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The Americans with Disabilities Act: Correcting Discrimination of Persons with Mental Disabilities in the Arrest, Post-Arrest, and Pretrial Processes

Jennifer Fischer*

Introduction

Stories of the problems faced by persons with mental illness in the criminal justice system range from tragic to frustrating. For example, Chuck, with a history of drug abuse and physical and mental health problems, died in jail after the police arrested him for possession of a controlled substance.¹ Controlled substance possession is a common reason for the arrest of persons with mental illness, but certainly not one that should lead to death.² After the police gave Chuck the incorrect medications, he had an adverse reaction.³ Instead of providing medical treatment, however, the police strapped him to a chair.⁴ Making it worse, the police lied to his mother about his whereabouts and did not let her see him until he was dying in the hospital.⁵ He died, not because of outright cruel treatment, but because of neglect.⁶

Risdon Slate is an Associate Professor of Criminology at Florida Southern College.⁷ Despite his doctorate and extensive knowledge of the criminal justice system, when he was brought to

* J.D. expected 2005, University of Minnesota Law School. My sincerest thanks go to Professor Michael Perlin for his guidance and support in writing this article.

1. LAURA LEE HALL ET AL., NATIONAL ALLIANCE FOR THE MENTALLY ILL, TRIAD REPORT, SHATTERED LIVES: RESULTS OF A NATIONAL SURVEY OF NAMI MEMBERS LIVING WITH MENTAL ILLNESSES AND THEIR FAMILIES (2003) [hereinafter TRIAD REPORT], at www.nami.org/content/Navigationmenu/Inform_yourself/About_Public_Policy/Policy_Research_Institute/Triad/NAMI_TRIAD_Report_FINAL.pdf.

2. See *infra* Part I.B.1.

3. TRIAD REPORT, *supra* note 1, at 22.

4. *Id.*

5. *Id.*

6. *Id.*

7. *The Impact of the Mentally Ill on the Criminal Justice System: Hearing Before the Subcomm. on Crime of the House Comm. on the Judiciary*, 106th Cong. 63 (2000) (statement of Risdon Slate, Associate Professor of Criminology, Florida Southern College).

jail after exhibiting bizarre behavior during a manic episode, the police ignored his wife's advice about his medication.⁸ During his stay in jail he never saw medical personnel or received medical treatment, another prisoner assaulted him, and the police placed him in an isolation cell to punish him for behaviors brought on by his illness.⁹ He was released only after a probation officer with whom he had previously worked intervened on his behalf.¹⁰ If these kinds of experiences can happen to someone with a loving, caring family and an extensive background in the criminal justice system, they can happen to anyone with a mental illness.

Unfortunately, the more typical story involves someone like James who has no support systems.¹¹ James grew up in Brooklyn in a middle class family and was studying engineering when he was first hospitalized for paranoid schizophrenia.¹² Years of moving in and out of hospitals, the death of his parents, and lost contact with siblings left James homeless—sleeping in a park, eating out of garbage cans, and drinking malt liquor to deal with the voices he heard.¹³ James had no psychiatrist and no insurance.¹⁴ One day, while arguing loudly with voices in his head and swinging his arms on a street corner, he was arrested for accidentally hitting a police officer.¹⁵ Thirty hours later he met his lawyer who recognized that James probably had a mental illness.¹⁶ Based on this recognition, the lawyer had the choice of asking the judge for a psychiatric examination, resulting in weeks in jail waiting for the results, or pleading guilty to a lesser charge and being released immediately.¹⁷ The prosecutor and the defense lawyer agreed on a lower charge and James received community service.¹⁸ Once James was on his own, however, he was back on the street with no place to sleep, no benefits, and no idea of where to turn for help.¹⁹ When he was picked up later for trespassing,

8. *Id.* at 64.

9. *Id.*

10. *Id.*

11. HEATHER BARR, URBAN JUSTICE CENTER, PRISONS AND JAILS: HOSPITALS OF LAST RESORT 1 (1999), available at <http://www.prisonworks.com/scans/MIRreport.pdf>. It should be noted that "James" is a composite based on two people. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.* at 1-2.

17. *Id.* at 2.

18. *Id.*

19. *Id.*

the judge wanted to send him to jail for failing to do his community service,²⁰ thus starting the cycle too common for persons with mental illness—arrested and released, only to be arrested again.

These stories are all too common and reflect the difficulties that many people with a mental illness face in society today.²¹ Not only were these people arrested as a result of manifestations of their mental illness, but also when the police were made aware of their disabilities, the police made few efforts to properly respond and help them by providing proper medical treatment.²² Substance abuse and homelessness are common among persons with a mental illness and increase their risk of exposure to the criminal justice system.²³

These failures to properly address the problems of mental illness have led to jails and prisons in the United States becoming de facto mental hospitals. The Department of Justice estimates that at least 7% of all jail inmates and 16% of all prison inmates have a mental condition or have had an overnight stay in a hospital.²⁴ While there is no consensus on the reasons for these numbers, hundreds of thousands of individuals with a mental illness have been incorrectly labeled as criminals based on manifestations of their illnesses.²⁵

Many in the mental disability rights community believed that help had arrived in the form of the Americans with Disabilities Act (ADA),²⁶ signed into law by President George Bush, Sr., on July 26, 1990.²⁷ Disability activists and politicians lauded it as bringing freedom to those with disabilities.²⁸ Yet many persons

20. *Id.*

21. See, e.g., Kate Stanley, *Instead of Psychiatric Care, He Got Jail*, STAR TRIB. (Minneapolis), Jun. 1, 2003, at 1AA (describing how Gerald Lund wound up in jail instead of a psychiatric hospital after his family called the police to escort him to the hospital).

22. See *infra* notes 78-116, 129-149 and accompanying text.

23. See *infra* notes 68-77 and accompanying text.

24. PAULA M. DITTON, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 1 (July 1999).

25. H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483, 486 (1998).

26. 42 U.S.C. §§ 12131-651 (2003).

27. 42 U.S.C. §§ 12131-165 (2003); MICHAEL L. PERLIN, 3 MENTAL DISABILITY L. CIV. AND CRIM. § 5A-2 (2d ed. 2000); Ira P. Robbins, *George Bush's America Meets Dante's Inferno: The Americans with Disabilities Act in Prison*, 15 YALE L. & POL'Y REV. 49, 73 (1996).

28. MICHAEL L. PERLIN, THE HIDDEN PREJUDICE 175 (2000) [hereinafter PREJUDICE].

with a mental illness continue to be punished rather than treated.²⁹

Surprisingly little case law has addressed the phenomenon of the criminalization of persons with a mental illness.³⁰ This Article will show that the criminalization of persons with a mental illness is a violation of the ADA, and will demonstrate how the ADA can be used to create systemic change in the treatment of persons with mental illness and help end the discrimination against persons with a mental illness in the arrest, post-arrest, and pretrial processes. Part I of this Article will address the history of the criminalization of persons with a mental illness and some of the factors creating it.³¹ Part II will focus on the ADA and Congress' intention in passing it.³² It will also discuss the case law applying the ADA in arrest, post-arrest, and pretrial situations, and the Supreme Court's decision in *Olmstead v. L.C.*,³³ providing a framework for cases applying the ADA in discriminatory institutionalization cases.³⁴ Part III will establish that the criminalization of persons with a mental illness, such as in the cases of Chuck, Risdon, and James, constitutes discrimination under the ADA and as such requires states to institute or improve mental health treatment, police training, and diversion programs for persons with a mental illness.³⁵

I. From the Snake Pits to the Streets to the Jail: The Criminalization of Persons with a Mental Illness

Jails and prisons around the country are replacing mental health institutions as repositories for persons with a mental illness.³⁶ In Illinois, the Cook County Jail identified more than

29. See *infra* Part I.

30. See William D. Gorn et al., Annotation, *Rights of Prisoners Under Americans with Disabilities Act and Rehabilitation Act*, 163 A.L.R. FED. 285 (2000). Most cases applying the ADA are post-conviction cases regarding treatment of persons with a mental illness in prisons. *Id.* However, these cases are not related to this Article, which focuses on systems that should be in place to prevent the jailing of persons with a mental illness in the first place. See *infra* notes 268-278 and accompanying text.

31. See *infra* notes 36-150 and accompanying text.

32. See *infra* Parts II.A-B.

33. 527 U.S. 581 (1999).

34. See *infra* Parts II.C-D.

35. See *infra* notes 242-289 and accompanying text.

36. See Deborah Reed, *National Developments in Diversion from Incarceration Programs*, 2 CMTY. MENTAL HEALTH REPORT 37, 38 (2002), at http://www.northshorelij.com/workfiles/lawandpsych/cmhr_2_3_p_37.pdf (stating this process is sometimes referred to as transinstitutionalization).

1,000 out of 11,000 inmates as having a mental illness.³⁷ In New York, Riker's Island is the state's largest de facto psychiatric institution, holding at least 2,850 inmates with a mental illness on any given day.³⁸ The Los Angeles County Jail has been reputed to be the nation's largest de facto psychiatric institution.³⁹ This downtown Los Angeles facility alone houses about 2,800 persons with a mental illness.⁴⁰ Studies vary in their estimates of the percentage of inmates with a mental illness in the jails and prisons, ranging from 6% to 31%;⁴¹ yet, rates of serious mental illness in the general population are at only 2-3%.⁴² What is the reason for this disparity?

The term "criminalization of the mentally ill" was coined in 1972 after an observation that there were an increasing number of persons with a mental illness in a county jail who were subject to arrest and prosecution for minor crimes.⁴³ This observation came toward the end of the deinstitutionalization movement of the

37. Mark Heyrman, *Mass Incarceration: Perspectives on U.S. Imprisonment: Mental Illness in Prisons and Jails*, 7 U. CHI. L. SCH. ROUNDTABLE 113, 113 (2000).

38. BARR, *supra* note 11, at 4. In 1999, a class action lawsuit was filed on behalf of the 25,000 inmates treated for mental illness each year at Riker's Island to obtain prerelease planning to ensure continued provisions for treatment following release. Susan Saulny, *City Agrees to Help Care for Mentally Ill Inmates After Release*, N.Y. TIMES, Jan. 9, 2003, at B4.

39. Julie Marquis, *State's First Lady Calls for Mental Health Reform*, L.A. TIMES, July 20, 1999, at B8.

40. *Id.*

41. E. FULLER TORREY ET AL., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 14 (Public Citizens Research Group and National Alliance for the Mentally Ill, 1992) [hereinafter NAMI REPORT]. These findings are similar to the results of other studies. See Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, NAT'L INST. OF JUST. J. 8, 12 (July 2000), available at <http://www.ojp.usdoj.gov/nij/journals/jr000244.htm> (finding nearly 9% of male detainees and more than 18% of female detainees meeting the criteria for having a lifetime severe mental disorder). It is possible that these numbers are underestimates because of the way the studies were conducted. Cameron Quanbeck et al., *Mania and the Law in California: Understanding the Criminalization of the Mentally Ill*, 160 AM. J. OF PSYCHIATRY 1245, 1245 (2003). Using other more sensitive methods during a study at the Los Angeles County Jail, researchers found that 28% of male and 31% of female arrestees either had a significant history of mental illness or manifested symptoms when they were arrested. *Id.*

42. Quanbeck, *supra* note 41, at 1245.

43. Lamb & Weinberger, *supra* note 25, at 484. This Article considers that criminalization of persons with a mental illness includes all contact with the criminal justice system starting from the time of arrest. Some other commentators, however, consider criminalization to start from the time of prosecution, while others include only incarceration in jails and prisons. *Id.* See, e.g., Quanbeck, *supra* note 41, at 1245 (stating that in the mid-1800s a system of care for persons with a mental illness—arguably "institutionalization"—was established, and in 1880 during a census of U.S. jails only 0.7% of inmates suffered from a mental illness).

1960s and 1970s.⁴⁴ Notwithstanding lofty definitions and goals identified with deinstitutionalization, it has come to represent the large-scale release of committed patients from mental health institutions without sufficient community preparation to receive them.⁴⁵

There is no consensus on the factors resulting in the criminalization of persons with a mental illness.⁴⁶ However, the factors most often cited include: a higher rate of drug and alcohol abuse among persons with a mental illness, homelessness, law enforcement policies and barriers, and societal attitudes.⁴⁷ Most of these factors are exacerbated by a lack of community support to address them.⁴⁸ Whatever the causes, jails and prisons do not provide a solution for persons with a mental illness.⁴⁹

44. See LeRoy L. Kondo, *Therapeutic Jurisprudence: Issues, Analysis, and Applications: Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 24 SEATTLE U. L. REV. 373, 387 (2000).

45. See PERLIN, *supra* note 27, § 4B-2. According to the National Institute of Mental Health, the official definition of deinstitutionalization involves three processes: (1) the prevention of inappropriate admissions to mental health facilities by providing community treatment alternatives; (2) the adequate preparation and transfer to the community of institutionalized patients not requiring institutionalized care; and (3) "the establishment and continued maintenance of community support systems for non-institutionalized persons receiving mental disability services." *Id.* See *infra* notes 56-64 and accompanying text.

46. Kondo, *supra* note 44, at 375-77 (compiling problems pinpointed in other sources such as deinstitutionalization, Social Security cutbacks resulting in homelessness, arrests for non-violent offenses, and mercy arrests); Lamb & Weinberger, *supra* note 25, at 486 (citing causes commonly believed to result in the criminalization of persons with a mental illness, including: deinstitutionalization, "the unavailability of long-term hospitalization in state hospitals for persons with chronic and severe mental illness, more formal and rigid criteria for civil commitment," the lack of adequate community support systems, the difficulty persons with a mental illness have in accessing community mental health treatment, particularly for those persons coming from the criminal justice system, "a belief by law enforcement personnel that they can deal with deviant behavior more quickly and efficiently within the criminal justice system than in the mental health system," and the public's attitudes toward persons with mental disorders); JUDGE DAVID L. BAZELON, CENTER FOR MENTAL HEALTH LAW, CIVIL RIGHTS AND HUMAN DIGNITY, 1998-1999 ANNUAL REPORT 6 (2000) available at <http://www.bazelon.org/bazanrpt.pdf> (last visited Sept. 21, 2004) ("Many are arrested for nonviolent misdemeanors or 'crimes of survival' such as stealing food or trespassing. Others are detained in 'mercy arrests' by police officers who find the public mental health system unresponsive and the process of accessing its emergency services cumbersome.").

47. See, e.g., Lamb & Weinberger, *supra* note 25, at 486.

48. See *infra* Part I.B.

49. See *infra* Part I.C.

A. *Out of the Snake Pits and into the Street:
Deinstitutionalization*

From the mid-1800s to the 1950s, institutionalization of persons with a mental illness was the norm.⁵⁰ Commentators suggest that deinstitutionalization began in 1954 with the introduction of the antipsychotic drug Thorazine.⁵¹ In the year following its introduction, the number of patients in state mental hospitals declined for the first time in a century.⁵² Nonetheless, in 1955 there were still an estimated 559,000 patients in state psychiatric institutions.⁵³ The horrible conditions of these institutions led commentators to refer to them as “snake pits.”⁵⁴ It is, therefore, no wonder that the policy of deinstitutionalization arose.⁵⁵ The more important issues are why it has failed and how it can be corrected.

Deinstitutionalization was based on the laudable ideal that severe mental illness should be treated using the least restrictive alternative.⁵⁶ President Jimmy Carter’s Commission on Mental Health defined the least restrictive alternative as “the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services.”⁵⁷ For three decades, the “least restrictive alternative” has been a staple of civil mental disability law.⁵⁸

50. Kondo, *supra* note 44, at 383-86.

51. Nancy K. Rhoden, *The Limits Of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 379 (1982).

52. *Id.*

53. *Id.* at 378.

54. *See id.* at 375.

55. *See, e.g.*, PERLIN, *supra* note 27, § 4B-2. Professor Perlin, in his treatise on Mental Disability Law, cites five forces that spurred the development of deinstitutionalization: (1) the recognition that high readmission rates and alternatives to large, impersonal institutions needed to be addressed; (2) the exploration of ways that community care could be provided; (3) the creation of opportunities for community programs to be reimbursed for caring for persons with a mental illness through new and amended grant and entitlement programs; (4) the improvement of antipsychotic drugs allowing them to be administered in the community; and (5) the “due process revolution” leading courts to strike down vague involuntary commitment statutes, to impose durational limitations on commitments, and to extend the “least restrictive alternative” doctrine to decision-making. *Id.*

56. E. FULLER TORREY, *OUT OF THE SHADOWS* 10-11 (John Wiley & Sons, Inc. eds., 1997) [hereinafter SHADOWS].

57. *Id.*

58. Michael L. Perlin, *Their Promises of Paradise: Will Olmstead v. L.C. Resuscitate the Constitutional “Least Restrictive Alternative” Principle in Mental Disability Law?*, 37 HOUS. L. REV. 999, 1010-12 (2000) (arguing that the least

Despite these good intentions, the community-based initiatives that were to replace the mental health institutions the never fully materialized.⁵⁹ As originally envisioned, deinstitutionalization involved the replacement of psychiatric hospitals with outpatient clinics, residential programs, supported employment, and other necessary services.⁶⁰ However, not only are the mental health treatment, housing, and rehabilitation resources insufficient to meet the needs of persons with a mental illness in most communities,⁶¹ those who have been in jail may not

restrictive alternative doctrine “has been invoked in virtually every major challenge to the limitations of the substantive involuntary civil commitment power, as well as in nearly every significant test case seeking a judicial declaration of a right to treatment, a right to refuse treatment, or a right to aftercare and/or deinstitutionalization,” and is “incorporated in many civil commitment statutes,” and is daily “invoked at individual commitment hearings” [hereinafter L.R.A.]; see also *Sell v. United States*, 539 U.S. 166, 177-83 (2003) (allowing the Government to involuntarily administer antipsychotic drugs to a defendant with a mental illness facing serious criminal charges to render that defendant competent to stand trial, but only after taking account of less intrusive alternatives); *Riggins v. Nevada*, 504 U.S. 127, 135 (1992) (holding that a “less intrusive alternative” methodology must be used to determine whether a defendant in a competent-to-stand-trial insanity defense pleader has the right to refuse the involuntary administration of antipsychotic medications at trial); *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (articulating a constitutionally-minimal standard of “reasonably nonrestrictive confinement conditions”); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (integrating least restrictive alternative principles into involuntary civil commitment challenges).

59. Rhoden, *supra* note 51, at 392-94 (suggesting that factors contributing to the failure of deinstitutionalization include that it did not begin as a formalized policy, but was, rather, an organic process; that the lack of a social consensus about deinstitutionalization impeded its implementation; that the various policies were “implemented in a disorganized and unrealistic manner”; that services were rarely delivered in “an organized, systemic manner”; and that “rigid funding policies” meant to facilitate deinstitutionalization “make it difficult for money to follow patients from institutions to community settings”); see also L. Elaine Sutton Mbionwu, *Special Needs Populations with Mental Illness in the Criminal Justice System*, 6 PROT. & ADVOC. NEWS 3 (2001), at <http://www.napas.org/I-6/Crim%20Jus%20P&A%20news%2010-01.htm> (identifying six problems with deinstitutionalization: “1) lack of appropriate discharge planning; 2) lack of person-centered planning; 3) uninvolved family members; 4) absence of community supports; 5) budget-cuts and dollars that did not follow the individuals into the community”; and 6) communities that were neither “ready nor had the capacity to absorb this special needs population.”).

60. NAMI REPORT, *supra* note 41, at 52; see also Rhoden, *supra* note 51, at 400.

61. For example, neither the criminal justice system nor the local mental health agencies are providing adequate case management essential to a well-functioning mental health program. Lamb & Weinberger, *supra* note 25, at 487. In addition, requirements that people with a mental illness come to an outpatient clinic for treatment is inappropriate when what many of them need is outreach services. *Id.* The President’s 2003 New Freedom Commission on Mental Health found in its final report that the

[m]ental health delivery system is fragmented and in disarray . . . lead[ing] to unnecessary and costly disability, homelessness, school failure

be able to access these resources if they are seen as difficult.⁶² As a result, the “least restrictive setting” has often taken the form of “a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies.”⁶³ Thus, it is not deinstitutionalization that has led to the criminalization of persons with a mental illness, but the failure to provide community treatment alternatives. In a sense, by criminalizing persons with mental illness, deinstitutionalization never really occurred; society has simply changed the form of the institution.⁶⁴

B. From the Streets to the Jail: Factors Contributing to the Criminalization of Persons with a Mental Illness

One study shows that 42-50% of persons with a mental illness will be arrested at some point in their lives,⁶⁵ compared

and incarceration In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs.

PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 3 (2003), available at <http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html> (last visited Sept. 22, 2004).

62. See Lamb & Weinberger, *supra* note 25, at 487. Persons with a mental illness who have been in jail often find mental health treatment out of their reach because the mental health system resists providing treatment to people it describes as resistant to treatment, dangerous, seriously substance abusing, and “sociopathic.” *Id.* “This reluctance extends to virtually all areas of community based care, including therapeutic housing, social and vocational rehabilitation, and general social service.” *Id.* As a result, “these mentally ill persons are left for the criminal justice system to manage.” *Id.*

63. *Olmstead v. L.C.*, 527 U.S. 581, 609 (1999) (Kennedy, J. concurring) (quoting SHADOWS, *supra* note 56, at 11); see also Rhoden, *supra* note 51, at 375 (describing the conditions persons with a mental illness find themselves in as a result of deinstitutionalization).

64. See Reed, *supra* note 36, at 38 (describing diversion programs as a result of criminalization of mentally ill persons).

65. Jeffrey Draine et al., *Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons with Serious Mental Illness*, 53 PSYCHIATRIC SERVICES 565, 566 (2002); see also John S. Brekke et al., *Risks for Individuals with Schizophrenia Who Are Living in the Community*, 52 PSYCHIATRIC SERVICES 1358, 1359 (2001) (evaluating “clients in an assertive community treatment program over a one-year period” to find that “41% had at least one police contact but were not arrested, and 28% were arrested and incarcerated” (citing N. Wolff et al., *A New Look at an Old Issue: People with Mental Illness and the Law Enforcement System*, 24 J. MENTAL HEALTH ADMIN. 152 (1999)); Robin Clark et al., *Legal System Involvement and Costs for Persons in Treatment for Severe Mental Illness and Substance Use Disorders*, 50 PSYCHIATRIC SERVICES 641, 644 (1999) (83% (169 individuals) of a sample of 223 individuals with a co-occurring substance abuse disorder had contact with the legal system and more than half of these had been arrested at least once in a three-year period).

with another study that indicates only 7-8% of the general population will have contact with the police.⁶⁶ Other studies show that persons with a mental illness are more likely to be arrested than the general population.⁶⁷ Factors that contribute to these higher arrest rates include: (1) a greater incidence of drug and alcohol abuse among persons with serious mental illnesses; (2) homelessness; (3) mercy, emergency, and nuisance bookings; (4) barriers to effective police responses; and (5) faulty public perceptions of mental illness.

1. Drug and Alcohol Abuse

Although the rate of criminal behavior for persons with a mental illness is not higher than that of the general population, this changes when the mental illness co-occurs with substance abuse.⁶⁸ Unfortunately, as was the case with Chuck and James, people with a mental illness often use alcohol and illegal drugs as self-medication to relieve the symptoms of their illness.⁶⁹ As using illegal drugs is a crime, and alcohol itself may lead to behavior that may be considered criminal, when a person with a mental illness has a co-occurring substance abuse problem, the odds of him or her being arrested increase significantly.⁷⁰ According to

66. Brekke et al., *supra* note 65, at 1363.

67. Linda Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 AM. PSYCHOL. 794, 794 (1984). Observers watched Chicago officers over a 2,200 hour, fourteen-month period, and documented 1,382 officer/citizen encounters. *Id.* at 797-98. Of this number, officers arrested only 27.9% of the suspects without mental disorders and 46.7% of the suspects with mental disorders. *Id.* at 798. *See also* Brekke et al., *supra* note 65, at 1364 (finding the arrest rate for persons with schizophrenia in Los Angeles 45% higher than the arrest rate for the general population).

68. Heyrman, *supra* note 37, at 114; *see also* DITTON, *supra* note 24, at 1 (stating that “[s]tate prison inmates with a mental condition were more likely than other inmates to be incarcerated for a violent offense” and “more likely than others to be under the influence of alcohol at the time of current offense”); Lamb & Weinberger, *supra* note 25, at 488 (“... mental illness may appear to the police as simply alcohol or drug intoxication, especially if the mentally ill person has been using drugs or alcohol at the time of arrest.”); TRIAD REPORT, *supra* note 1, at 22 (describing a story of an individual with a mental illness who died because he did not receive proper medication in jail).

69. Heyrman, *supra* note 37, at 114 (2000); *see also* NATIONAL ALLIANCE FOR THE MENTALLY ILL, DUAL DIAGNOSIS AND INTEGRATED TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDER (2003) at www.nami.org/Content/ContentGroups/Helpline1/Dual_Diagnosis_and_Integrated_Treatment_of_Mental_Illness_and_Substance_Abuse_Disorder.htm (last visited October 12, 2004) (discussing the consequences of alcohol abuse co-occurring with a mental illness) [hereinafter DUAL DIAGNOSIS]. Various studies show a range of 14.7-61% of those affected with severe mental disorders are also affected by substance abuse. *Id.*

70. Heyrman, *supra* note 37, at 114.

the Department of Justice, six in ten inmates with a mental illness were under the influence of alcohol or drugs at the time of their arrest, and about a third were found to be alcohol dependent.⁷¹ This kind of abuse is even higher among the indigent, such as James, who have less access to supportive living situations, health care, and proper medication.⁷²

2. Homelessness

Deinstitutionalization and the absence of community support led to an increase in the numbers of homeless, like James, who have a mental illness.⁷³ The combination of mental illness and homelessness, in turn, appears to be a major factor in the arrest rate of persons with a mental illness.⁷⁴ The Department of Justice found that 30% of inmates with a mental illness in jail were homeless for a period in the twelve months prior to their arrest.⁷⁵ This is almost twice the homeless rate of other inmates.⁷⁶ Some of this disparity can be attributed to the increase in municipal ordinances criminalizing behavior by homeless persons, which may, in turn, be a reflection of society's perceptions of the homeless and of persons with a mental illness.⁷⁷

71. DITTON, *supra* note 24, at 7.

72. Heyrman, *supra* note 37, at 114; *see also* TRIAD REPORT, *supra* note 1, at 12 (nearly 10% of those surveyed had no health insurance); DUAL DIAGNOSIS, *supra* note 69 (stating the reasons for a higher rate of drug abuse among "people with mental illnesses who became indigent by reason of their illness" as including: "living in marginal neighborhoods where drug use prevails"; poor social skills resulting in finding acceptance easier in groups that use a lot of drugs; and a belief that identification as a drug addict is more socially acceptable than being identified as having a mental illness).

73. PERLIN, *supra* note 27, § 4B-3.2c. While deinstitutionalization is one factor in the increased number of homeless who have a mental illness, there are other factors as well. For example, about a third of the people whose benefits were discontinued following the Reagan administration cutbacks of Supplemental Social Security Income had a mental illness. *Id.* § 4B-3.2d. This has been a significant factor in the increase in homelessness. *Id.*

74. PERLIN, *supra* note 27, § 4B-3.1a.

75. DITTON, *supra* note 24, at 3. Other studies show similar results. *See, e.g.*, Daniel A. Martell et al., *Base-Rate Estimates of Criminal Behavior by Homeless Mentally Ill Persons in New York City*, 46 PSYCHIATRIC SERVICES 596, 597 (1995) (finding that 43% of defendants with a mental illness in New York City were homeless when arrested).

76. DITTON, *supra* note 24, at 5.

77. *See* PERLIN, *supra* note 27, § 4B-3.1a (citing ordinances such as sleeping in public and loitering).

3. Mercy Bookings, Emergency Detention, and Misdemeanors

With a lack of community resources and numerous other obstacles, police officers often use their own techniques to obtain treatment for persons with a mental illness.⁷⁸ Mercy bookings occur when officers invent charges against individuals with a serious mental illness so they can have shelter, food, and "access to some form of treatment."⁷⁹ In most cases, officers take this action because they believe that there are no appropriate community alternatives available, and so they bring the person with the mental illness to jail.⁸⁰ Aggravating this problem is the fact that some states allow detention of persons with a serious mental illness even with no criminal charges against them.⁸¹ According to a 1992 survey, states with such laws are almost twice as likely to do detain as states without such laws.⁸² In addition, oftentimes families will intentionally have their family member with a mental illness arrested because it is the only way to obtain psychiatric treatment.⁸³

As of 1997, roughly 70% of persons with a mental illness held in local jails were there for non-violent crimes, with a quarter of offenders having been charged with public-order offenses.⁸⁴ According to a 1992 survey conducted by the National Alliance for the Mentally Ill, examples of disorderly conduct and public nuisance charges include homelessness, roaming public streets, urinating in public, and "just acting strangely" or hallucinating.⁸⁵ Not only are some of these charges not really crimes, they are also

78. See Heyrman, *supra* note 37, at 115-16.

79. NAMI REPORT, *supra* note 41, at 43.

80. See H. Richard Lamb et al., *The Police and Mental Health*, 53 PSYCHIATRIC SERVICES 1266, 1267 (2002) [hereinafter *Police and Mental Health*].

81. See MISS. CODE ANN. § 41-21-67(4) (2003) (stating that "an emergency patient may be detained at a "mental health facility or any other available suitable location as the court may so designate . . . [provided], [h]owever, the respondent shall not be held in . . . jail unless the court finds that there is no reasonable alternative"). *But see* FLA. STAT. ANN. § 394.459(1) (2003) (stating that the noncriminal mentally ill "shall not be detained or incarcerated in the jails of this state").

82. NAMI REPORT, *supra* note 41, at 44-45 (noting that in states like Mississippi, Kentucky, and Florida, persons with a serious mental illness may be held for weeks while waiting for a bed in a state hospital).

83. *Id.* at 47.

84. DITON, *supra* note 24, at 4.

85. NAMI REPORT, *supra* note 41, at 19-20 n.20.

most likely manifestations of an untreated mental illness.⁸⁶

4. Barriers to Effective Police Responses

Following deinstitutionalization, police departments reported an increase in mental illness-related calls. For example, in a suburb of Philadelphia, from 1975 to 1979, the police reported an increase of 227.6% in mental illness-related incidents.⁸⁷ When Agnews State Hospital, in Santa Clara County, California, was closed in the early 1970s, the number of people with a mental illness in the county jail increased by 300%.⁸⁸ This trend continued through the 1990s, with twenty-five states showing an increase in the number of inmates with a mental illness from 1991 to 1999.⁸⁹ An additional three states reported anecdotal evidence of an increase.⁹⁰ This has obviously altered the job of police officers.⁹¹

Police are typically the first to be called to respond to situations involving persons with a mental illness and they have a legal obligation to respond to these calls.⁹² In all states, the police have the authority to transport persons with a mental illness for psychiatric evaluation and treatment if there is probable cause to believe that the person's mental condition rises to a level where he or she is a danger to herself, himself, or others.⁹³ Consequently, the police are inherently responsible for determining if a person is in need of treatment and, if so, deciding whether treatment at a hospital or detention in a jail is more appropriate.⁹⁴ Thus, the police may act as involuntary gatekeepers—determining whether the legal or mental health system can better meet the needs of the

86. H. Richard Lamb & Leona L. Bachrach, *Some Perspectives on Deinstitutionalization*, 52 PSYCHIATRIC SERVICES 1039, 1042 (2001).

87. J.C. Bonovitz & J.S. Bonovitz, *Diversions of the Mentally Ill into the Criminal Justice System: The Police Intervention Perspective*, 138 AM. J. PSYCHIATRY 973 (1981).

88. Quanbeck et al., *supra* note 41, at 1245 (citing G.E. Whitmer, *From Hospitals To Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 AM. J. ORTHOPSYCHIATRY 65 (1980)).

89. U.S. DEPT OF JUSTICE, NATIONAL INSTITUTE OF CORRECTIONS, PROVISION OF MENTAL HEALTH CARE IN PRISONS 2-3 (2001), *available at* <http://www.nicic.org/pubs/2001/016724.pdf> (last visited Oct. 11, 2004) [hereinafter PROVISION OF MENTAL HEALTH CARE IN PRISONS].

90. *Id.*

91. Teplin, *supra* note 41, at 9.

92. *Police and Mental Health*, *supra* note 80, at 1266.

93. *Id.*

94. *Id.*

individual with a mental illness.⁹⁵

Police responses to the gatekeeper function range from officers who see it as their duty, to officers who resent it.⁹⁶ These personal feelings can affect the exercise of the officer's discretion if there is no oversight, and result in inconsistent police responses.⁹⁷ These responses may vary from officers who arrest persons with a mental illness more often, to officers who make more of an effort to obtain hospitalization, to others who simply release the person with the mental illness with no charge and no treatment.⁹⁸

Officers and departments who want to provide proper treatment often face significant barriers, such as time and distance.⁹⁹ Officers often face lengthy wait times at emergency rooms.¹⁰⁰ When officers must wait for emergency room care, they cannot attend to their other obligations.¹⁰¹ Additionally, mental health professionals may often question the opinion of the officer and refuse admission or admit the person for too brief a period.¹⁰² Another problem, particularly in rural areas, is the great distance to a psychiatric facility.¹⁰³ In the face of these problems, officers are tempted to rely on processes with which they have more familiarity and control, such as arrest.¹⁰⁴

In addition to these barriers, the training that police receive to identify and deal with mental illness is generally inadequate.¹⁰⁵ When asked, officers have expressed a desire to learn more about issues related to mental illness, such as how to recognize when someone has a mental illness, how to deal with psychotic behavior including violence or potential violence when it arises, and how to respond to a person who is threatening suicide.¹⁰⁶ Officers would also like to know more about available community resources, and

95. *Id.*

96. *Id.*

97. *Id.* at 1267.

98. *Id.*

99. *Id.*; NAMI REPORT, *supra* note 39, at 44-45.

100. *Police and Mental Health*, *supra* note 77, at 1267.

101. *Id.*

102. *Id.*; see also Heyrman, *supra* note 37, at 115-16 (describing to what lengths some officers are willing to go to get hospital treatment for a person with a mental illness).

103. NAMI REPORT, *supra* note 41, at 44-45.

104. See *Police and Mental Health*, *supra* note 80, at 1267.

105. *Id.* at 1269 (referring to J.R. Husted et al., *California Law Enforcement Agencies and the Mentally Ill Offender*, 23 BULL. AM. ACAD. OF PSYCHIATRY & L. 315, 315 (1995)).

106. *Police and Mental Health*, *supra* note 80, at 1269.

how they can be accessed.¹⁰⁷

A lack of sufficient training among officers may result in not recognizing a mental illness or misidentifying symptoms of mental illness as drug or alcohol intoxication, which becomes even more confusing when the person with the mental illness has been using those substances.¹⁰⁸ When officers must use force to subdue a person, they may also be more likely to miss symptoms of mental illness.¹⁰⁹

Fatal encounters between police and persons with a mental illness are visible in the news.¹¹⁰ It appears that oftentimes these situations arose because of a combination of the person with the mental illness not receiving proper treatment and encountering an improper police response, aggravating the situation.¹¹¹ One

107. *Id.*

108. *Id.* at 1267.

109. *Id.*

110. For example, in Minnesota there have been at least four shooting deaths by police of people suffering from mental illness since 2000, and at least one killing of a police officer. Heron Marquez Estrada, *St. Paul Sued Over Death of Man Killed By Cops*, STAR TRIB. (Minneapolis), Sept. 26, 2003, at B3 (reporting on Ki Yang, a man with a history of schizophrenia, shot to death by police after charging at police with a BB gun resembling a rifle and a 20-inch sickle-like blade); David Chanen, *Shootings Highlight Police Moves to Change Procedure*, STAR TRIB. (Minneapolis), Dec. 17, 2000, at A13 (reporting on the police shooting of Rocco Dandrea, a man described as having a mental illness, after he pointed a toy gun at the police); Heron Marquez Estrada & David Chanen, *Man Killed By Police Had Disorder*, STAR TRIB. (Minneapolis), Nov. 2, 2000, at A1 ("Less than 24 hours after an unsuccessful attempt by relatives to have Alfred Sanders committed for a mental evaluation, the 29 year old man was shot to death . . . by Minneapolis police after he reportedly sped toward them."); Joy Powell, *Questions Linger About What Cops Knew Before They Fired on Mentally Ill Woman*, STAR TRIB. (Minneapolis), July 2, 2000, at A1 (reporting on the police shooting of Barbara Schneider, a woman suffering from bipolar disorder, after they entered her apartment and she came at them with a knife calling them the "Satan Squad"). Similar news can be found elsewhere. See Editorial, *Cops and the Mentally Ill*, L. A. TIMES, Nov. 9, 1999, at B8 (stating that between 1994 and 1999, Los Angeles police shot 37 people who exhibited irrational behavior or symptoms of mental illness, 25 of whom died) [hereinafter L.A. Times Editorial]; Pete Donohue & John Marzulli, *Slashed Officer Recalls Horror*, NEWSDAY, Apr. 29, 1999, at 20 (reporting forcible submission of suspect with a mental illness by police after suspect slashed an officer with a knife).

111. See L.A. Times Editorial, *supra* note 110 (reporting that from 1994 to 1999 at least a dozen killings of persons who had a mental illness or were considered unstable were the result of confrontations involving questionable police tactics and use of deadly force); Bernard K. Melekian, *It Takes More than Cops to Handle the Anguished Loose on the Streets*, L.A. TIMES, Dec. 22, 1999, at B9 (writing as Chief of Police in Pasadena that both improved training of the police and increased community mental health opportunities are needed to stop the problem of violent encounters between the police and persons with a mental illness). Other examples are: an officer killed Margaret Laverne Mitchell after fearing that she was going to harm him with a screwdriver; an officer shot and injured J. Pantera after he threw

possible reason for this improper response is the perception by officers that persons with a mental illness are more prone to violence, which may cause officers to approach them more aggressively, possibly escalating the situation and even evoking unnecessary violence.¹¹² Although there is a minority violent subgroup of persons with a mental illness who pose a large challenge both to mental health professionals and to the police, the majority of persons who have a mental illness are not violent.¹¹³ Nonetheless, it is becoming increasingly apparent that neither the police nor the psychiatric emergency teams alone are able to respond to these individuals and the kinds of situations they pose.¹¹⁴ In order to resolve these crises, reduce criminalization, and protect persons with a mental illness, it is necessary for the two systems to work closely together.¹¹⁵ In fact, studies show that communities with specialized response systems combining the criminal justice system and the mental health system, including greater training for officers, had arrest rates of persons with an apparent mental illness a third less than those without specialized systems.¹¹⁶

5. Public Views of Mental Illness

Public views of mental illness add to the difficulty in diverting persons with a mental illness out of the criminal justice system.¹¹⁷ For example, people have a variety of views of persons with a mental illness that include seeing them as different, less

a grapefruit at the officer's car. L.A. Times Editorial, *supra* note 106. See also, e.g., Powell, *supra* note 110, at A1 (in response to complaints of loud music and request for mental health crisis team, police barged into the apartment and shot and killed a woman with a mental illness despite being given warnings to ask for help from building manager); Dan Morrison, *Seattle Case Where Cops Held Fire*, NEWSDAY, Apr. 8, 1997, at A03 (comparing the shooting deaths of three men and a teenager by police after the victims threatened the police and others with weapons to an eleven-hour standoff in Seattle where police eventually subdued a patient with a mental illness threatening police and others with a sword). But see *Police and Mental Health*, *supra* note 80, at 1269 (noting that "suicide by cop," defined as a suicidal individual acting in a life-threatening way toward officers or civilians specifically to provoke officers to fire at the suicidal individual in self-defense or to protect others, accounts for 11-46% of those shot, depending on location and length of time).

112. See Amy Watson et al., *Police Officers' Attitudes Toward and Decisions About Persons with Mental Illness*, 55 PSYCHIATRIC SERVICES 49, 52 (2004).

113. See *infra* notes 120-128 and accompanying text.

114. Henry J. Steadman et al., *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, 51 PSYCHIATRIC SERVICES 645, 648-49 (2000).

115. *Id.*

116. *Id.*

117. Lamb & Weinberger, *supra* note 25, at 488-89.

than human, dangerous and frightening, like children, incompetent to participate in normal activities, or not trying hard enough to be normal.¹¹⁸ Some people see mental illness as a deliberate attempt to avoid punishment, and others view diversion as special treatment for people who have committed crimes.¹¹⁹

One of the largest stigmas placed on persons with a mental illness is the belief that they are prone to violence.¹²⁰ This ignorance and fear also leads to discrimination and policies that may contribute to the criminalization of persons with a mental illness.¹²¹ For example, the belief that persons with a mental illness are prone to violence may influence the placement of transitional housing, the availability of community treatment, and employment opportunities.¹²²

While it is true that individuals with a severe mental illness are more likely to commit acts of violence, only a small percentage of people who have a mental illness become violent, and those violent offenses account for only a small fraction of the violence in America.¹²³ For example, in one study of offenders with a mental illness approximately half of all violent offenses committed by persons with a mental illness were committed by participants with substance abuse disorders.¹²⁴ On the contrary, participants with psychotic disorders accounted for only 1% of the violent offenses.¹²⁵ The same study showed that persons with a mental illness committed only 10% of violent crimes.¹²⁶ In fact, persons with a mental illness are more likely to be victims of violence than to be

118. PREJUDICE, *supra* note 28, at 43-47.

119. See Lamb & Weinberger, *supra* note 25, at 489; PREJUDICE, *supra* note 28, at 46.

120. See STEPHEN BLUMENTHAL & TONY LAVENDER, VIOLENCE AND MENTAL DISORDER 14-16 (2000); see also Heather Stuart & Julio E. Arboleda-Flórez, A Public Health Perspective on Violent Offenses Among Persons with Mental Illness, 52 PSYCHIATRIC SERVICES 654, 659 (2001). A 1980 study of college students showed that 52% believed that "aggression, hostility, [and] violence" were common or very common attributes" of mental illness. SHADOWS, *supra* note 56, at 56 ("A 1987 study of residents of Ohio revealed that 'perceived dangerousness' was the single most important factor contributing to the stigma of mental illness.").

121. SHADOWS, *supra* note 56, at 57.

122. Stuart & Arboleda-Flórez, *supra* note 120, at 659.

123. *Id.* 657; see also BLUMENTHAL & LAVENDER, *supra* note 120, at 52-54 (explaining why psychiatric diagnosis are unproductive as predictors of violence); Elizabeth Walsh et al., *Violence and Schizophrenia: Examining the Evidence*, 180 BRIT. J. PSYCHIATRY 490, 494 (2002) ("[A]lthough a statistical relationship does exist between schizophrenia and violence, only a small proportion of societal violence can be attributed to persons with schizophrenia.").

124. Stuart & Arboleda-Flórez, *supra* note 120, at 657.

125. *Id.*

126. *Id.*

arrested for it.¹²⁷ Of individuals with a mental illness who become violent, past history of violence, concurrent abuse of drugs and alcohol, and failure to take medications contribute to this tendency and could be targeted for special attention.¹²⁸ Thus, society's fear concerning violent tendencies of individuals with a mental illness is unfounded and needs to change if the criminalization of this population is going to end.

*C. Jails and Prisons as the New Mental Health Institutions:
An Ineffective and Unhealthy Answer*

In 1998, there were over 280,000 persons with a mental illness held in jails.¹²⁹ Inmates with mental illness face substantial problems in jail and strain scarce resources.¹³⁰ One of the primary problems is that jails have rigid rules, with a primary objective of punishing those who have broken laws and teaching them how to follow the rules.¹³¹ This system assumes everyone understands the rules and punishes those who are presumed to choose not to follow them.¹³² As such, persons with mental illnesses are more likely than their counterparts to be charged with breaking prison or jail rules.¹³³ Often, persons with a mental illness do not understand these rules or are simply exhibiting

127. Brekke et al., *supra* note 65, at 1365 (finding that individuals with schizophrenia in Los Angeles are at least fourteen times more likely to be victims of violent crime than to be arrested for one).

128. See BARR, *supra* note 11, at 12 (discussing New York City's Assertive Community Treatment team model as a mobile team that works with difficult or treatment-resistant clients by bringing psychiatric, case management, drug treatment, and vocational services to the client's home).

129. DITTON, *supra* note 24, at 1.

130. HUM. RTS. WATCH, ILL-EQUIPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 49-69 (2003), available at <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf> (last visited Oct. 10, 2004) [hereinafter HUM. RTS. WATCH]. For example, in Pennsylvania it costs an additional \$60 a day to incarcerate a prisoner with a mental illness—from \$80 for the average prisoner to \$140 for the prisoner with a mental illness. *Id.* at 49. Yet, prison mental health budgets are being cut due to the fiscal crisis facing the United States. *Id.* at 50. Inmates in Alabama have reported needing to harm themselves in order to receive needed treatment, but this may only result in disciplinary action and segregation. *Id.* at 137. In California, a federal judge handed down an opinion against the California Department of Corrections citing "a rampant pattern of improper or inadequate care that nearly defies belief." *Madrid v. Gomez*, 889 F. Supp. 1146, 1212 (N.D. Cal. 1995) (quoting Dr. Start's report).

131. HUM. RTS. WATCH, *supra* note 130, at 53, 60.

132. *Id.* at 53.

133. DITTON, *supra* note 24, at 9. For example, 51.9% of state prison inmates without a mental illness were charged with breaking prison rules, compared to 62.2% of inmates with a mental illness. *Id.*

manifestations of their mental illness.¹³⁴ Punishments for noncompliance may take the form of segregation, beatings, and other forms of abuse, and at the very least exacerbate the illness.¹³⁵ Problems with following the rules and misunderstood manifestations of the mental illness also frequently result in prisoners with a mental illness serving more time in prison than other offenders.¹³⁶

The behavior of inmates with mental illness may trigger violent responses by other inmates.¹³⁷ This abuse may take the form of beatings, exploitation, extortion, and rape.¹³⁸ As one jail official eloquently said, “[t]he bad and the mad just don’t mix.”¹³⁹ This behavior may be made worse by the policies of the jail. For example, in Los Angeles, inmates with a mental illness are easily targeted because they wear uniforms of a different color and have the letter “M” on their nametags.¹⁴⁰ Risk of suicide and self-mutilation are also major problems, with the risk of suicide at two-and-a-half times that of the U.S. population at large.¹⁴¹

These difficulties, particular to inmates with a mental illness, require additional attention from jail staff, taking them away from other duties.¹⁴² A contributing problem is the lack of training for correctional officers about the problems of persons with a serious mental illness.¹⁴³ According to a 2001 survey by the National Institute of Corrections, while forty departments of corrections in the United States require correctional staff to receive training on how to manage inmates with a mental illness, the training is minimal.¹⁴⁴ Only thirty offer pre-service training, all offering less than four hours, and only twenty-two provide in-service training, with most offering less than four hours of training annually.¹⁴⁵

134. HUM. RTS. WATCH, *supra* note 130, at 65.

135. *Id.* at 65, 78-86, 147-60.

136. DITTON, *supra* note 24, at 8. In state prisons, offenders with a mental illness could expect to serve fifteen months longer than other offenders from the time of admission to the time of expected release. *Id.* This was not true, however, for inmates with mental illness in local jails who were expected to serve less time than other inmates. *Id.*

137. HUM. RTS. WATCH, *supra* note 130, at 56.

138. *Id.* at 56-57.

139. SHADOWS, *supra* note 56, at 32.

140. Duncan Campbell, *300,000 Mentally Ill People in US Jails*, THE GUARDIAN (Manchester), Mar. 3, 2003, at 15.

141. HUM. RTS. WATCH, *supra* note 130, at 174-78.

142. *Id.* at 75.

143. *Id.* at 76.

144. PROVISION OF MENTAL HEALTH CARE IN PRISONS, *supra* note 89, at 9.

145. *Id.*

A lack of access to psychiatric treatment exacerbates the problems faced by inmates with a mental illness.¹⁴⁶ In 1999, the Department of Justice reported that only 41% of inmates in local jails received treatment for mental illness since admission.¹⁴⁷ Protecting persons with a mental illness from those who may try to hurt them, including themselves, treating those that are injured, and fighting lawsuits brought in response to beatings by guards creates enormous costs for states.¹⁴⁸ Incarcerating persons with a mental illness also often results in a worsening of psychiatric symptoms and other medical conditions.¹⁴⁹ Given all of these difficulties, it does not seem that jail is the answer to the problems faced by persons with a mental illness.

The criminalization of persons with a mental illness has been increasing since the deinstitutionalization movement in the 1970s, resulting in a higher percentage of individuals with a mental illness coming into contact with the criminal justice system.¹⁵⁰ The primary reason is a lack of community treatment alternatives to address many of the problems that result in a higher arrest rate, including a lack of mental health treatment, drug and alcohol abuse, and homelessness.¹⁵¹ Contributing to these problems are arrests of persons with a mental illness for no crime at all, mercy bookings, or arrests for manifestations of the mental illness.¹⁵² These inappropriate arrests are caused by a variety of barriers to effective police response, including a lack of training and public misconceptions of mental illness. Whatever the reasons, jail is not the answer to the problems faced by persons with a mental illness. The ADA provides a legal means to work toward the systemic change that needs to take place to address these problems and

146. HUM. RTS. WATCH, *supra* note 130, at 94-140.

147. DITTON, *supra* note 24, at 1. Interestingly, there are exceptions where some persons with a mental illness find jail or prison a positive experience, usually because it was the only place they could get treatment. HUM. RTS. WATCH, *supra* note 130, at 27.

148. See, e.g., Hector Tobar, *County OKs Payment in Jail Beating*, L.A. TIMES, June 9, 1992, at B1 (stating that Los Angeles County Officials in June 1992 settled for \$1.75 million a case involving a paranoid schizophrenic inmate who had been severely beaten by guards at the jail because he had been violating "rules requiring inmates to remain silent, place their hands in their pockets and keep their shirts tucked in"); HUM. RTS. WATCH, *supra* note 130, at 87-88 (indicating that the State of Connecticut paid out \$2.9 million to the estate of inmate Timothy Perry, a twenty-one-year-old man with schizophrenia who died at the hands of prison officials using excessive force to restrain and sedate him).

149. HUM. RTS. WATCH, *supra* note 130, at 53-56.

150. See *supra* notes 59-64 and accompanying text.

151. See *supra* notes 65-116 and accompanying text.

152. See *supra* notes 87-128 and accompanying text.

significantly diminish the criminalization of persons with a mental illness.

II. The ADA: A Revolution for Persons with a Mental Illness

Advocates have called the ADA “a breathtaking promise,” “the most important civil rights act passed since 1964,” and the “Emancipation Proclamation for those with disabilities.”¹⁵³ The House Committee of the Judiciary called it “a clear and comprehensive national mandate to end discrimination against individuals with disabilities.”¹⁵⁴ Passage of the ADA led mental disability rights activists to hope that it would alleviate some of the problems that lead to the criminalization of persons with a mental illness.¹⁵⁵ Much of this hope is based upon Congress’ intention that passage of the ADA would lead to systemic change that would result in the elimination of discrimination against individuals with disabilities.¹⁵⁶

Despite congressional intentions, the ADA has had only limited success in the courts in arrest, post-arrest, and pretrial situations, and it has done little to alleviate the criminalization of persons with a mental illness.¹⁵⁷ The Supreme Court’s decision in *Olmstead v. L.C.*, however, provides a new framework for decisions affecting persons with mental disabilities under the ADA.¹⁵⁸

A. Establishing and Remediating a Violation of the ADA

Title II of the ADA is the most useful to persons with mental disabilities in the pretrial context by focusing on public entities and services.¹⁵⁹ In order to establish a claim, a person must show:

153. PREJUDICE, *supra* note 28, at 175.

154. HOUSE COMM. ON THE JUDICIARY, AMERICANS WITH DISABILITIES ACT OF 1990, H.R. REP. NO. 101-485(III), at 23 (1990).

155. L.R.A., *supra* note 58, at 1028.

156. 42 U.S.C. § 12101 (2003).

157. *See infra* Part II.C.

158. 527 U.S. 581, 604 (1999). This case is discussed in Part II.D.

159. 42 U.S.C. §§ 12131-65 (2003). There are two other primary titles: Title I, which prohibits discrimination in employment situations, 42 U.S.C. §§ 12111-17, and Title III, which focuses on the accessibility requirement for private entities, 42 U.S.C. §§ 12181-89. Currently, there is a circuit split as to whether Title II of the ADA is a valid exercise of Congress’ Section Five power under the Fourteenth Amendment. Jennifer Lav, *Conceptualizations of Disability and the Constitutionality of Remedial Schemes Under the Americans With Disabilities Act*, 34 COLUM. HUM. RTS. L. REV. 197, 233 (2002). In 2001, the Court decided in *University of Alabama v. Garrett* that it is unconstitutional for private individuals to collect money damages from states for Title I violations of the ADA unless there

(1) that she or he is a qualified individual with a disability; (2) that she or he was excluded from participation in or denied benefits of a public entity's services, programs, or activities, or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was because of the individual's disability.¹⁶⁰ Proof of intentional discrimination is unnecessary to establish an ADA violation.¹⁶¹

To become a qualified individual under the ADA, a person must have a disability that, "with or without reasonable modifications to rules, policies, or practices . . . or the provision of auxiliary aids and services," allows the individual with the disability to meet the eligibility requirements in order to receive "services or participate in programs or activities provided by a public entity."¹⁶²

Prisoners with a mental disability are qualified individuals under the ADA. According to the Supreme Court in *Pennsylvania Department of Corrections v. Yeskey*,¹⁶³ prisoners with disabilities who are held against their will are qualified individuals under the ADA because prisons are public entities,¹⁶⁴ and because meeting the eligibility requirements and participating in programs or activities does not require voluntariness. This means that a person held against her will for committing a crime is eligible to participate in the services provided by a prison.¹⁶⁵ Thus, prisoners

is a pattern of discrimination by the states in violation of the Fourteenth Amendment. 531 U.S. 356, 374 (2001). However, this has little effect on the issue presented here which is looking only for injunctive remedies.

160. 42 U.S.C. § 12132 (2003); see also *Panzardi-Santiago v. Univ. of Puerto Rico*, 200 F. Supp. 2d 1 (P.R. Dec. 2002) (reaffirming this standard).

161. *Alexander v. Choate*, 469 U.S. 287, 296-97 (1985). In *Alexander*, the Supreme Court held that it is unnecessary to find intent to discriminate in a federally funded program for a violation to exist under the Rehabilitation Act. *Id.* Because both the Rehabilitation Act and the ADA use the same language regarding discrimination of the disabled, courts have applied this same holding to the ADA. See, e.g., *Concerned Parents to Save Dreher Park Ctr. v. City of West Palm Beach*, 846 F. Supp. 986, 991 (S.D. Fla. 1994) ("Certainly intentional discrimination is banned by Title II. But further, actions that have the effect of discriminating against individuals with disabilities likewise violate the ADA."); see *Peoples v. Nix*, 3 Am. Disabilities Cas. (BNA) 873 (E.D. Pa. 1994) ("A showing of discriminatory intent is not necessary to sustain a claim of violation of the ADA.").

162. 42 U.S.C. § 12131 (2003).

163. 524 U.S. 206 (1998).

164. In *Yeskey*, the Supreme Court held that the ADA applied to inmates in state prisons by arguing that state prisons fell "squarely within the statutory definition of public entity." 524 U.S. 206, 209-10 (1998). The ADA defines a "public entity" as "any State or local government; [and] any department, agency, special purpose district, or other instrumentality of a State or States or local government." 42 U.S.C. § 12131.

165. *Yeskey*, 524 U.S. at 211. *Yeskey* had been sentenced to serve eighteen to

with a mental illness qualify under *Yeskey* because a mental illness is considered a disability under the ADA.¹⁶⁶

In order to remedy discrimination under the ADA, public entities must make reasonable modifications to policies, practices, and procedures unless the public entity can demonstrate that making such modification would result in a fundamental alteration.¹⁶⁷ The Supreme Court in *Olmstead v. L.C.* explained that the fundamental-alteration component may be used “to show that in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.”¹⁶⁸ However, this argument does not allow the state to delay making the modification indefinitely.¹⁶⁹

B. The ADA: Congressional Focus on Systemic Change and Elimination of Barriers to Equal Participation by Persons with Disabilities

The language of the ADA shows an understanding by Congress that the environment society has constructed through its policies, practices, and structures often excludes those with disabilities and is thus a form of discrimination.¹⁷⁰ For example, the ADA’s definition of a disability includes disabilities that limit the person’s major life activities.¹⁷¹ To be a qualified individual with a disability, the ADA requires both a medical condition and a

thirty-six months in a Pennsylvania correctional facility. *Id.* at 208. The sentencing court recommended that he be placed in Pennsylvania’s Motivational Bootcamp for first-time offenders. *Id.* The successful completion of the bootcamp would have allowed *Yeskey* to be released on parole after six months. *Id.* However, he was refused admission due to a medical history of hypertension. *Id.* The question the Court addressed was only whether the ADA applied to inmates in state prisons. It did not address whether preventing *Yeskey* from attending the bootcamp was a violation of the ADA. *Id.*

166. 42 U.S.C. § 12101(a)(1) (2003).

167. 28 C.F.R. § 35.130(b)(7) (2003) (“A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would *fundamentally alter* the nature of the service, program, or activity.”) (emphasis added).

168. 527 U.S. 581, 604 (1999).

169. *See id.* at 605-06.

170. *Lav*, *supra* note 159, at 211.

171. 42 U.S.C. § 12102(2) (2003) (“The term ‘disability’ means, with respect to an individual – (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual . . .”).

need for "reasonable modifications" to be eligible for programs.¹⁷² "Reasonable modifications" are then required in order to remedy the discrimination faced by the disabled.¹⁷³ This language acknowledges the barriers created by society and requires that these barriers be removed in order for persons with disabilities to become equal participants in society.¹⁷⁴

Congress' findings emphasize its mandate for systemic change by focusing on both the medical and environmental causes of discrimination against persons with disabilities.¹⁷⁵ Specifically, Congress found historical isolation and segregation of individuals with disabilities, discrimination in institutionalization and access to public services, and discrimination due to "overprotective rules and policies."¹⁷⁶ Congress also borrowed language from the famed footnote four of the Supreme Court's opinion in *United States v. Carolene Products*¹⁷⁷ in finding that "individuals with disabilities are a discrete and insular minority . . . subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society."¹⁷⁸ Congress found that this discrimination arose due to characteristics beyond the control of the disabled and from faulty assumptions about the ability of the disabled "to participate in, and contribute to, society."¹⁷⁹ This language acknowledges the socially imposed barriers limiting the full participation of persons with disabilities in society. Additionally, it indicates Congress' intention to create a "protected class" status for persons with disabilities by challenging the Supreme Court's decision in *City of Cleburne v. Cleburne Living Center*.¹⁸⁰ In *City of Cleburne*, the Court held that persons with mental disabilities are not a protected class, but indicated that laws discriminating against persons with mental disabilities deserved something more than rational basis review and found the law at issue discriminatory.¹⁸¹ In establishing persons with a

172. Lav, *supra* note 159, at 210; see *supra* note 162 and accompanying text for the definition of a qualified individual with a disability.

173. 28 C.F.R. 35.130(b)(7) (2003); see also *supra* note 167 and accompanying text.

174. HOUSE COMM. ON THE JUDICIARY, AMERICANS WITH DISABILITIES ACT OF 1990, H.R. REP. NO. 101-485 (III), at 49-50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, at 473.

175. Lav, *supra* note 159, at 211-12.

176. 42 U.S.C. § 12101(a).

177. 304 U.S. 144, 152-53 n.4 (1938).

178. 42 U.S.C. § 12101(a) (2003).

179. *Id.*

180. 473 U.S. 432 (1985); L.R.A., *supra* note 58, at 1028-29.

181. *City of Cleburne*, 473 U.S. at 432.

disability as a protected class, states are thus required to show a compelling governmental interest before discriminatory policies may be upheld in court.¹⁸²

C. Disability Jurisprudence in Law Enforcement Since the ADA

Courts have been hesitant to acknowledge Congress' intentions for systemic change and the elimination of barriers in the area of law enforcement. Courts have generally found that the ADA applied to arrest, post-arrest, and pretrial situations.¹⁸³ They have, however, generally limited violations to situations of clear discrimination, rather than, for example, arrests for criminal offenses that were manifestations of the mental illness. Courts' decisions in arrest, post-arrest, and pretrial cases can be divided into three categories: (1) wrongful arrest cases, in which the person is arrested due to a disability;¹⁸⁴ (2) "exigent circumstance" cases, in which the court finds that the person with the mental disability denied herself the benefits of police protection through her own criminal acts;¹⁸⁵ and (3) post-arrest and pretrial cases, involving police treatment of the disabled during transport to the police station and interrogation.¹⁸⁶

1. Wrongful Arrest Cases

In wrongful arrest cases, the courts have found the ADA

182. L.R.A., *supra* note 58, at 1029-30.

183. See *City of Cleburne*, 473 U.S. at 446. At least two cases do not fall into this general framework; their logic, however, has either been rejected by the Supreme Court or not followed by the other courts. See *Patrice v. Murphy*, 43 F. Supp. 2d 1156 (W.D. Wash. 1999). A deaf plaintiff alleged that the police had discriminated against her because the officer failed to make a reasonable accommodation of her disability by not providing her with an interpreter in order to allow her to benefit from police services. *Id.* Although the court acknowledged the application of the ADA to a wrongful arrest situation, it held that an arrest was not an activity or service from which a plaintiff could be excluded from or denied the benefits of due to their stressful and sometimes dangerous circumstances. *Id.* at 1160. While the outcome is similar to that of the reasonable accommodation cases, its logic is anomalous. See also *Rosen v. Montgomery County*, 121 F.3d 154 (4th Cir. 1997). In *Rosen dicta*, the court said that the ADA does not apply to arrest situations because it is not a program or activity of the County because it is not voluntary. *Id.* at 157. The argument relied on the district court decision in *Gorman v. Bartch*, 925 F. Supp. 653, 655 (W.D. Mo. 1996), which was reversed by the Eighth Circuit. 152 F.3d 907 (8th Cir. 1998). In *Yeskey*, the Supreme Court rejected the argument that to be eligible for the activity or service, an arrest must be voluntary. 524 U.S. 206, 211 (1998).

184. See *infra* Part II.C.1.

185. See *infra* Part II.C.2.

186. See *infra* Part II.C.3.

applicable when subjects were arrested due to manifestations of their disabilities that were not, in themselves, crimes. In *Lewis v. Truitt*,¹⁸⁷ the court found that there was potential discrimination under the ADA where the deaf defendant alleged that the police arrested him because he could not understand what they were saying and did not properly respond to their requests.¹⁸⁸ In *Jackson v. Sanford*,¹⁸⁹ the district court held that the ADA applied to a case involving a defendant who, as a result of a stroke, had physical difficulties that were confused with intoxication and resulted in an arrest for driving under the influence.¹⁹⁰

Congress specifically discussed the type of discrimination occurring in the wrongful arrest cases as the type of discrimination against which the ADA was meant to protect.¹⁹¹ In particular, the House Judiciary Committee stated that people with epilepsy and other disabilities "are frequently inappropriately arrested and jailed because police officers have not received proper training in the recognition of and aid of seizures."¹⁹² The Judiciary Committee felt that this kind of discriminatory treatment of persons with disabilities could be avoided with proper training.¹⁹³

2. Exigent Circumstances Cases

Other courts agree that, although the ADA applies to wrongful arrest situations, it does not apply when the petitioner's actions create an exigent circumstance that prevents her from receiving the benefit of police protection or medical treatment.¹⁹⁴ For example, in *Hainze v. Richards*,¹⁹⁵ the police responded to a call of a family member asking them to transport the petitioner, who had a mental illness and was under the influence of alcohol and antidepressants, to the hospital for mental health treatment.¹⁹⁶ The police had been notified that the petitioner had

187. 960 F. Supp. 175 (S.D. Ind. 1997).

188. *Id.* at 178-79.

189. 3 Am. Disabilities Cas. (BNA) 1366 (D. Me. 1994).

190. *Id.* at 1371.

191. House Comm. on the Judiciary, Americans With Disabilities Act of 1990, H.R. Rep. No. 485 (III), at 50 (1990), reprinted in 1990 U.S.C.C.A.N. 473.

192. *Id.*

193. *Id.*

194. See, e.g., *Hainze v. Richards*, 207 F.3d 795 (5th Cir. 2000); *Thompson v. Williamson County*, 219 F.3d 555 (6th Cir. 2000); *Gohier v. Enright*, 186 F.3d 1216 (10th Cir. 1999); *McKlemurry v. Hendrix*, 971 F. Supp. 1089 (S.D. Miss. 1997).

195. 207 F.3d 795 (5th Cir. 2000).

196. *Id.* at 797.

been threatening to commit “suicide by cop.”¹⁹⁷ On arrival, the police pointed their guns at him.¹⁹⁸ The petitioner began walking toward them with a knife and when he did not stop after a police order, the officer shot him.¹⁹⁹ The petitioner survived and was convicted of aggravated assault.²⁰⁰ The Fifth Circuit held that the officers did not deny the petitioner the benefits and protections of the county’s mental health training, but rather his own illegal actions denied him that benefit.²⁰¹ The court also held that “Title II does not apply to an officer’s on the street responses to reported disturbances . . . prior to the officer’s securing the scene and ensuring that there is no threat to human life.”²⁰² However, the court also explained that once public safety was no longer an issue, the “deputies would have been under a duty to reasonably accommodate [the petitioner’s] disability in handling and transporting him to a mental health facility.”²⁰³

In *Thompson v. Williamson County*,²⁰⁴ the petitioner’s brother called 911 because the petitioner had a mental illness and threatened their father with a machete.²⁰⁵ After responding the first time and failing to find the petitioner, the officers responded again after the petitioner’s brother called for help and his mother agreed to sign an arrest warrant.²⁰⁶ When the officer arrived, the petitioner moved toward the officer with two machetes.²⁰⁷ The officer ordered him to drop them, which the petitioner did not do, so the officer shot and killed him.²⁰⁸ The court held that “if the decedent was denied access to medical services, it was because of his violent, threatening behavior, not because he was mentally disabled” and, therefore, there was no ADA claim.²⁰⁹

In *Gohier v. Enright*,²¹⁰ the Tenth Circuit held somewhat differently than the other exigent circumstances cases. It found the officer’s actions were warranted in self-defense, but

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.* at 801.

202. *Id.*

203. *Id.* at 802

204. 219 F.3d 555 (6th Cir. 2000).

205. *Id.* at 556.

206. *Id.*

207. *Id.*

208. *Id.*

209. *Id.* at 558.

210. 186 F.3d 1216 (10th Cir. 1999).

acknowledged the possibility of a claim based on the need for officers to "reasonably accommodate" the offender's mental illness.²¹¹ In *Gohier*, the officer stopped the decedent, who was walking down the street, in response to reports of a man hitting vehicles with a baseball bat and pipe, even though decedent did not fit the description.²¹² The officer identified himself and asked the decedent to talk to him.²¹³ The decedent started walking toward the officer with his hand behind his back and a "crazed" look on his face.²¹⁴ The officer shouted for him to show his hands, and when he did, the officer thought he had a knife in his hands.²¹⁵ The officer decided the decedent had a mental illness and retreated behind his car.²¹⁶ However, the decedent kept moving toward him and acted as if he were going to steal the police car.²¹⁷ When the officer moved to stop him, he thought the decedent was about to stab him, and he shot and killed decedent.²¹⁸ The Tenth Circuit held that arrests are not excluded from the scope of Title II and found that the decedent's unlawful conduct was the *result* of his disability.²¹⁹ Nonetheless, the court held that the decedent's threatening behavior warranted the police response of self-defense.²²⁰ The court clarified, however, that there may have been a valid claim that Colorado Springs should "better train its police officers to recognize reported disturbances that are likely to involve persons with mental disabilities, and to investigate and arrest such persons in a manner reasonably accommodating their disability."²²¹

3. Post-Arrest and Pretrial Cases

Courts have also found that services following arrest and during pretrial detention and investigation are subject to the requirements of the ADA. For example, in *Gorman v. Barch*,²²²

211. *Id.*

212. *Id.* at 1217.

213. *Id.* at 1218.

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. *Id.*

219. *Id.* at 1221.

220. *Id.* at 1222.

221. *Id.*

222. 152 F.3d 907, 907 (8th Cir. 1998). Gorman was a paraplegic who was arrested and transported to the police station in a van with no special equipment to secure the wheelchair. *Id.* at 909-10. Furthermore, he claimed that he was denied the opportunity to empty his urine bag before leaving. *Id.* at 909. In order to

the Eighth Circuit applied the reasoning of *Yeskey* to hold that transporting an arrestee to a police station is a service subject to the protections of the ADA.²²³ In its analysis, the Eighth Circuit found that a local police department falls within the statutory definition of "public entity" and that to be a qualified individual, participation need not be voluntary.²²⁴

The U.S. District Court for New Jersey similarly held in *Calloway v. Glassboro Department of Police*²²⁵ that the reasoning of *Yeskey* applied to station-house investigative questioning.²²⁶ The court found that station-house investigative questioning qualifies as an activity under the ADA and, therefore, a qualified person with a disability cannot be excluded from participation in or denied the benefits of the activity in an "appropriate manner."²²⁷ In *Calloway*, this holding meant that a deaf individual may need the assistance of a qualified interpreter "to provide information to the police concerning the commission of crimes, whether in a witness or a suspect capacity."²²⁸

One court also recognized exigent circumstances precluding the application of the ADA in pretrial detention situations. In *McKlemurry v. Hendrix*,²²⁹ the petitioner had a long history of mental illness and was arrested for possession of alcohol, a violation of his probation.²³⁰ Although his family sought to have him civilly committed, the court found that it could not do so as long as criminal charges were outstanding.²³¹ The court held that although the petitioner's mental disability may have contributed to his probation violation, because the denial of a mental evaluation and civil commitment was based upon a valid criminal charge and not on the basis of the disability, there was no viable ADA claim.²³²

All of these courts, therefore, have established that when an officer is attempting to arrest, or is arresting, investigating,

transport him, the police tied his upper body to the wire mesh behind the bench. *Id.* at 910. On the drive to the station, the tie broke causing Gorman to fall to the floor injuring his back and shoulders as well as causing his urine bag to break, soaking him with urine. *Id.* The unsecured wheelchair also sustained damage. *Id.*

223. *Id.* at 912.

224. *Id.*

225. 89 F. Supp. 2d 543 (D. N.J. 2000).

226. *Id.* at 555.

227. *Id.* at 555-56.

228. *Id.* at 556.

229. 971 F. Supp. 1089 (S.D. Miss. 1997).

230. *Id.* at 1090.

231. *Id.* at 1092.

232. *Id.* at 1096.

transporting or detaining a person, both the activity and the person with a mental illness who is the focus of the police activity are subject to the protections of the ADA. These holdings could logically be extended to cover cases of mercy arrests and other arrests where no actual crime was committed, but where the person with the mental disability was arrested solely because of her disability. The courts have generally found, however, that in arrest and pretrial situations, when there are exigent circumstances caused by the person with the mental disability, it is those circumstances that prevent the person from receiving police protection or medical treatment, not discrimination by the officer. Where an exigent circumstance is found, the courts have held that there is no ADA violation.

D. Olmstead v. L.C.: Unjustified Institutionalization and Segregation Are Discriminatory

Contrary to the exigent circumstances cases, the Supreme Court in *Olmstead v. L.C.*²³³ held that discrimination does not only arise when one is overtly discriminated against because of one's disability. Instead, the plurality held that "unjustified institutional isolation" and "unjustified segregation" of persons with disabilities are also forms of discrimination based on disability and are prohibited by the ADA.²³⁴ In reaching this holding, the Court relied on language in the Attorney General's regulations implementing the provisions of Title II that services, programs, and activities must be administered in the "most integrated setting appropriate to the needs of qualified individuals with disabilities."²³⁵

In *Olmstead*, the Court applied Title II to two patients in a mental health institution who were approved for a community-based program, but who remained confined to a psychiatric unit because of inadequate funding.²³⁶ The state argued that the respondents were not denied community placement because of their disabilities, but rather because the facilities necessary for their transfer were unavailable, and the denial was not, therefore, discriminatory.²³⁷ This is similar to the holdings of the exigent circumstances cases, but here the state was arguing that the exigent circumstance was insufficient community treatment

233. 527 U.S. 581 (1999) (plurality).

234. *Id.* at 598, 600.

235. *Id.* at 592 (citing 28 C.F.R. § 35.130(d) (1998)).

236. *Id.* at 593.

237. *Id.* at 598.

facilities, whereas in the exigent circumstance cases, the exigency was the alleged criminal act of the defendant.²³⁸ Unlike the exigent circumstances cases, however, the majority held that when an individual has a mental illness and is not provided with community-based treatment deemed appropriate by the state's own professionals, such lack of treatment is unjustified segregation and therefore discriminatory and a violation of the ADA.²³⁹

The Court in *Olmstead* gave two reasons why unjustified institutionalization and segregation are discriminatory.²⁴⁰ The first is that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."²⁴¹ The second is that "confinement in an institution severely diminishes the everyday life activities of individuals . . ."²⁴² As a result, the Court found that discrimination existed because "[i]n order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice."²⁴³

III. Using the ADA to Reduce the Criminalization of Persons with a Mental Illness from the Arrest and Pretrial Processes

Courts have clearly supported the application of the ADA in cases of wrongful arrests, in the provision of police services following arrests, and in pretrial detention.²⁴⁴ In cases where crimes have been alleged, however, courts have been unwilling to find ADA violations, even when it was clear that the act was a manifestation of the mental illness.²⁴⁵ The courts make this distinction by focusing only on the behavior of the individual at the time of the arrest and the police response to that behavior.²⁴⁶ This

238. See *supra* Part II.C.2.

239. *Olmstead*, 527 U.S. at 598-603.

240. *Id.* at 600.

241. *Id.*

242. *Id.* at 601.

243. *Id.* at 600-01.

244. See *supra* Parts II.C.1, 3.

245. See *supra* Part II.C.2.

246. *Id.*; see, e.g., *Hainze v. Richards*, 207 F.3d 795, 797 (5th Cir. 2000) (finding

logic, however, ignores the fact that the criminal behavior is caused by the mental illness and may have been preventable had there been appropriate systems available.²⁴⁷ An alternative approach that conforms to the Supreme Court's decision in *Olmstead* is that discussed by the Tenth Circuit in *Gohier v. Enright*.²⁴⁸ *Gohier* raised the possibility that the ADA violation may occur earlier than the act itself—for example, the violation may be in not providing reasonable accommodations for the mental illness, such as failing to provide sufficient training for the police or adequate mental health care.²⁴⁹

A. Proper Analysis of Exigent Circumstances Cases Under *Olmstead*

The exigent circumstances cases in the lower courts have been decided incorrectly. California's former first lady, Sharon Davis, compared the treating of persons with a mental illness in jail after they committed an offense to treating the sick only when they go to an emergency room.²⁵⁰ To argue that the unjustified institutionalization analysis is different because a crime was committed and because the institution is a jail misses the point. Persons with a mental illness who are arrested due to manifestations of their illness and put in jail may be "relinquish[ing] participation in community life [that] they could

an exigent circumstance when the person with the mental illness walked toward the officer with a knife and did not stop when ordered); *Thompson v. Williamson County*, 219 F.3d 555, 556 (6th Cir. 2000) (finding an exigent circumstance when the person with the mental illness came at the officer with a machete); *Gohier v. Enright*, 186 F.3d 1216, 1218 (10th Cir. 1999) (finding an exigent circumstance when the defendant acted as if he were going to stab the officer); *McKlemurly v. Hendrix*, 971 F. Supp. 1089, 1096 (S.D. Miss. 1997) (finding an exigent circumstance was the possession of alcohol, a probation violation).

247. Only one court has acknowledged that the unlawful act was a result of the person's disability in terms of the ADA. See *Gohier*, 186 F.3d at 1221.

248. *Id.*

249. *Id.* There may be situations where the available resources do not help a violent offender with a mental illness and the police may have no other recourse but to defend themselves. That said, there should be more systems in place to ensure that the individual with a mental illness does not arrive at the situation where she or he becomes violent in the first place. Moreover, there should be training to ensure that the actions of police are not aggravating an already difficult situation. The court, when determining if an ADA violation has taken place, should be examining what was in place to prevent these situations from occurring. There is already evidence that this kind of community treatment and police training can alleviate difficult situations. See *infra* notes 272, 278 and accompanying text.

250. Marquis, *supra* note 39, at B8.

[have] enjoy[ed] given reasonable accommodations”²⁵¹ For example, it has been shown that having appropriate community services available to persons with a mental illness will result in their committing fewer crimes.²⁵² This result may stem from reduced drug and alcohol dependency, reduced homelessness, and better mental health treatment.²⁵³ These “reasonable modifications” could thus significantly diminish the criminalization of persons with a mental illness.²⁵⁴

Without these kinds of services, however, many, if not most of these people are being jailed for preventable manifestations of their mental illness rather than criminal intent.²⁵⁵ There is no difference between this kind of institutionalization and segregation and the kind that was unjustifiable in *Olmstead*; the harms in both cases are due in large part to a failure to provide “reasonable accommodations.”²⁵⁶ Because the institutionalization and segregation derive from manifestations of the individual’s mental illness, they are unjustified and discriminatory and, therefore, a violation of the ADA.²⁵⁷

Moreover, based on Congress’ expressed intent to create systemic change and to provide protected class status for persons with disabilities, making improvements to mental health care and police training, and creating diversion programs should be viewed as removing barriers that prevent the full participation of persons with a mental illness in society.²⁵⁸ Congress itself spoke about the need to provide training to public employees, particularly officers, about disability to prevent inappropriate arrests based on acts resulting from the disability.²⁵⁹ Without these “reasonable modifications,”²⁶⁰ persons with a mental illness continue to be

251. *Olmstead*, 527 U.S. at 601; see *supra* note 243 and accompanying text.

252. See PERLIN, *supra* note 27, at 73 (“[T]here is an ample body of evidence indicating that a well-conceived deinstitutionalization program with a variety of rehabilitative services offered intensively has a positive and significant effect on the length of the ex-patients’ ‘tenure’ in the community.”); Lamb & Weinberger, *supra* note 25, at 489 (“[I]t has been found that court-mandated and -monitored treatment in lieu of jail was effective in obtaining a good outcome for chronically and severely mentally ill persons who committed misdemeanors.”); see also *infra* Part III.B.

253. See *supra* note 252 and accompanying text; *supra* Part I.B.1-2, *infra* Part III.B.

254. See *supra* note 167 and accompanying text; *infra* Part III.B.

255. See *supra* Part I.

256. See *supra* note 243 and accompanying text; *supra* Part I.

257. See *supra* Parts I, II.D.

258. See *supra* Part II.B.

259. See *supra* notes 191-193 and accompanying text.

260. See *supra* note 167 and accompanying text.

unjustifiably segregated and institutionalized and therefore discriminated against in violation of the ADA.²⁶¹

The National Institute of Justice (NIJ), funded by the U.S. Department of Justice, has recognized Congress' mandate and the resulting responsibility of law enforcement "to distinguish criminal behavior from conduct that is the product of mental illness but has no criminal intent."²⁶² The NIJ has stated that a "failure to work with mental health authorities to ensure the appropriate response to 'nuisance' offenders," by making the distinction between criminal conduct resulting from a mental illness and criminal conduct resulting from criminal intent, may violate the ADA.²⁶³ This is just one example of reasonable modifications that must take place in order to eliminate the criminalization of persons with a mental illness and to satisfy the mandate of the ADA.

The proper test then, after looking at the ADA and *Olmstead* should be, first, to examine if the mental health treatment alternatives and law enforcement activities are structured in such a way that persons with a mental illness are discriminated against based upon a manifestation of their disability.²⁶⁴ If such discrimination exists, then the courts should look to see if the structure is inherently required, or if it stems from a failure to make reasonable modifications in these areas that would prevent the discrimination from occurring.²⁶⁵ If a court finds that there has been a failure to make reasonable modifications to the existing structures, then the courts should find that there has been a violation of the ADA.²⁶⁶

B. Reasonable Modifications to Reduce the Criminalization of Persons with Mental Illness

In order to remedy the criminalization of persons with a mental illness, the ADA requires that public entities make reasonable modifications unless the public entity can demonstrate that making the modification would result in a "fundamental alteration."²⁶⁷ Advocates have proposed a variety of reasonable

261. See *supra* Part II.D.

262. PAULA N. RUBIN & SUSAN W. MCCAMPBELL, NATIONAL INSTITUTE OF JUSTICE, THE AMERICANS WITH DISABILITIES ACT AND CRIMINAL JUSTICE: MENTAL DISABILITIES AND CORRECTIONAL FACILITIES 2 (1995), available at <http://www.ncjrs.org/txtfiles/amdisact.txt> (last visited Oct. 8, 2004).

263. *Id.*

264. See *Lav, supra* note 159, at 227.

265. See *id.*

266. See *id.*

267. See *supra* notes 167-169 and accompanying text.

modifications. One recommendation is to improve access to community mental health services, including the provision of outreach teams, supportive housing, case management programs, and other programs.²⁶⁸ Supportive housing, for example, addresses many of the factors that have led to the criminalization of persons with a mental illness by providing a place to live with on-site mental health services including case management, psychiatry, medication management, and counseling, which is much less expensive than incarceration.²⁶⁹ These kinds of services have been shown to reduce arrests of persons with a mental illness.²⁷⁰

Other recommendations involve the combined efforts of both the mental health and the criminal justice systems, such as the development of crisis response teams and jail diversion programs.²⁷¹ Some communities have already established mobile crisis teams to respond to calls concerning persons with a mental illness.²⁷² Studies of these programs have shown arrest rates ranging 2-13% (with an average of 7%) contrasting with a 21% arrest rate for non-specialized officers in contact with persons who had an apparent mental illness.²⁷³

Still other recommendations involve the criminal justice system alone. One such recommendation is to repeal the laws that permit jails to be used for emergency detention of persons with mental illness not charged with a crime.²⁷⁴ Other

268. See BARR, *supra* note 11, at v; NAMI REPORT, *supra* note 41, at 97-102; Lamb & Weinberger, *supra* note 25, at 489-90.

269. BARR, *supra* note 11, at 11. Supportive housing for an individual in New York City costs about \$33 per day compared to a cost of jail incarceration at \$175 per day or prison incarceration at \$88 per day. *Id.* at 8-11.

270. See Clark et al., *supra* note 65, at 647.

271. See BARR, *supra* note 11, at v; NAMI REPORT, *supra* note 41, at 97-102; Lamb & Weinberger, *supra* note 25, at 489-90.

272. See Lamb & Weinberger, *supra* note 25, at 489-90. Different strategies have been developed around the country to provide mobile teams of police, mental health professionals, or both to respond to crises involving persons with a mental illness. *Id.* Some communities achieve this by providing special mental health training to sworn police officers who act as liaisons with the mental health system. *Id.* This model also emphasizes psychiatric emergency services with a no-refusal policy for persons brought to them by police. *Id.* These officers can act both on-site during emergency situations and as consultants to other officers at the scene. *Id.* Another method is for police departments to hire mental health consultants who provide on-site and telephone consultations to officers in the field. *Id.* Similarly, some jurisdictions have arrangements with the local community mental health service system to respond to special needs incidents. *Id.* Finally, some jurisdictions deploy teams of officers and mental health professions to resolve emergency situations. *Id.*

273. See Lamb et al., *supra* note 80, at 1268.

274. NAMI REPORT, *supra* note 41, at 97.

recommendations focus on the provision of mental health services during the detention of a person with a mental illness.²⁷⁵ These include ensuring that a mental health professional evaluates an arrested person with a mental illness within twenty-four hours of admission to a jail, and providing ongoing psychiatric services, including medications, on a timely basis for persons incarcerated within a jail.²⁷⁶ Another recommendation is to provide sufficient training on serious mental illnesses to police officers and corrections officers when they are hired and through continuing education.²⁷⁷ An additional recommendation is to develop alternatives to incarceration programs for people with a mental illness.²⁷⁸

States would probably argue that these recommendations would create a fundamental alteration of services.²⁷⁹ However, the fundamental alteration occurred following the deinstitutionalization of persons with a mental illness. Not only were these persons released to communities that did not have a mental health system ready to accommodate them, but also the police were forced to deal with an increasing number of mental illness-related incidents without having proper training.²⁸⁰ A better community mental health treatment system should already exist. Furthermore, policies and training should be in place to ensure that law enforcement is as concerned with protecting persons with a mental illness, even from themselves, as it is with those who do not have a mental illness.

Nonetheless, states would likely argue that they do not have the resources to make the "reasonable modifications" necessary to eliminate the criminalization of persons with a mental illness.²⁸¹ Congress noted, however, "[w]hile the integration of people with disabilities will sometimes involve substantial short-term burdens, both financial and administrative, the long-range effects of integration will benefit society as a whole."²⁸² In addition, based on initial studies, making the suggested recommendations would

275. *Id.* at 97-100.

276. *Id.* at 98.

277. *Id.* at 100.

278. See BARR, *supra* note 11, at v; NAMI REPORT, *supra* note 41, at 97-102; Lamb & Weinberger, *supra* note 25, at 489-90.

279. See *supra* notes 167-169 and accompanying text.

280. See *supra* Part I.

281. See *supra* notes 167-169 and accompanying text.

282. HOUSE COMM. ON THE JUDICIARY, AMERICANS WITH DISABILITIES ACT OF 1990, H.R. REP. NO. 101-485 (III), at 50 (1990), *reprinted in* 1990 U.S.C.A.N. 445, 473.

ultimately reduce costs rather than increase them, as the revolving door between mental health institutions and jails is costly, both to persons with a serious mental illness and to society.²⁸³ For example, a study in New Hampshire of individuals with a serious mental illness showed that providing stable, supervised housing and effective treatment of co-occurring substance abuse reduced legal costs, arrests, and incarcerations.²⁸⁴

In New York City in 1999, to incarcerate an individual in jail cost approximately \$175 per day and in prison it cost approximately \$88 per day.²⁸⁵ However, in considering the potential cost savings of diversion, one must look not only at the costs of incarceration, but the costs of physical and mental health care provided while the person with a mental illness is incarcerated.²⁸⁶ For example, New York City spent over \$115 million per year for physical and mental health services for jail inmates.²⁸⁷ In comparison to the cost of incarceration, supportive housing, which includes mental health services, cost New York City only \$33 per day—a significant savings over incarceration.²⁸⁸

Other costs and savings must be examined as well. Diversion out of the criminal justice system at an early stage saves both the cost of incarceration and many of the processing costs.²⁸⁹ Halting the revolving door would create a huge potential for reducing the direct costs of crime, such as costs from injury to victims and property damage.²⁹⁰ Beyond the direct savings, there are many more societal benefits: reduced jail overcrowding, resulting in space for serious criminals; reduced police time responding to calls involving someone with a mental illness, allowing the police to focus more appropriately on their job of law enforcement; reduced crime due to fewer untreated persons with a serious mental illness; and, most importantly, increased numbers of productive

283. See BARR, *supra* note 11, at 8, 10; NAMI REPORT, *supra* note 41, at 44.

284. Clark et al., *supra* note 65, at 647.

285. BARR, *supra* note 11, at 8-9.

286. *Id.* at 9.

287. *Id.*

288. *Id.* at 11.

289. *Id.* at 10-11. The processing costs include the costs for:

the police who arrest and process the person; the court pens where the person is held; the defense attorney . . . ; the Assistant District Attorney . . . ; the judges . . . their staff and court officers; the rent, maintenance and overhead of the courthouse; the jail where the person is detained; transportation to and from the jail, et cetera.

Id. at 9.

290. BARR, *supra* note 11, at 10.

members of society.²⁹¹

Conclusion

Chuck, with his history of drug abuse, James, as a homeless person, and Risdon, in his failure to take his medications, all faced problems similar to many other persons with mental disabilities in their dealings with the criminal justice system.²⁹² The criminalization of persons with a mental illness has been increasing since deinstitutionalization in the 1960s and 1970s.²⁹³ The primary reason for this is a lack of community treatment alternatives to address their mental health care needs as well as other problems faced by persons with a mental illness, such as drug and alcohol abuse and homelessness.²⁹⁴ Contributing to these problems is the fact that persons with a mental illness are often arrested either for no crime at all, or for manifestations of their mental illnesses.²⁹⁵ The police, on the other hand, face a variety of barriers to providing an effective response, including a lack of training and public misconceptions of mental illness.²⁹⁶

The ADA is one means to eliminate some of the systemic barriers to ending the criminalization of persons with a mental illness.²⁹⁷ In passing the ADA, Congress expressed a desire to eliminate the barriers faced by persons with a disability that prevent their full participation in society.²⁹⁸ Unfortunately, while courts have found the ADA applicable to cases involving wrongful arrests made clearly because of the disability, they have applied an exigent circumstances exception when an alleged criminal offense was committed, even when it was a manifestation of the

291. NAMI REPORT, *supra* note 41, at 56-57; *see also* Clark, *supra* note 65, at 647 (discussing the reduced costs and societal benefits of diverting treatment of the mentally ill away from the criminal system); PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, *supra* note 61, at 4. Dorothy P. Rice and L. Stephen Miller estimate that the annual indirect cost of mental illness to the United States is \$79 billion. PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, *supra* note 61, at 3 (citing Dorothy P. Rice & L. Stephen Miller, *The Economic Burden of Schizophrenia: Conceptual and Methodological Issues and Cost Estimates*, in SCHIZOPHRENIA 321-34 (M. Moscarelli et al. eds., 1996)). They further estimate that almost \$4 billion is lost annually in productivity for individuals who are incarcerated and who must provide family care. *Id.*

292. *See supra* Introduction.

293. *See supra* Part I.A.

294. *See supra* Part I.B.1, 2.

295. *See supra* Part I.B.3.

296. *See supra* Part I.B.4, 5.

297. *See supra* Part II.A, B.

298. *See supra* Part II.B.

mental disability.²⁹⁹ This analysis ignores both Congress' desire for systemic change and the Supreme Court's holding in *Olmstead*, where the plurality held that continued detention due to the failure to provide appropriate treatment alternatives resulted in unjustified segregation and institutionalization.³⁰⁰

A lack of community-based treatment alternatives and law enforcement's inability to appropriately respond to persons with a mental illness through appropriate policies and programs result in the unjustified institutionalization of persons with a mental illness in jails and prisons, and too often result in their deaths.³⁰¹ The current failure in both of these areas has resulted in the criminalization of persons with a mental illness and is, therefore, discriminatory, and a violation of the ADA.³⁰² This violation calls for reasonable modifications to be made to remedy the discrimination and to remove the barriers to equality that are faced by people such as Chuck, James, and Risdon.³⁰³

299. *See supra* Part II.C.

300. *See supra* Part III.A.

301. *See supra* Part III.A.

302. *See supra* Part III.A.

303. *See supra* Part III.B.

