–496.

to address the varying needs of people with mental illness and substance use disorders,<sup>15,16</sup> and that treatment can be effective in helping people manage and recover from both of these conditions.<sup>17</sup> Unfortunately, throughout the United States, inadequate community-based treatment options exist for individuals with mental illness. Consequently, too many people with mental illness end up in crisis, landing them in much more restrictive settings than needed, including emergency rooms, hospitals, and jails.

## The Services Gap

Among the reasons for the unmet need for intensive community-based services are too few qualified staff and insufficient funding from state and local governments. In many communities, there are shortages of adult or child psychiatrists, licensed clinicians, paraprofessionals, and community mental health agencies. Psychiatric crisis services are often nonexistent or insufficient to respond to, divert, or refer individuals back into the mental health system, leaving law enforcement professionals with the dilemma of having to arrest a person because no treatment diversion option exists. Throughout the country, communities lack the capacity to provide intensive community-based mental health services, including Assertive Community Treatment, mobile crisis services, intensive case management, peer outreach and support, and supported housing, all of which have been proven successful in reducing arrest and incarceration as well as other forms of institutionalization.<sup>18</sup> For people with mental illness and co-occurring substance use disorders, there is not enough medication-assisted treatment, detoxification services, or peer outreach and support, among other treatment options.

Adding to the problem, such treatment and service options that do exist are often not accessible to many people with mental illness. Lack of (or inadequate) insurance coverage, restrictive eligibility requirements for services, geographical barriers, transportation challenges, limited access to telehealth, and long waiting lists can all present major barriers to accessing treatment.

## Coordination among Systems

Even when services are available, there can be problems when systems do not coordinate well together. Too often, a fragmented, uncoordinated service system results in people “falling through the cracks” and ending up in crisis. Within a mental health system, different types of service providers – for example, psychiatric inpatient hospitals and community-based providers – do not always effectively coordinate an individual’s transition back to the community. This can place individuals at risk of not having medication prescriptions filled, or of missing important psychiatrist appointments. Similarly, a lack of coordination between the criminal justice system, correctional settings, and mental health providers puts people with mental illness at risk when reentering the community from the correctional system. Law enforcement and the criminal justice system must also coordinate with the mental health system to help persons with mental illness avoid entering the criminal justice system in the first place. In *Examples and Resources to Support Criminal Justice Entities in Compliance with Title II of the Americans with Disabilities Act*, the U.S. Department of Justice (USDOJ) recognizes that government support of “criminal justice entities to coordinate with, and divert to, community-based services” may be required to prevent

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- 15 Institute of Medicine (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, DC: The National Academies Press.
  - 16 U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2011). [Description of a good and modern addictions and mental health service system](#).
  - 17 U.S. Department of Health and Human Services (1999). [Mental health: A report of the Surgeon General](#). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
  - 18 Substance Abuse and Mental Health Services Administration (2019). *Principles of community-based behavioral health services for justice-involved individuals: A research-based guide*. HHS Publication No. SMA-19-5097. Rockville, MD: Office of Policy, Planning, and Innovation.

unnecessary institutionalization of people with disabilities.<sup>19</sup>

Coordination with systems outside the realm of mental health and law enforcement are also vital in order to incorporate social determinants of health such as affordable housing and employment. Access to housing and employment is highly relevant to an individual's ability to live successfully with mental illness in integrated, community-based settings.

It is important to note that the often-cited wave of deinstitutionalization that began in the mid-twentieth century is not principally responsible for the disproportionate representation of people with serious mental illness in our criminal justice system.<sup>20</sup> As criminal justice psychologist Arthur Lurigio has shown, "The emptying of state hospitals began a decade before the precipitous growth of crime and the politicization of the crime problem in the 1960s and 25 years before the implementation of the policy of mass incarceration."<sup>21</sup> Therefore, when state or local public entities are developing alternatives to the criminal justice system, they must consider the least restrictive settings based on need, rather than simply adding inpatient treatment beds.

## Applying *Olmstead* Principles to the Criminal Justice System

As public entities seek to ensure that people with mental illness can live in the most integrated settings possible, their task is made more complex by many factors beyond mental illness itself (see "Other Policy Areas" below). Nevertheless, *Olmstead* applies and requires state and local governments to administer services to people with disabilities in the most integrated setting appropriate. From an *Olmstead* perspective, the incarceration of people with mental

illness prompts an investigation of *how* people with mental illness arrive in the criminal justice system, just as we have explored the factors that led them to be inappropriately housed in other institutional and segregated settings.

Here, we discuss the relevance of several key elements of the *Olmstead* decision in addressing the criminalization of people with mental illness, and describe how they are applicable to individuals needlessly institutionalized in jails and prisons. As we show, *Olmstead* provides important guidance and leverage to public entities as they develop and implement strategies to reduce the incarceration of people with mental illness.

## Segregated Settings

Since the *Olmstead* decision, there has been significant discussion about the definitions of integrated/segregated settings, and also litigation and settlement agreements that identify what integrated and segregated settings are. The USDOJ defines segregated settings as:

Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.<sup>22</sup>

Within the mental health system, psychiatric inpatient hospitals, nursing homes, and large board and care facilities (often known as

19 U.S. Department of Justice, Civil Rights Division (2017). [Examples and resources to support criminal justice entities in compliance with Title II of the Americans with Disabilities Act.](#)

20 Pinals, D. & Fuller, D. (2017). [Beyond beds: The vital role of a full continuum of psychiatric care.](#) National Association of State Mental Health Program Directors.

21 Lurigio, A. (2011). [People with serious mental illness in the criminal justice system: Causes, consequences, and correctives.](#) *The Prison Journal*, 91(3): Supplement 66S–86S.

22 U.S. Department of Justice (2011). [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.\*](#)

boarding homes, adult homes, assisted living for people with mental illness, and personal care homes) are commonly identified as institutional, segregated settings. *Olmstead* activities in many states focus on decreasing the reliance on these types of facilities for people who do not need or want them, and on the development of community-based, integrated settings.

Understanding how *Olmstead* applies to the correctional system begins with an understanding that jails and prisons are institutions and that they are a type of segregated setting. In an *Olmstead* framework, jails and prisons fit number 2 of the USDOJ definition above. Moreover, the same community-based services that are effective in preventing needless institutionalization within the mental health system also prevent needless institutionalization in jails and prisons. When state or local governments do not make these services available in sufficient supply, people with mental illness are needlessly institutionalized in mental health institutions or in jail and prisons.

## **The Integration Mandate**

In authorizing the ADA, Congress expressed that segregating people with disabilities is a form of discrimination under the Act.<sup>23</sup> Yet in many systems, there is a lack of awareness about the requirements of the ADA for people with mental illness and other disabilities. Getting public entities to understand federal disability law and their obligations to prevent and eliminate discrimination against people with disabilities is essential to serving people with mental illness in integrated settings. In our work nationally, we frequently hear unfounded assumptions about the types of settings people need (e.g., long-term hospitalization or supervised group living) and about what constitutes integration. We still hear statements from institutional staff that this is the person's

"home." We also see situations where community-based services are unavailable to many, yet significant funds are directed to support individuals in costly institutional placements.

The "integration mandate" is a fundamental aspect of the ADA, requiring public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."<sup>24</sup> "The most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."<sup>25</sup> For most individuals, receiving services in the community is the most integrated setting, and an absence of such services, leading to institutionalization, reflects a violation of the ADA.

A public entity must take action if its programs result in unjustified segregation of people with disabilities. The USDOJ states that "a public entity may violate the ADA's integration mandate when it: (1) directly or indirectly operates facilities and or/programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; and/or (3) through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs."<sup>26</sup>

As we have noted, many individuals with mental illness in correctional settings are there because community-based services and settings were not available to meet their needs. Public funding is used to sustain the costs of housing people in the segregated correctional system. Unfortunately, public entities frequently preserve this status quo rather than plan for and provide more efficient and effective community-based alternatives. The implied policy – whether intentional or unintentional – is that

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23 [Olmstead v. L.C. \(98-536\) 527 U.S. 581](#) (1999).

24 [Americans with Disabilities Act Title II Regulation 35.130](#).

25 [Ibid.](#)

26 U.S. Department of Justice (2011). [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.](#)

the reliance on correctional settings to house people with mental illness is justified. As a result, many systems are failing to meet their obligations under the integration mandate, and perpetuating discrimination.

Responsibility and accountability to address the integration mandate are often missing, especially when public entities do not fully understand the ADA and *Olmstead* to begin with. Sometimes, *no* systems assume responsibility and accountability when, in fact, *all* public entities bear responsibility and accountability under the ADA.

### **Risk of Institutionalization**

The ADA and the *Olmstead* decision apply to persons at serious risk of institutionalization or segregation, as well as to those currently residing in institutional or other segregated settings.<sup>27</sup> Public entities have an obligation to address the factors in their systems that may put individuals with mental illness at risk of coming into contact with the criminal justice system and becoming incarcerated. The US-DOJ has explained that an *Olmstead* violation could occur if “a public entity’s failure to provide community services or its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual’s eventual placement in an institution.”<sup>28</sup>

In service systems across the country, the overuse of emergency services, inpatient care, and encounters with law enforcement can be traced to a lack of community-based treatment and services. In a community with no hotline, mobile crisis team, or mental health respite facility, the only option for a person in crisis or their family may be to call the police – whose only option may be to arrest the person.

A plaintiff could show sufficient risk of needless institutionalization if law enforcement is the default crisis response in the system – with no options to refer to community-based mental health services.

Budget cuts, loss of insurance coverage, and tightened program eligibility requirements increase the risk of needless institutionalization in jails and prisons by reducing access to community services, increasing financial burdens on individuals’ ability to pay for medication and treatment, and jeopardizing housing.<sup>29</sup> Homelessness and housing instability are major factors that increase risk of institutionalization in correctional settings.<sup>30</sup> When people with mental illness lack access to comprehensive, community-based treatment and support services, they are at greater risk of ending up in institutional, segregated settings, including correctional facilities.<sup>31</sup>

As insufficient community-based services can lead to needless institutionalization, including incarceration, public entities should consider how the availability of services, or lack thereof, places people with mental illness at risk of institutionalization, including in jails and prisons.

### **Reasonable Modification**

Inadequate access to community-based services, resulting in overreliance on institutional or segregated settings, is discriminatory – meaning that public entities must alter, or “reasonably modify,” their policies, procedures, and practices as necessary to comply with the ADA’s integration mandate.<sup>32</sup>

On the service delivery side, systems may need to modify policies and program requirements in order to meet the needs of people with

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27 [Ibid.](#)

28 [Ibid.](#)

29 Health Management Associates (2011). [Impact of proposed budget cuts to community-based mental health services](#). Austin, TX: Texas Conference of Urban Counties.

30 National Law Center on Homelessness and Poverty. No Safe Place: The Criminalization of Homelessness in U.S. Cities. [https://nlchp.org/wp-content/uploads/2019/02/No\\_Safe\\_Place.pdf](https://nlchp.org/wp-content/uploads/2019/02/No_Safe_Place.pdf).

31 Musumeci, M. & Claypool, H. (2014). [Olmstead’s role in community integration for people with disabilities under Medicaid: 15 years after the Supreme Court’s Olmstead decision](#). Issue Brief. Menlo Park, CA: Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid & the Uninsured.

32 [Americans with Disabilities Act Title II Regulation 35.130](#).



mental illness in integrated settings. Where community-based services are insufficient, and individuals with mental illness are instead housed in more restrictive settings, systems may need to reallocate funding to promote more community-based opportunities.

Crime control policies established in many communities, also known as public nuisance laws, tend to target people with mental illness. People with mental illness who are poor, hungry, or experiencing homelessness may be arrested or receive fines for non-violent, misdemeanor, or petty crimes for activities like loitering, panhandling, or camping. Often, people with mental illness are arrested for not being able to pay fines, starting a cycle of incarceration. If a person is arrested and incarcerated, their behavior sometimes creates additional problems in the jail, resulting in additional penalties, lack of treatment, and seclusion and restraint. Individuals who receive citations are sometimes arrested if they have no financial means to pay the fines. These state and local laws and ordinances could be seen as discriminating against people with mental illness, showing why reasonable modifications should be made in order to minimize needless incarceration.

A significant number of people with mental illness have co-occurring substance use disorders. Fragmented mental health and substance abuse treatment systems fail to provide fully integrated care for such persons, further exacerbating both conditions and elevating the risk for arrest and incarceration.<sup>33</sup> Further, people with co-occurring disorders are often arrested for drug law violations, accounting in part for the large numbers of people with mental illness who are incarcerated.

While increased funding is often needed to expand the capacity of community-based

services, reasonable modifications to policies are an important component to ensure community integration. In addition, investment in expanding community-based services reduces costs of serving individuals with mental illness in hospitals, emergency departments, shelters, and jails.

## Olmstead Planning

The Supreme Court stated in its decision that states should have “a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings.”<sup>34</sup> According to the USDOJ, *Olmstead* plans “must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting.” Plans “must contain concrete and reliable commitments to expand integrated opportunities” and “reasonable timeframes and measurable goals.” Plans should have funding in place to support implementation, “commitments for each group of persons who are unnecessarily segregated,” and a process to evaluate and demonstrate progress.<sup>35</sup> The involvement of key stakeholders in the planning process is important.<sup>36</sup> Programs and services that can support people with mental illness in community-based settings often overlap with other areas, requiring multiple systems to be involved in the *Olmstead* planning process. *Olmstead* planning typically involves public entities and stakeholders from several different areas in order to address systemic issues such as housing, transportation, and employment. To address the problem of incarceration, it is important to bring law enforcement and others in criminal justice into *Olmstead* planning as well, providing an opportunity to engage in cross-system analysis, mapping, and strategizing.

33 Lurigio, A. & Swartz, J. (2000). Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness. In U.S. Department of Justice, Office of Justice Programs, National Institute of Justice *Criminal justice 2000: Policies, processes, and decisions of the criminal justice system* (45–108). Washington, D.C.: U.S. Department of Justice.

34 [Olmstead v. L.C. \(98-536\) 527 U.S. 581](#) (1999).

35 U.S. Department of Justice (2011). [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.](#)

36 National Association of State Mental Health Program Directors (2015). [Assessment #6: Olmstead risk assessment and planning checklist.](#)

Most states recognize the need to maintain comprehensive and effectively working *Olmstead* plans, and some state plans establish diversion from the criminal justice system as a goal, specifically identifying types of programs they want to expand, such as mobile crisis services, crisis intervention teams, Assertive Community Treatment, and supportive housing.

Many states, however, have plans that do not address diversion from the criminal justice system – while still others do not have *Olmstead* plans at all, or have plans that have not been updated in many years. Even though states and local systems may engage in jail diversion activities like those described above, few do so in the context of responsibilities as a public entity under the ADA and *Olmstead*.

Some settlement agreements become de facto *Olmstead* plans, and several touch on issues related to the criminal justice system. For example, Delaware’s settlement agreement, which concluded in 2016, included as class members people with mental illness who were at risk of incarceration, and directed some resources, such as permanent supportive housing and Assertive Community Treatment, to such individuals.<sup>37</sup> In Georgia’s settlement agreement with the USDOJ, individuals with serious mental illness who are at risk of hospitalization in state hospitals or who are being released from jails or prisons are part of the class, but the agreement is silent on those at risk of incarceration.<sup>38</sup> Georgia’s agreement, as well as Oregon’s Performance Plan,<sup>39</sup> require planning and training with law enforcement and the criminal justice system to identify ways to divert class members from justice system involvement.

## Diversion Efforts

Although not necessarily part of states’ formal *Olmstead* planning, efforts designed to divert people with mental illness away from the criminal justice system, and toward community-based treatment and support resources, have been undertaken by several state and local systems across the United States.

- The [Stepping Up initiative](#) is a national effort to implement local system changes that can reduce the number of people with mental illness in jails.<sup>40</sup> Through technical assistance and planning, the initiative – led by the [National Association of Counties](#), the [American Psychiatric Association Foundation](#), and the [Council of State Governments Justice Center](#) – helps counties to develop and adopt cross-system action plans.
- Sequential Intercept Mapping is used by communities to assess resources, gaps, and opportunities at key points where people with mental illness can be identified, engaged, and diverted from the criminal justice system; the process itself can foster partnerships that strengthen the community’s capacity to develop effective diversion activities.<sup>41</sup>
- In many communities, crisis intervention teams (CITs) and 24-hour drop-off centers create bridges between law enforcement and mental health services and treatment. CITs are an innovative model of first-responder-based crisis intervention to help persons with mental health disorders and addictions access medical treatment rather than placing them in the criminal justice system due to illness-related behaviors.<sup>42</sup> Crisis drop-off centers that are open 24 hours a day and have a ‘no refusal’ policy enable law enforcement to divert persons with mental illness away from the criminal

37 [United States v. State of Delaware](#) (2011).

38 [United States v. State of Georgia et al](#) (2010). Civil Action No. 1:10-CV-249-CAP.

39 Oregon Health Authority (2016). [Oregon’s performance plan for mental health services for adults with serious and persistent mental illness](#).

40 Stepping Up Initiative (undated). [The Stepping Up Initiative: A national initiative to reduce the number of people with mental illnesses in jails](#). Retrieved on August 23, 2019.

41 Laier, L. (2012). [What exactly is a sequential intercept mapping?](#) *Policy Research Associates Blog* September 28, 2012.

42 CIT International, Inc. (undated). [CIT is more than just training...it’s a community program](#). Retrieved on August 23, 2019.

justice system.<sup>43</sup> Crisis drop-off center staff can then manage the crisis and triage the individual to the least restrictive setting.

These initiatives are mostly focused on interventions and coordination of activities with the criminal justice system, and are useful for diverting people who have come into contact with the criminal justice system. However, systems should also focus planning efforts and funding on upstream community-based treatment and services to reduce the likelihood that persons with mental illness will ever come into contact with law enforcement.

## Policy Considerations

Many policy issues must be considered when examining the criminalization of mental illness through an *Olmstead* lens. Significant socio-economic problems that people with mental illness often experience – such as poverty, homelessness, and unemployment – are contributing factors in the overrepresentation of people with mental illness in the criminal justice system.

According to the U.S. Surgeon General, people of lower socioeconomic status are more likely than those of higher socioeconomic status to be diagnosed with a serious mental disorder.<sup>44</sup> Further, the unrelenting stress of being poor can precipitate mental illness.<sup>45,46</sup> Mental health disorders can perpetuate the cycle of poverty by interfering with an individual's capacity to function in either paid or non-income roles, leading

to decreased social, as well as economic, productivity. Thus, they may engage in petty or misdemeanor offenses associated with poverty, such as shoplifting. Additionally, people with mental health conditions who are in poverty often cannot afford mental health care; as their symptoms go untreated, their mental health conditions may become more severe, placing them at increased risk of contact with law enforcement.

The affordable housing crisis in this country is a significant challenge that directly relates to the problem of people with mental illness finding themselves in jails, prisons, state hospitals, nursing homes, board and care facilities, and homelessness. There is not a single housing market in the United States in which a person with mental illness whose sole income is Supplemental Security Income (SSI) can afford the fair market rent.<sup>47</sup> The correlations between mental illness and homelessness, and between homelessness and jail, are stark. Twenty percent of the total homeless population counted during the 2018 HUD point-in-time count had a severe mental illness,<sup>48</sup> and estimates of mental illness among those who are homeless are much higher. Rates of homelessness among jail inmates are approximately 7.5 to 11.3 times the annual rate of homelessness in the general population.<sup>49</sup> Formerly incarcerated people are almost 10 times more likely to be homeless than the general public.<sup>50</sup> Rental or other housing subsidies are needed and are among the community-based services that reduce incarceration and institutionalization of people with mental illness.

43 CMHS National GAINS Center (2007). Practical advice on jail diversion: Ten years of learnings on jail diversion from the CMHS National GAINS Center. Delmar, NY: CMHS National GAINS Center.

44 U.S. Department of Health and Human Services (1999). [Mental health: A report of the Surgeon General](#). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

45 Eaton, W. W. & Muntaner, C. (1999). Socioeconomic stratification and mental disorder. In A. V. Horwitz & T. L. Scheid (Eds.), *A handbook for the study of mental health: Social contexts, theories, and systems* (259-283). New York, NY: Cambridge University Press.

46 Lurigio, A. (2011). [People with serious mental illness in the criminal justice system: Causes, consequences, and correctives](#). *The Prison Journal Supplement* to 91(3) 66S–86S.

47 Schaak, G., Sloane, L., Arienti, F., & Zovitoski, A. (2017). [Priced out: The housing crisis for people with disabilities](#). Boston, MA: Technical Assistance Collaborative.

48 U.S. Department of Housing and Urban Development (2018). [HUD 2018 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations](#). Washington, D.C.: U.S. Department of Housing and Urban Development.

49 Greenberg, G. & Rosenheck, R. (2008). [Jail incarceration, homelessness, and mental health: A national study](#). *Psychiatric Services*, 59(2): 170–177.

50 Coulout, L. (2018) [Nowhere to go: Homelessness among formerly incarcerated people](#). Published online by the Prison Policy Initiative. Retrieved on August 23, 2019.

In general, people of color are overrepresented in the correctional system, largely due to failures to address racial and socio-economic challenges experienced by these groups.<sup>51</sup> People of color are also likely to have less access to community-based mental health care,<sup>52</sup> and are overrepresented in institutional settings such as psychiatric hospitals and corrections.<sup>53</sup> Racial inequity must be considered in all aspects of addressing the overrepresentation of people with mental illness in the criminal justice system.

## Recommendations

Criminal justice diversion and re-entry activities in communities around the country are important and are showing positive results. While a range of improvements can be made to address the overrepresentation of people with mental illness in the criminal justice system, we offer four recommendations that can raise awareness about the responsibilities of public entities under the ADA and *Olmstead*, improve system-level planning and coordination, and expand access to community-based services.

### Educate Leadership

Adding compliance with the ADA and *Olmstead* to current efforts to reform criminal justice systems should motivate policymakers. Educating leaders in public entities across sectors (e.g., state and local mental health authorities, law enforcement, housing finance agencies, and public housing authorities) can help them make the connection between funding community-based services and criminal justice reform efforts. Focus areas for education should include the roles and responsibilities of public entities under the ADA; data regarding the disproportionate number of people with mental illness in the correctional system; examples of the successful development of service capacity and coordination with the criminal justice system; and

the ways in which inadequate community-based service systems elevate the risk of incarceration for people with mental illness.

### Update *Olmstead* Plans

*Olmstead* plans in several states have not been updated in many years; some state plans only partially address criminal justice system diversion; and some states still have no *Olmstead* plans at all. We need a renewed push by policymakers and stakeholders, such as consumers and law enforcement, for states to update and implement *Olmstead* plans that clearly identify strategies for individuals who are at risk of institutionalization in correctional settings. For example, plans could propose concrete strategies, resources, and numeric goals to prevent unnecessary incarceration, such as actions to decriminalize status offenses, plans to develop and fund a specific number of supported housing units, and steps that will be taken to expand a range of non-residential crisis and community-based services for high-risk individuals.

As we have noted, it is important to include programs and partnerships with law enforcement and the criminal justice system in *Olmstead* planning. Yet such measures largely address the issue at a point when a crisis has already occurred. *Olmstead* plans should also include true upstream solutions for comprehensive community-based services in order to reduce first-time interactions with law enforcement and the criminal justice system.

### Establish Shared Responsibility and Accountability

No single public entity “owns” the issues of mental illness or other disabilities. All public entities are accountable and responsible for the integration mandate under the ADA and

51 Mauer, M. (2006). *Race to incarcerate*. Washington, DC: The Sentencing Project.

52 McGuire, T. G. & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs (Project Hope)*, 27(2): 393-403.

53 Primm, A., Osher, F., & Gomez, M. (2005). Race and ethnicity, mental health services and cultural competence in the criminal justice system: Are we ready to change? *Community Mental Health Journal*, 41(5): 557-569.

*Olmstead*. Many state *Olmstead* plans are driven by a state mental health authority or an umbrella agency such as a department of human services, suggesting that *Olmstead* is the responsibility of that specific entity. While responsibility for leading a planning process may rest with one entity, multiple entities must be identified and held accountable for identifying system gaps; establishing policies; and developing, implementing, and funding programs that prevent people with mental illness from entering the criminal justice system unnecessarily. Successful *Olmstead* planning efforts that bring multiple stakeholders to the table are often driven through the authority of the Governor's office to establish accountability and shared responsibility, and to ensure the involvement of multiple public entities.

### **Designate Adequate Resources**

Resources must be made available to ensure access to community-based services that can prevent individuals with mental illness from being arrested and incarcerated unnecessarily. Resource allocation must be deliberate and consistent with an *Olmstead* plan, and must address treatment, housing, and other initiatives designed to create access to evidence-based practices in the community. While it is important to direct resources toward crisis and criminal justice system diversionary services, resources must also be available to support access to community-based services that can reduce the likelihood that people with mental illness will come into contact with law enforcement to begin with. Likewise, community-based services must have sufficient capacity to receive referrals from law enforcement when interactions do occur; otherwise, the only option for law enforcement is to bring people into restrictive settings like the criminal justice or acute care hospital system.

Systems struggle to envision spending and budgets beyond their bureaucratic silos at the state or local level, resulting in inefficient use of public funds. Opportunities to leverage other funds, such as federal Medicaid dollars, can help offset costs elsewhere. While many systems do not provide enough funding to ensure sufficient capacity to access community-based services, reallocating existing funds away from support for people with mental illness in correctional settings and toward community-based prevention strategies will increase efficiency and produce better health and public safety outcomes.

### **Future Related Work**

In this brief, we have discussed the applicability of the ADA and *Olmstead* decision to the disproportionate number of people with mental illness in correctional settings in the United States, with a focus on preventing individuals from being incarcerated.

However, there are also issues related to civil rights under *Olmstead* and the ADA within correctional settings that require examination. Several states face challenges regarding timely access to competency, treatment, and restoration services for incarcerated individuals with mental illness (e.g., Washington, Oregon, Colorado, Pennsylvania). Far too many inmates with mental illness spend time in solitary confinement,<sup>54</sup> and individuals with mental illness spend more time incarcerated than inmates who do not have mental illness and are released early on probation.<sup>55</sup> People with mental illness often do not receive treatment or medications while incarcerated.<sup>56</sup>

When individuals with mental illness are ready for release from a correctional setting, they face many challenges to lining up benefits,

54 Metzner, J. & Fellner, J. (2010) [Solitary confinement and mental illness in U.S. prisons: A challenge for medical ethics](#). *Journal of the American Academy of Psychiatry and the Law*, 38(1): 104–108.

55 James, D. & Glaze, L. (2006) [Mental health problems of prison and jail inmates](#). Bureau of Justice Statistics Special Report (Pub no NCJ 213600). Washington, D.C.: Bureau of Justice Statistics.

56 Reingle Gonzalez, J. & Connell, N. (2014) [Mental health of prisoners: Identifying barriers to mental health treatment and medication continuity](#). *American Journal of Public Health*, 104(12): 2328–2333.

medications, treatment providers, housing, and other important supports that can reduce their risk of recidivism into the criminal justice system.<sup>57</sup> Medicaid policies in some states jeopardize successful re-entry by presenting barriers to coverage upon release that place individuals at risk of going without medications, psychiatric care, and other important services.<sup>58</sup> Problems between correctional settings and community-based providers with continuity of care at re-entry creates additional risk.

These are important areas for further discussion so that systems can address the needs of people with mental illness within the context of their civil rights under the ADA and *Olmstead* law.

## Closing Remarks

The promise of the Americans with Disabilities Act in 1990 and the U.S. Supreme Court's *Olmstead* decision in 1999, affirming the right of people with disabilities to live in the most integrated settings possible, remains unfulfilled for people with mental illness who too frequently end up in the criminal justice system due to inadequate community-based services. In many systems, *Olmstead* has provided leverage so that people with mental illness are less likely to live in psychiatric hospitals, nursing homes, and other segregated settings today compared to decades ago. In this 20th anniversary year of *Olmstead*, the criminalization of people with mental illness in communities throughout the nation is a form of discrimination that must be addressed by public entities.

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57 Blandford, A. & Osher, F. (2013) [Guidelines for the successful transition of individuals with behavioral health disorders from jail and prison](#). Delmar, NY: GAINS Center for Behavioral Health and Justice Transformation.

58 [Ibid.](#)

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