Caging the Incompetent: Why Jail-Based Competency Restoration Programs Violate the Americans with Disabilities Act under *Olmstead v. L.C.*

Alexandra Douglas*

Introduction

> *"[I]mprisonment is the punitive solution to a whole range of social problems that are not being addressed by those social institutions that might help people lead better, more satisfying lives . . . [T]he prison becomes a way of disappearing people in the false hope of disappearing the underlying social problems they represent."*
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> —Angela Davis[1]

> *"[I]f any one of us were challenged to devise an environment that was uniquely* ill suited *to address the needs of psychologically vulnerable persons . . . we would be hard pressed to come up with anything worse than the modern American prison."*
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> —Craig Haney[2]

As she was leaving a Sunday school lesson at the East Cambridge House of Corrections on a frigid morning in 1841, Dorothea Lynde Dix kindly requested a tour of the facility.[3] At the time, it was commonplace for individuals with mental illness to be warehoused in county jails, and the East Cambridge House of Corrections was widely regarded as "a community repository for the indigent insane."[4] A jail official escorted Dix to an underground cavern, where mentally ill women were cramped in filthy cells without heat.[5] The official attempted to

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1. Angela Y. Davis, Abolition Democracy: Beyond Empire, Prisons, and Torture 40–41 (2005).

2. Craig Haney, *"Madness" and Penal Confinement: Some Observations on Mental Illness and Prison Pain*, 19 Punishment & Soc'y 3, 311 (2017).

3. *See* David Gollaher, Voice for the Mad: The life of Dorothea Dix 127 (1995); Andrew G. Wood, *Dix, Dorothea Lynde*, Am. Nat'l Biography (Feb. 2000), http://www.anb.org/view/10.1093/anb/9780198606697.001.0001/anb-9780198606697-e-1500181 [https://perma.cc/R6XE-WFQU].

4. Gollaher, *supra* note 3, at 127; *see also* Alisa Roth, Insane: America's Criminal Treatment of Mental Illness 81 (2018) (explaining that Massachusetts and other states passed legislation requiring penal institutions to house individuals with mental illness in the nineteenth century).

5. *See* Gollaher, *supra* note 3, at 127; Wood, *supra* note 3.

mollify Dix's indignation at the ghastly sight, explaining that heat was simply unnecessary, for "lunatics could not tell the difference between hot and cold."[6]

Enraged by the official's callousness, Dix launched an eighteen-month tour of jails and poorhouses across Massachusetts to document the plight of the state's mentally ill.[7] After surveying conditions in nearly five hundred towns, Dix summarized her findings and expressed an urgent demand for mental health care reform in *Memorial to the Legislature of Massachusetts*.[8]

"I tell what I have seen," wrote Dix.[9] "I come as the advocate of helpless, forgotten, insane, and idiotic men and women."[10] Addressing the legislature in the first person, Dix commanded attention to "the *present* state of insane persons confined within this Commonwealth, in *cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods*, and *lashed into obedience*."[11] Through a series of bleak vignettes, Dix exposed readers to the dehumanizing conditions she uncovered on her small-town jail tour through hell:

> *Concord*. A woman from the hospital in a cage in the almshouse. In the jail several, decently cared for in general, but not properly placed in a prison. Violent, noisy, unmanageable most of the time. *Lincoln*. A woman in a cage. *Medford*. One idiotic subject chained, and one in a close stall for seventeen years. *Pepperell*. One often doubly chained, hand and foot; another violent; several peaceable now. *Brookfield*. One man caged, comfortable. *Granville*. One often closely confined; now losing the use of his limbs from want of exercise. *Charlemont*. One man caged.[12]

Memorial sparked public uproar and government action.[13] The Massachusetts legislature appropriated funds to build a hospital, marking the first victory in what would become Dix's nation-wide campaign to create a network of state-run mental health hospitals.[14]

The parallels between Dix's era and the present are striking. Just as county jails served as a repository for the mentally ill in the nineteenth century, the number of inmates with mental health conditions in modern jails and prisons has exploded in recent decades.[15] Jails were, and continue to be, "institutions of last resort" for

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6. GOLLAHER, *supra* note 3, at 127.
7. *See* GOLLAHER, *supra* note 3, at 127; Wood, *supra* note 3.
8. *See* Wood, *supra* note 3.
9. Dorothea Lynde Dix, *Memorial to the Legislature of Massachusetts* (1843), *available at* https://www.disabilitymuseum.org/dhm/lib/detail.html?id=737&page=all [https://perma.cc/39MJ-TBJH].
10. *Id.*
11. *Id.*
12. *Id.*
13. *See* GOLLAHER, *supra* note 3, at 3; Wood, *supra* note 3.
14. *See* GOLLAHER, *supra* note 3, at 3; Wood, *supra* note 3.
15. *See* discussion *infra* Part I.

indigent individuals with pressing mental health care needs.[16] Well-intentioned reformers like Dix advocated for the creation of mental institutions—envisioned as a more humane setting than jail, but institutional confinement nonetheless.[17] Similarly, in response to the swelling population of inmates with mental illness, many modern advocates call for improving mental health resources *within* correctional facilities and for re-constructing psychiatric 'asylums.'[18] In both eras, the notion that (predominately poor) persons with mental illness deserve to live fully integrated lives in their communities is incompatible with the general public's prejudice toward mental illness.[19] And then, as now, state and national governments failed to fund robust social services to make community living viable for all.[20]

Nowhere is the evidence of history repeating itself more glaring than the plight of individuals adjudged incompetent to stand trial (IST). Thousands of criminal defendants are referred for inpatient competency restoration treatment each year, yet the number of available state hospital beds is steadily declining.[21] IST inmates are routinely placed on lengthy wait-lists, biding their time in jail until a highly sought-after hospital bed opens up.[22] This "logjam" in jail can last for months, if not years.[23]

The worst cases look something like this: police pick up a homeless woman with mental illness for a non-violent misdemeanor, like disturbing the peace. Rather than connecting her with mental health or social services, the officers book her in jail. When she exhibits odd behavior in court, a judge orders a competency evaluation and, when found incompetent to proceed, restoration treatment. Because the state only provides restoration services in the psychiatric hospital, her name is tacked onto the end of a long list and she waits in jail. For months, she endures abysmal conditions of confinement, vulnerable to abuse by fellow inmates and guards, deprived of meaningful mental health care. When she is

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16. *See* GOLLAHER, *supra* note 3, at 3; HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 22 (2003) ("[T]oday the jails and prisons are the facilities of last resort.") (quoting Human Rights Watch interview with Richard Lamb, Los Angeles, California, January 31, 2003).

17. The asylum system that Dix advocated for proved to be scarcely more humane than jails and poorhouses. Even hospitals that began with therapeutic aims gradually devolved into warehouses for the mentally ill due to overcrowding and lack of resources. *See, e.g.*, ROTH, *supra* note 4, at 84–86.

18. *See, e.g.* Liat Ben-Moshe, *"The Institution Yet to Come" : Analyzing Incarceration Through a Disability Lens*, *in* THE DISABILITY STUDIES READER 132, 138 (Lennard J. Davis ed., 4th ed. 2013) [hereinafter Ben-Moshe, *The Institution Yet to Come*]; Dominic A. Sisti, et al., *Improving Long-Term Psychiatric Care: Bring Back the Asylum*, 313 JAMA 243, 244 (advocating for "a return to asylum-based long-term psychiatric care" as one component of psychiatric services reform).

19. *See* Susan McMahon, *Reforming Competence Restoration Statutes: An Outpatient Model* 30 (Mar. 1, 2018), available at https://ssrn.com/abstract=3132700 (describing the "sanist myths" that individuals with mental illness are dangerous and require treatment in hospital settings).

20. *See* discussion *infra* Part I.

21. *See* discussion *infra* Part I.A.

22. *Id.*

23. *Id.*

finally transferred to the state hospital, she has already served a term far exceeding the likely sentence for her petty charge. If she is ultimately restored and transferred back to jail to resume the trial process, her defense attorney can only hope that her mental health does not deteriorate, restarting the cycle anew.

In desperation, many localities are seeking alternatives to traditional inpatient restoration. Jail-based competence restoration (JBCR) is one alternative rising in popularity.[24] In JBCR programs, IST defendants receive restoration services while confined in jail, rather than being transferred to psychiatric facilities for treatment. A coalition of fiscally conscious policymakers, exasperated sheriffs, and pragmatic judges support JBCR programs as a cheap and efficient strategy to reduce the IST logjam. Detaining IST defendants for longer terms in jail under the guise of restoration, however, brings us "full circle" to the early nineteenth century, when Dix laid bare the indefensible segregation of mentally ill persons in jails and poorhouses.[25] State policymakers who are serious about getting to the root of the logjam crisis should instead fund robust community-based competence restoration (CBCR) programs, which have proven to be an inexpensive and effective alternative to inpatient restoration.[26]

This note will argue that in addition to being an archaic response to a modern problem, JBCR programs violate the integration mandate of the Americans with Disabilities Act (ADA), interpreted by the Supreme Court in *Olmstead v. L.C.* Detaining IST individuals in maximally restrictive facilities, when a viable community-based alternative exists, perpetuates the needless institutionalization of individuals with mental illness and robs IST patients of the benefits of treatment in a more integrated setting. Specifically with regards to IST defendants who would succeed in community placement and are detained without consideration of this potentiality, JBCR constitutes disability-based discrimination.

Part I of this note situates the IST logjam at the intersection between deinstitutionalization and mass criminalization. These broad policy trends have overlapped to create a burgeoning population of criminal defendants with mental health care needs, a subset of whom are adjudged incompetent to stand trial. Part II discusses the doctrinal underpinnings of the competence standard and provides an overview of the restoration process. Competence restoration has traditionally been provided in state psychiatric facilities, but many jurisdictions are grasping for less resource-intensive alternatives, including JBCR. This part will explain why JBCR programs appear to be a cheap and efficient strategy for addressing the IST logjam but are inherently flawed. Confined in jail, IST defendants are unlikely to receive adequate mental health services and are vulnerable to

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24. *See* discussion *infra*, Part II.C.

25. *See* DORIS A. FULLER, ET AL., TREATMENT ADVOCACY CENTER, GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS 2016 5 (2016) [hereinafter GOING, GONE].

26. *See* discussion *infra*, Part III.B.2.

unconscionable abuse. Simply put, jails are the worst possible place to be a person with severe mental illness.

JBCR programs are especially problematic because a less restrictive, community alternative exists. Part III suggests that JBCR programs facilitate the needless segregation of IST patients, violating the integration mandate of the ADA, interpreted by the Supreme Court in *Olmstead v. L.C.* This part advocates for CBCR as a more integrated alternative. Finally, Part IV connects the values underlying the ADA's integration mandate with the movement to abolish prisons. In line with the ADA and *Olmstead's* imposition of an affirmative obligation on public entities to provide community services, prison abolition advances the creation of non-carceral alternatives. By casting state development of community services as an ethical imperative, a prison abolition ethic provides further support for expanding CBCR to achieve the vision articulated in the ADA and *Olmstead*.

I. WHAT IS A LOGJAM AND WHY IS IT HAPPENING?

A. THE IST LOGJAM

Adam was thirty-seven when his mental illness spiraled out of control.[27] He was a college graduate, had a successful job in marketing, and lived with supportive parents in Colorado.[28] But when he stopped taking his medication to avoid the troublesome side effects, his symptoms gradually became more severe.[29] Upon returning home one evening to find his house in disarray, Adam's father instinctively called the police, seeking medical assistance for his son.[30] The police promptly arrested Adam and booked him into jail.[31]

So began Adam's entanglement with the criminal justice system. While on probation, Adam was charged with felony assault for spitting on a police officer.[32] Two months later, a judge found Adam incompetent to proceed.[33] His public defender advocated for his transfer out of jail and into the state hospital for restoration treatment, while Adam begged the court to let him plead guilty so he could be released on time-served.[34] Neither prevailed. Eight months later, Adam was still in jail, stuck on a wait-list for admission to the state hospital.[35]

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27. Allison Sherry, *Colorado Increasingly in Contempt as More Judges Recognize that Jail isn't a Mental Health Answer*, COLO. PUB. RADIO (Sept. 11, 2018), http://www.cpr.org/news/story/colorado-increasingly-in-contempt-as-judges-begin-to-agree-that-jail-isn-t-a-mental [https://perma.cc/TEG3-GSUS].

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. Sherry, *supra* note 27.

33. *Id.*

34. *Id.*

35. Michael Roberts, *Why Mentally Ill Colorado Man Has Spent Eight Months in Jail for Spitting*, WESTWORD (Oct. 5, 2018, 6:00 AM), https://www.westword.com/news/disability-law-colorado-suing-reggie-bicha-over-colorado-man-jailed-for-spitting-10866776 [https://perma.cc/XY5X-2GWU].

Adam was just one of three hundred IST individuals in limbo in Colorado jails in September, 2018.[36] Some had been stalled for over one hundred days, waiting to undergo competence restoration treatment in state hospitals.[37] The interminable delays prompted a new round of litigation in an on-going lawsuit originally filed by Disability Law Colorado in 2008.[38] Iris Eytan, who represents IST defendants in the lawsuit against the State, characterizes the current backlog as "the worst it's been in 10 years."[39] The Colorado Department of Human Services has essentially thrown up their hands, attributing the crisis to severe hospital bed shortages and skyrocketing requests for competency evaluations.[40]

In 2003 and 2004, the Colorado legislature reduced funding to state hospitals by eleven million dollars—eliminating 103 hospital beds—and slashed thirty million dollars from the community mental health center budget.[41] At the same time, the hospitals experienced a sharp increase in referrals for competence evaluations, which rose from 433 in 2003 to a whopping 815 by 2006.[42] State hospital staff are "not willfully denying treatment" to IST defendants; they simply do not have sufficient resources to meet increasing forensic mental health demand.[43]

The catastrophe in Colorado is emblematic of the logjam crisis across the United States. In courthouses everywhere, the number of criminal defendants whose competency status is called into question is rising.[44] At the same time, state hospital beds are disappearing.[45] As a result, defendants like Adam are wait-listed for inpatient competence restoration services, then languish in jail while their criminal cases grind to a halt.[46]

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36. *See* Sherry, *supra* note 27.

37. *Id.* According to Disability Law Colorado, the wait-times ranged from 58.6 days to 186 days. *Expert Sought for Colorado Mental Health Oversight*, CBS DENVER (Dec. 10, 2018, 5:01 PM), https://denver.cbslocal.com/2018/12/10/expert-sought-colorado-mental-hospital-oversight/ [https://perma.cc/V9N8-3E76].

38. Under a 2016 settlement agreement, no defendant may be held in jail over twenty-eight days before transfer to a mental health institute for competency evaluation or restoration services. *See* Ctr. for Legal Advocacy v. Bicha, No. 11-CV-02285-NYW, 2018 WL 5892669 5 (D. Colo. Nov. 9, 2018).

39. Jennifer Brown, *Colorado to Spend $20 Million to Relieve Ongoing Backlog of Mental Competency Evaluations; Critics Say Problem Was Foreseeable*, DENVER POST (Dec. 28, 2017, 5:42 PM), https://www.denverpost.com/2017/12/28/colorado-mentally-ill-crimes-competency-evaluations/ [https://perma.cc/799D-SPBD].

40. *See Expert Sought for Colorado Mental Health Oversight*, *supra* note 37.

41. Hall Wortzel, et al., *Crisis in the Treatment of Incompetence to Proceed to Trial: Harbinger of a Systematic Illness*, 35 J. AM. ACAD. PSYCHIATRY L. 357, 358 (2007).

42. *Id.*

43. *Id.*

44. *See, e.g.*, DORIS A. FULLER, ET AL., TREATMENT ADVOCACY CENTER, EMPTYING THE 'NEW ASYLUMS': A BEDS CAPACITY MODEL TO REDUCE MENTAL ILLNESS BEHIND BARS 1 (2017) [hereinafter NEW ASYLUMS]. Incompetency to stand trial is a legal concept and is not synonymous with mental illness. This article focuses on the approximately ninety percent of IST criminal defendants who have severe mental illness. *See* Marisol Orihuela, *The Unconstitutionality of Mandatory Detention During Competency Restoration*, 22 Berkeley J. Crim. L. 1, 6 n.17 (2017).

45. *See infra*, Part I.B.

46. *See* Orihuela, *supra* note 44, at 7 ("[C]ompetency proceedings halt the regular criminal process.").

IST defendants referred for restoration are among the fastest growing population of jail inmates with urgent mental health care needs.[47] Each year, approximately sixty thousand defendants are detained pre-trial for competence evaluations.[48] Roughly twenty percent, or twelve thousand defendants, are found IST and remanded for restoration services.[49] The overwhelming majority of IST defendants are court-ordered to receive inpatient treatment, most commonly in forensic wards at state psychiatric hospitals.[50] In several jurisdictions, inpatient restoration is mandatory for all IST defendants, regardless of individual circumstances.[51] Even in states with more flexible statutes on the books, IST defendants are "overcommitted" to detention pending restoration because the law tends to default to inpatient treatment.[52]

Of the approximately thirty-eight thousand public hospital beds nationwide, half are reserved for forensic patients.[53] Nearly four thousand beds—ten percent of the total—are occupied by IST defendants.[54] In many states, pretrial IST defendants comprise the largest and fastest growing category of patients receiving services in state hospitals.[55] In Texas, the number of IST defendants occupying state hospital beds surpassed the number of civilly committed patients in 2014.[56] Similarly, the Los Angeles mental health court reported a threefold

47. From 2005–2014, nineteen states experienced an increase in the number of IST defendants admitted to state hospitals for restoration. *See* WIK, ET AL., NAT'L ASSOC. OF STATE MENTAL HEALTH PROGRAM DIRECTORS, FORENSIC PATIENTS IN STATE PSYCHIATRIC HOSPITALS: 1999-2016 39 (2017); GOING, GONE, supra note 25, at 21 (explaining that the number of pretrial offenders with mental illness in line for hospital beds is "exploding").

48. *See, e.g.*, W. Neil Gowensmith, et al., *Lookin' for Beds in all the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges*, 22 PSYCHOL. PUB. POL'Y & L. 293, 293 (2016).

49. Some estimates place the number of defendants referred for restoration as high as eighteen thousand. *See id*. at 293.

50. *See* W. LAWRENCE FINCH, FORENSIC MENTAL HEALTH SERVICES IN THE UNITED STATES, NAT'L ASSOC. STATE MENTAL HEALTH PROG. DIRECTORS 11 (2014); Gowensmith, et al., *supra* note 48, at 293 (noting that only a small number of states provide outpatient restoration services to a fraction of IST defendants).

51. In her review of state competence restoration statutes, legal scholar Susan McMahon found that nine states and the federal government mandate inpatient restoration treatment. The federal statute, for example, directs district courts to commit IST defendants to the custody of the Attorney General "for treatment in a suitable facility." *See* McMahon, *supra* note 19, at 21 (citing 18 U.S.C. § 4241 (2012)).

52. Additionally, flexible statutes allow a judge's bias to seep into the decision-making process, increasing the likelihood that a defendant will be needlessly committed to inpatient restoration. *See id*. at 21–24.

53. GOING, GONE, *supra* note 25, at 1–2.

54. *See* Wortzel, et al., *supra* note 41, at 357. Reserving bed space for IST defendants decreases bed space for civil patients, creating "a bed shell game with life-and-death implications" for individuals with mental illness inside and outside of the criminal justice system. GOING, GONE, *supra* note 25, at 9.

55. *See* GOING, GONE, *supra* note 25, at 26; WIK, ET AL., *supra* note 47, at 52 (finding a seventy-two percent increase in the number of IST patients receiving competence restoration services between 1999 and 2014, based on a survey of twenty-six states).

56. Robert Earley, *Texas Must Face Need to Treat the Mentally Ill — and Not in Our Jails*, FORT WORTH STAR-TELEGRAM (Apr. 10, 2017, 5:23 PM), https://www.star-telegram.com/opinion/opn-columns-blogs/other-voices/article143828729.html [https://perma.cc/97RW-YQ9H].

increase in competence evaluation referrals from 2010 to 2015, from 944 to 3,528 defendants.[57]

State hospitals are not growing to meet the increased demand for bed space. In fact, the trend is the exact opposite. A recent survey conducted by the Treatment Advocacy Center found that states eliminated approximately six thousand hospital beds from 2010 to 2016.[58] The pressing forensic demand for a vanishing supply of psychiatric hospital beds is precisely why IST defendants are routinely tacked onto the end of long wait-lists for transfer to treatment facilities.[59] The Treatment Advocacy Center's survey found that seventy-eight percent of state hospital officials maintained a wait-list for forensic beds.[60] Three states reported that defendants wait in jail as long as *six months to a year* before transfer to treatment facilities—a period of detention that may very well exceed the sentence likely to be imposed for the defendant's charge.[61] As detailed below, prolonged time in jail yields "nightmarish results" for IST inmates.[62]

A pattern of protracted delays in transferring IST defendants from jail to restoration treatment has provoked high-profile lawsuits in a number of states.[63] In 2015 the ACLU of Pennsylvania sued the state Department of Human Services (DHS) and two psychiatric hospitals on behalf of inmates waiting in jail for competency evaluation and restoration services.[64] Several plaintiffs had been stuck in jail for well over a year.[65] At the time of filing, one plaintiff had been detained for eleven months.[66] His charge? Stealing three Peppermint Patties.[67] The ACLU

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57. Abby Sewell, *L.A. County Supervisors Order Report on Unexplained Surge in Mental Competency Cases*, L.A. TIMES (Mar. 8, 2016, 12:49 PM), https://www.latimes.com/local/lanow/la-me-ln-mental-competency-cases-20160308-story.html [https://perma.cc/HKR7-JJKS].

58. County, general, and private hospital beds have declined concurrently with state hospital beds. GOING, GONE, *supra* note 25, at 7. There were 11.7 hospital beds per 100,000 people in 2016, down from a high of 337 beds in 1955. NEW ASYLUMS, *supra* note 44, at 1.

59. *See, e.g.*, Wortzel, et al., *supra* note 41, at 357. IST inmates may wait even longer for transfer to inpatient facilities than other categories of defendants who are prioritized for treatment. California, for example, prioritizes sexually violent predators, defendants with mental illness who have been convicted, and defendants found not guilty by reason of insanity. *See* McMahon, *supra* note 19, at 7.

60. *See* GOING, GONE, *supra* note 25, at 9 (finding that most states maintained a wait-list of approximately thirty days).

61. *See id.*

62. Wortzel, et al., *supra* note 41, at 357. *See also* discussion *infra* Part II.B.

63. *See* GOING, GONE, *supra* note 25, at 32 (identifying lawsuits against public agencies and officials regarding the wait-listing of pretrial detainees with mental illness in over a dozen states since 2014).

64. The ACLU also sued on behalf of defendants who had been found un-restorable but remained in the state hospital. *See* Vaidya Gullapalli, *Judged Incompetent to Stand Trial, People with Mental Illness Still Languish in Pennsylvania Jails*, SOLITARY WATCH (Nov. 19, 2015), https://solitarywatch.org/2015/11/19/judged-incompetent-to-stand-trial-people-with-mental-illness-still-languish-in-pennsylvania-jails/ [https://perma.cc/PX5K-CJ24].

65. *Id.*

66. *Id.*

67. *Id.*

revived the lawsuit in 2017 as wait-times rocketed to 325 days on average.[68] In a similar suit in Alabama in 2018, the district court entered a consent decree requiring the Commissioner of the Alabama Department of Mental Health to provide timely psychiatric services to detained pretrial defendants awaiting competence evaluation and restoration services.[69] The lawsuit alleged that class members waited up to nine months in jail before transfer to an appropriate treatment facility.[70] Similar suits around the country have brought the logjam crisis to the fore, compelling states to seek solutions.

B. DEINSTITUTIONALIZATION MEETS MASS CRIMINALIZATION

Tom Dart, sheriff of the Cook County jail, remarked, "If you have someone diagnosed with a mental illness, can you think of a worse place to put them than a jail?"[71] Yet it is axiomatic that jails and prisons are the nation's 'de facto mental health facilities.'[72] Approximately forty thousand individuals with mental illness are institutionalized in state psychiatric hospitals, but nearly four-hundred thousand are confined in jails and prisons.[73] The jails in Los Angeles, New York City, and Chicago are the nation's largest 'providers' of psychiatric care.[74] In forty-four states and the District of Columbia, more individuals with serious mental illness are detained in a correctional facility than receiving services in the largest psychiatric hospital in that state.[75] In 2006, the U.S. Bureau of Justice Statistics

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68. Dan Simmons-Ritchie, *ACLU Revives Lawsuit Against Pa. Over 'Off the Charts' Delays to Treat Mentally Ill Defendants*, PENNLIVE (May 11, 2017), https://www.pennlive.com/news/2017/05/dont_publish_aclu_revives_laws.html [https://perma.cc/7X7W-2RQZ].

69. *Federal Court Enters Consent Decree to Remedy Delays in Psychiatric Services for Person with Mental Illness and Intellectual Disabilities Held in Jails*, ACLU OF ALABAMA (Jan. 26, 2018), https://www.aclualabama.org/en/press-releases/federal-court-enters-consent-decree-remedy-delays-psychiatric-services-persons-mental [https://perma.cc/Y4KJ-8DYY].

70. *Id.*

71. Matt Ford, *America's Largest Mental Hospital is a Jail*, ATLANTIC (June 8, 2015), https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/ [https://perma.cc/BL4R-SZCF].

72. *See, e.g.*, Michael L. Perlin & Alison J. Lynch, *Had to Be Held down by Big Police: A Therapeutic Jurisprudence Perspective on Interactions between Police and Persons with Mental Disabilities*, 43 FORDHAM URB. L.J. 685, 685 (2016).

73. *See* MEIGHAN B. HAUPT, NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRECTORS (NASMHPD) MEDICAL DIRECTORS COUNCIL, THE VITAL ROLE OF STATE PSYCHIATRIC HOSPITALS 6 (Joe Parks & Alan Q. Radke, eds., 2014) (finding that 207 state operated psychiatric hospitals serve approximately 40,600 people nationwide); NEW ASYLUMS, *supra* note 44, at 1 ("In 2016, nearly 400,000 inmates in US jails and prisons were estimated to have a mental health condition."); *see also* Ben-Moshe, *The Institution Yet to Come*, *supra* note 17, at 134 (acknowledging that estimating the number of prisoners with a psychiatric diagnosis "with any degree of precision" is impossible, "even if taking the label of 'mental illness' as a viable construct").

74. Naomi M. Weinstein & Michael L. Perlin, *Who's Pretending to Care for Him: How the Endless Jail-to-Hospital-to-Street-Repeat Cycles Deprives Persons with Mental Disabilities the Right to Continuity of Care*, 8 WAKE FOREST J. L. & POL'Y 455, 467 (2018).

75. E. FULLER TORREY, ET AL., TREATMENT ADVOCACY CENTER, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 7 (2014).

reported that over half of all prison and jail inmates had a mental illness.[76] A more recent study found that fourteen percent of men in prison and twenty-six percent of men in jail had experienced "serious psychological distress" in the month prior to the survey.[77] The rate for women was even higher: twenty percent and thirty-two percent, respectively.[78] Research suggests that as many as two million individuals with serious mental illness are booked into jails every year.[79]

Alarmingly, the proportion of jail and prison inmates with mental illness appears to be rising.[80] In New York, for example, approximately thirty percent of inmates at Rikers Island jail had a mental illness in 2010.[81] By 2017, the number had jumped to forty-three percent.[82] Similarly, a recent study in California found that despite criminal law reforms aimed at reducing the number of inmates with mental illness, "the prevalence and severity of mental illness among [] state prisoners are dramatically on the rise."[83]

The predominant explanation for the growing proportion of inmates with mental illness over the last half-century pits the folly of deinstitutionalization as the root cause and criminalization as the inevitable byproduct.[84] The deinstitutionalization movement, which began in the 1950s and accelerated through the 1980s, led to large-scale closures of psychiatric facilities.[85] In the span of a few decades, the population of individuals institutionalized in state mental hospitals and facilities for people with disabilities decreased dramatically: from a peak of 560,000

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76. The findings were based on "inmates' reporting symptoms" of mental disorders that occurred in last year, "rather than an official diagnosis of a mental illness." Press Release, Bureau of Justice Statistics, *Study Finds More Than Half of all Prison and Jail Inmates Have Mental Health Problems* (Sept. 6, 2006), https://www.bjs.gov/content/pub/press/mhppjipr.cfm [https://perma.cc/8LPM-5R97].

77. JENNIFER BRONSON & MARCUS BERZOFSKY, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011–12 1 (2017) (reporting that more prisoners and jail inmates met the threshold for serious psychological distress than the standardized general population (5%)).

78. *Id.*

79. Steadman, et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVICES 6, 764 (2009).

80. *See* Michael L. Perlin, *Wisdom is Thrown into Jail: Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness* 17 MSU J. OF MED. AND L. 343, 344 (2013) [hereinafter Perlin, *Wisdom*].

81. ROTH, *supra* note 4, at 3.

82. *Id.*

83. STANFORD JUSTICE ADVOCACY PROJECT, CONFRONTING CALIFORNIA'S CONTINUING PRISON CRISIS: THE PREVALENCE AND SEVERITY OF MENTAL ILLNESS AMONG CALIFORNIA PRISONERS ON THE RISE 1–2 (2017) (finding that over thirty percent of California prisoners receive treatment for a "serious mental disorder," and that the percentage of state prisoners with mental illness increased by seventy-seven percent in the last decade).

84. *See, e.g.*, Micheal Rembis, *The New Asylums: Madness and Mass Incarceration in the Neoliberal Era*, *in* DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA 142 (Liat Ben-Moshe, Chris Chapman & Allison C. Carey, eds. 2014); Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 3 (2012) (explaining that "the trope of deinstitutionalization-as-disaster has taken on the aura of conventional wisdom").

85. *See generally* Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO STATE J. OF CRIM. L. 53, 54 (2011).

individuals in 1955 to 50,000 in 2003.[86] Legal scholar and political scientist Bernard Harcourt identifies three primary factors facilitating deinstitutionalization: the availability of psychiatric medicines to treat severe mental illness outside of institutional settings; federal social welfare programs that incentivized alternative settings for mental health care; and evolving social attitudes toward mental illness, including a growing awareness of inadequacies inherent in a "system of institutionalized care."[87]

Many deinstitutionalization battles were won in the judicial arena. Advocates sought robust protections against involuntary commitment to institutions, access to essential treatment, and humane living conditions in institutions.[88] Two landmark cases transformed the civil commitment standard.[89] In *O'Connor v. Donaldson*, the Supreme Court held that "a State cannot constitutionally confine, without more, a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[90] Lower courts subsequently interpreted the holding to mean that a patient must be proven "dangerous" before being civilly committed.[91] In *Lessard v. Schmidt*, a federal district court in Wisconsin further narrowed the standard by striking down Wisconsin's civil commitment law as unconstitutional.[92] The court held that involuntary hospitalization was only permissible upon finding an "extreme likelihood that if the person is not confined he will do immediate harm to himself or others."[93]

According to the 'deinstitutionalization-meets-mass-criminalization' trope, when psychiatric hospitals closed, hordes of formerly institutionalized people with severe mental illnesses were dumped out onto the streets without any support. They inevitably ended up homeless, committed crimes, and were funneled into jail to bypass stringent civil commitment laws.[94] Through the process of "trans-institutionalization," the same population that would have been treated in

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86. *See* Bagenstos, *supra* note 84, at 9; *see also* Harcourt, *supra* note 85, at 54 (explaining that "from 1955 to 1980, the number of persons institutionalized in mental health facilities declined by 75%").

87. Harcourt, *supra* note 85, at 65–71.

88. *See* ROBERT BERNSTEIN, IRA BURNIM & MARK J. MURHPY, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, DIVERSION, NOT DISCRIMINATION: HOW IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT CAN HELP REDUCE THE NUMBER OF PEOPLE WITH MENTAL ILLNESS IN JAILS 5 (2017).

89. *See* RISDON N. SLATE, ET AL., THE CRIMINALIZATION OF MENTAL ILLNESS: CRISIS AND OPPORTUNITY FOR THE JUSTICE SYSTEM 39 (2d ed. 2013).

90. 422 U.S. 563, 576 (1975).

91. SLATE, ET AL., *supra* note 89, at 39.

92. 349 F. Supp. 1078, 1103 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976), *superseded by statute as stated in* Flower v. Leean, No. 99-2999, 2000 U.S. App. LEXIS 9617 (7th Cir. May 3, 2000).

93. *Id*. at 1093.

94. *See* Perlin, *Wisdom*, *supra* note 80, at 348; Liat Ben-Moshe, *Why Prisons are Not "The New Asylums,"* 19 PUNISHMENT & SOCIETY 3, 275 (2017) ("[T]he hegemonic story is that deinstitutionalization led to 'dumping people in the streets,' or to 'mentally ill' people living in the streets or in jail via being homeless.") [hereinafter Ben-Moshe, *Not "The New Asylums"*].

mental health facilities is now given shelter and basic services in correctional facilities.[95]

Yet characterizing the criminalization of mental illness as an unpreventable byproduct of deinstitutionalization paints a shamefully incomplete picture. For one thing, the demographics of mental health patients formerly confined in psychiatric institutions does not mirror the demographics of jail and prison inmates.[96] More importantly, as legal scholar Samuel Bagenstos demonstrates, deinstitutionalization has been a successful process "in many significant respects."[97] In the last half century, the proportion of individuals with serious mental illness confined in psychiatric facilities decreased at a greater rate than the increase in those incarcerated, indicating that many people who would have been institutionalized are now living more fulfilling lives in their communities.[98]

Accounting for a more complex narrative reveals that the disproportionate incarceration rate of individuals with mental illness post-deinstitutionalization was not preordained. Rather, it is a predictable consequence of government resource allocation and social prejudice. State and federal legislatures have persistently failed to fund adequate clinical, housing, and vocational services for individuals with mental illness amidst a decades-long war on crime.[99] Evidence suggests that implementing intensive rehabilitative services in conjunction with deinstitutionalization successfully prevents prevents people with mental illnesses from being re-institutionalized in the criminal justice system.[100] Yet deprived of accessible and affordable treatment, individuals with mental illness are

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95. *See, e.g.*, GOING, GONE, *supra* note 25, at 2.

96. ROTH, *supra* note 4, at 75 (contrasting the elderly, female, and white former state psychiatric patients with young, male, people of color in jails and prisons).

97. Bagenstos, *supra* note 84, 7–12 (2012) (explaining that "the indictment of deinstitutionalization" rests on the "normative premise that institutionalization is preferable to community-based" services).

98. *See* Perlin, *Wisdom, supra* note 80, at 350.

99. *See, e.g.*, Chris Chapman, Allison C. Carey & Liat Ben-Moshe, *Reconsidering Confinement*, *in* DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA 16 (Liat Ben-Moshe, Chris Chapman & Allison C. Carey, eds. 2014) (arguing that the hegemonic deinstitutionalization narrative obfuscates neoliberal policies that expanded the carceral state while reducing affordable housing and financial support for individuals with disabilities); Loïc Wacquant, *Class, Race and Hyperincarceration in Revanchist America*, 28 SOCIALISM AND DEMOCRACY 3, 39 (2014) ("The 'upsizing' of the carceral function of government has been rigorously proportional to the 'downsizing' of its welfare role."); Marta Russell & Jean Stewart, *Disablement, Prison & Historical Segregation*, MONTHLY REV. (2002), https://monthlyreview.org/2001/07/01/disablement-prison-and-historical-segregation/ [https://perma.cc/Q3VV-P4BF] (arguing that mass incarceration of individuals with mental illness "has its roots in the U.S. capitalist health care system and the growth of the prison industry"); Bagenstos, *supra* note 84, at 12 (acknowledging the dearth of "adequate services and supports" for formerly institutionalized individuals); Rembis, *supra* note 84, at 149 (noting that state mental health care budgets have declined steadily since the 1970s); BERNSTEIN, ET AL., *supra* note 88, at 6–9 (arguing that lack of community support is the root cause of crime committed by many individuals with mental illness). Other factors contributing to the criminalization of mental illness include criminal procedure reform, discriminatory Medicaid and Medicare reimbursement policies, and a severe shortage of qualified mental health professionals, particularly in rural areas. *See, e.g.*, Perlin, *Wisdom*, *supra* note 80, at 361; GOING, GONE, *supra* note 25, at 9; Ben-Moshe, *Not "The New Asylums," supra* note 94, at 275–79.

100. *See* Perlin, *Wisdom, supra* note 80, at 350.

susceptible to experiencing acute psychotic symptoms.[101] Mental illness does not cause criminal behavior, but individuals with untreated symptoms and no social safety net may develop other risk factors for crime, including, "unemployment, poverty, homelessness, and substance abuse."[102]

Compounding the dearth of social support, people who exhibit signs of mental illness are disproportionately targeted by police.[103] Research suggests that roughly half of all individuals with a mental illness will be arrested at some point in their lives.[104] These routine arrests are not for violent crimes. Contrary to social stereotypes, the vast majority of mentally ill individuals will never commit a crime of violence.[105] In fact, individuals with mental illness are approximately fourteen times more likely to be *victims* of a violent crime than to be arrested for one.[106] Instead, officers target persons with perceived mental illness for nuisance crimes, like trespassing or disorderly conduct.[107] In Adam's case, described above, the arresting officer may have taken Adam to jail because he lacked sufficient mental illness training, harbored a prejudicial fear that Adam's behavior amounted to a dangerous threat, or because he believed booking Adam into jail would be a relatively quick and easy response to a complex problem.[108]

Surveys show that mental disabilities are perceived more negatively than any other disability.[109] In particular, individuals with mental illness are presumed to be prone to violence, incapable of functioning in society, untreatable, and deserving of punishment.[110] Stigmatization of mental illness has persisted for centuries,

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101. Perlin & Lynch, *supra* note 72, at 693.

102. *See id*. (citing John Junginger et al., *Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses*, 57 PSYCHIATRIC SERVS. 879, 882 (2006)).

103. *See id*. at 687. Encounters between individuals with mental illness and police may turn deadly. The Treatment Advocacy Center estimates that individuals with untreated serious mental illness are sixteen times more likely than other civilians to be killed by law enforcement. DORRIS A. FULLER, ET AL., TREATMENT ADVOCACY CENTER, OVERLOOKED IN THE UNDERCOUNTED: THE ROLE OF MENTAL ILLNESS IN FATAL LAW ENFORCEMENT ENCOUNTERS 1 (2015). For an analysis of how race intersects with perceived mental illness in police encounters, see Camille A. Nelson, *Racializing Disability, Disabling Race: Policing Race and Mental Status*, 15 BERKELEY J. CRIM. L. 1, 3 (2010) (discussing "the disparate, yet routine, use of excessive force by police against persons of color with mental illness").

104. *See* Jeffrey Draine, et al., *Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons with Serious Mental Illness*, 53 PSYCHIATRIC SERVS. 565, 566 (2002).

105. Some studies predict that fewer than one percent of individuals with mental illness will ever become violent. SLATE, ET AL., *supra* note 89, at 75.

106. *Id*., at 77.

107. *See* Perlin & Lynch, *supra* note 72, at 688.

108. *See* Weinstein & Perlin, *supra* note 74, at 466; H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care From Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY L. 529, 531–32 (2005) [hereinafter Lamb & Weinberger, *Shift*] (explaining that individuals with mental illness are "criminalized" each time they get arrested, increasing the likelihood that that future law enforcement officers or judges will funnel them into the criminal justice system).

109. Michael L. Perlin, *I Ain't Gonna Work on Maggie's Farm No More: Institutional Segregation, Community Treatment, the ADA, and the Promise of Olmstead v. L.C.*, 17 T. M. COOLEY L. REV. 53, 63 (2000).

110. *See, e.g*., McMahon, *supra* note 19, at 27 (characterizing defendants with mental illness as "the most misunderstood and stigmatized participants in the criminal justice system); Michael L. Perlin, *"What's Good Is Bad, What's Bad Is Good, You'll Find Out When You Reach the Top, You're on the Bottom": Are the*

but research suggests that Americans' fear of mentally ill individuals surged concomitantly with deinstitutionalization.[111] The criminalization of mental illness is thus best understood as a new chapter in a long history of society's attempts to keep "us" separate and safe from the "fearsome Other."[112]

II. INCOMPETENCY TO STAND TRIAL: DOCTRINE, PROCESS, AND PROBLEMS

A. JUDICIAL FINDING OF INCOMPETENCE AND RESTORATION PROCESS

The common law origins of the incompetency doctrine date back to mid-seventeenth century England.[113] In his commentaries, Blackstone explained that a criminal defendant's competence was essential to a fair trial.[114] A defendant who became "mad" after committing the offense should not be arraigned, he wrote, "because he is not able to plead . . . with the advice and caution that he ought."[115] Nor should he be tried, because, "how can he make his defense?"[116]

In *Dusky v. United States*, the Supreme Court articulated the modern standard for assessing a defendant's trial competence.[117] The trial judge must not only ensure that a criminal defendant is "oriented to time and place," but must also evaluate whether the defendant "has a sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as a factual understanding of the proceedings against him."[118] The practice of suspending criminal proceedings while the defendant undergoes competency restoration treatment is rooted in the constitutional right to due process of law.[119] In *Pate v. Robinson*, the Supreme Court explained that failure to protect an incompetent defendant from a criminal conviction would violate his or her right to a fair trial.[120] Further, in *Drope v. Missouri*, the Supreme Court

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Americans With Disabilities Act (and Olmstead v. L. C.) Anything More Than "Idiot Wind?", 35 U. MICH. J. L. REFORM 235, 238 (2001); Jennifer Fischer, *The Americans with Disabilities Act: Correcting Discrimination of Persons with Mental Disabilities in the Arrest, Post-Arrest, and Pretrial Processes*, 23 LAW & INEQ. 157, 172–73 (2005).

111. SLATE, ET AL., *supra* note 89, at 42.

112. *See* Nirmala Erevelles, *Crippin' Jim Crow: Disability, Dis-Location, and the School-to-Prison Pipeline*, *in* DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA 83 (Liat Ben-Moshe, Chris Chapman & Allison C. Carey, eds. 2014).

113. Bruce J. Winick, *Incompetency to Stand Trial*, *in* MENTALLY DISORDERED OFFENDERS 3 (John Monahan & Henry J. Steadman eds., 1983) [hereinafter Winick, *Incompetency*].

114. ROTH, *supra* note 4, at 181.

115. Winick, *Incompetency*, *supra* note 113, at 3.

116. *Id.*

117. 362 U.S. 402, 402 (1960).

118. This standard applies in federal courts. Winick, *Incompetency*, *supra* note 113, at 4. The precise terminology for competence standards varies widely among state courts, though most dictate that a defendant is incompetent to stand trial if, "as a result of mental disease or defect," the defendant, "lacks the capacity to understand the proceedings against him or her or to assist in his or her defense." *Id.* at 6.

119. *Id.* at 5–6.

120. 383 U.S. 375, 385–86 (1966).

deemed the prohibition against trying an incompetent defendant "fundamental to an adversary system of justice."[121]

Questions about a defendant's competence can be raised at any time during the trial process.[122] Though defense attorneys most frequently alert the court to concerns about their client's competence at arraignment, the judge may order an evaluation *sua sponte* if a defendant exhibits signs of mental illness in the courtroom.[123] The question of whether a defendant is incompetent to proceed is "often a difficult one," as the Supreme Court explained, there are "no fixed or immutable signs which invariably indicate the need for further inquiry to determine fitness to proceed."[124]

If a trial judge doubts a defendant's competence to proceed, the court will appoint an expert psychiatrist or psychologist to conduct an evaluation.[125] After evaluating the defendant, typically in the local jail,[126] the expert will summarize his or her findings in a written report and make a recommendation to the court.[127] If the parties do not stipulate to the expert's conclusion, the defendant is entitled to a formal hearing, where he or she can challenge the expert's opinion by presenting evidence and examining witnesses.[128] Because competency is a legal determination, not a medical one, the court has the final word on the defendant's fitness to proceed.[129] Judges, however, rarely disagree with the treatment professional's recommendation.[130] One study in New York found that the average length of competency hearings was only ten minutes long, and over a third of the hearings were conducted within just three minutes.[131] Another study found that judges concurred with expert psychiatrists' finding of incompetency ninety-two percent of the time.[132]

If the judge determines that the defendant meets the *Dusky* standard for competence, criminal proceedings resume as normal. If not, the defendant is placed on another wait-list; this one for treatment designed to restore competence.[133] For the overwhelming majority of criminal defendants, their commitment to inpatient facilities is automatic upon an incompetency finding, regardless of their

121. 420 U.S. 162, 172 (1974).
122. Winick, *Incompetency*, *supra* note 113, at 89.
123. *Id*. at 9.
124. *Drope*, 420 U.S. at 180.
125. Winick, *Incompetency*, *supra* note 113, at 9.
126. Gowensmith, et al., *supra* note 48, at 297.
127. Winick, *Incompetency*, *supra* note 113, at 13.
128. *Id*.
129. *Id*.
130. *Id*. at 14.
131. *See* Henry J. Steadman & Eliot Hartstone, *Defendants Incompetent to Stand Trial, in* MENTALLY DISORDERED OFFENDERS 45 (John Monahan & Henry J. Steadman eds., 1983).
132. *See id*. at 44–45 (finding these statistics particularly alarming because clinicians lack a "clear and accurate" understanding of the legal standard for incompetence).
133. Competence restoration treatment is distinct from general mental health treatment. The purpose is to render the defendant capable of proceeding in his or her criminal case, not to treat mental illness. *See id*. at 52.

underlying criminal charge, the severity of their illness, or their past treatment compliance.[134] This is where the crippling logjam, described above,[135] occurs.

Competence restoration treatment consists of identifying and remedying the specific symptoms of mental illness that impact a defendant's trial capacity.[136] There are three primary components: the administration of psychotropic medication, mental health treatment to alleviate symptoms of mental illness, and legal education.[137] The educational component is designed to familiarize patients with the justice system and trial process.[138] Patients might play courtroom trivia or engage in criminal trial role play. In a Washington, DC program, participants watch *My Cousin Vinnie* and discuss the film's relevance to a real courtroom.[139] Likewise, in Florida, patients participate in an elaborate mock game show and review *Law & Order* episodes.[140] In contrast to competence evaluations, restoration strategies have yet to be rigorously assessed for efficacy.[141]

Despite the lack of standardization among restoration programs, the average rate of restoration for IST defendants is quite high. A meta-analysis of restoration studies found that eighty-one percent of defendants were successfully restored to competence.[142] On average, the restoration process was completed in ninety to one hundred and twenty days.[143] "Knowledgeable observers" maintain that six months is sufficient time to restore most patients to competence.[144]

What if the defendant does not respond to treatment? In *Jackson v. Indiana*, the Supreme Court held that indefinite commitment of defendants whose competence was unlikely to be restored violates their due process and equal protection rights.[145] Yet the Court declined "to prescribe arbitrary time limits" on the maximum period a defendant can be confined pursuant to a finding of incompetency.[146] Nor did the Court interrogate the default assumption that competence

134. *See* Winick, *Incompetency, supra* note 110, at 16.

135. *See supra*, Part I.A.

136. *See* Kelly Goodness & Alan R. Felthous, *Treatment for Restoration of Competence to Stand Trial, in* PRINCIPLES AND PRACTICES OF FORENSIC PSYCHIATRY 259 (Richard Rosner & Charles Scott eds., 3rd ed. 2017).

137. *See* ROTH, *supra* note 4, at 185.

138. *See* Goodness & Felthous, *supra* note 136, at 261.

139. *See* Nicole R. Johnson & Philip J. Candilis, *Outpatient Competence Restoration: A Model and Outcomes*, 5 WORLD J. PSYCHIATRY 228, 230 (2015).

140. *See* ROTH, *supra* note 4, at 186.

141. *See* Gowensmith, et al., *supra* note 48, at 294 (explaining that more attention has been paid to competence evaluation procedures than to restoration); Alan R. Felthous & Joseph D. Bloom, *Jail-Based Competency Restoration*, 46 J. AM. ACAD. PSYCHIATRY L. 364, 369 (2018) (lamenting that "little scholarly attention has been given to the development of efficacious restoration modalities or model programs in general").

142. *See* Gowensmith, et al., *supra* note 48, at 294.

143. *See id.*

144. Winick, *Incompetency, supra* note 113, at 21.

145. 406 U.S. 715, 730–31 (1972).

146. *Id.* at 738.

restoration be conducted in inpatient mental health facilities.[147] In response to *Jackson*, many states revised their competence procedures to limit confinement to a "reasonable period."[148] In some states, the duration of incompetency commitment cannot exceed the maximum sentence for the underlying criminal charge.[149] For defendants charged with misdemeanors in New York, for example, commitment for competence restoration cannot exceed ninety days.[150] In light of *Jackson's* restriction, many IST defendants who are deemed permanently incompetent are subsequently hospitalized through the civil commitment process.[151]

B. EXACERBATING MENTAL ILLNESS UNDER THE GUISE OF DUE PROCESS

The primary purpose of the competence standard is to protect criminal defendants' due process rights.[152] But the evaluation and restoration process is so fraught with consequences for the intended beneficiary, some scholars and advocates wonder whether an IST defendant would be better served by pleading guilty.[153] Ethical obligations may even require a defense attorney to disregard the competency question in certain circumstances.[154] Some of the severe consequences imposed on defendants ordered to undergo competence restoration include isolation from friends and family, job loss, stigmatization, loss of dignity, unnecessary deprivation of liberty, forcible medication in hospital or jail, burdens on defense, loss of privilege against self-incrimination, compromised attorney-client privilege, and ultimately, worse trial outcomes.[155] Arguably, the most devastating

147. *See* McMahon, *supra* note 19, at 19 (explaining that the *Jackson* Court failed to scrutinize "the default position that commitment to an inpatient mental health facility was necessary for competence restoration"); Orihuela, *supra* note 44, at 3 (lamenting that *Jackson* has been interpreted broadly to permit mandatory detention).

148. Winick, *Incompetency, supra* note 113, at 21 (acknowledging that many states have also failed to respond to *Jackson's* mandate).

149. *Id*. at 22.

150. *Id*.

151. *Id*. at 23.

152. Harold Kaufman, *Evaluating Competency: Are Constitutional Deprivations Necessary*, 10 AM. CRIM. L. REV. 465, 468 (1972).

153. *See* Bruce J. Winick, *Incompetency to Stand Trial: An Assessment of Costs and Benefits, and a Proposal for Reform*, 39 RUTGERS L. REV. 243, 259 (1987) [hereinafter Winick, *Assessment*]; Perlin, *Wisdom*, *supra* note 80, at 360 (explaining reasons why "an effective and competent defense lawyer" might avoid raising their client's competency status); Josephine Ross, *Autonomy Versus a Client's Best Interests: The Defense Lawyer's Dilemma When Mentally Ill Clients Seek to Control Their Defense*, 35 AM. CRIM. L. REV.1343, 1372–81 (1998) (rooting suggestion that defense attorneys disregard competency concerns in an "ethic of care").

154. *See* Keri A. Gould, *A Therapeutic Jurisprudence Analysis of Competency Evaluation Requests: The Defense Attorney's Dilemma*,18 INT'L J. L. & PSYCHIATRY 83, 93–94 (1995).

155. *See, e.g*., Michael L. Perlin, *"For the Misdemeanor Outlaw": The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. R., 193, 201–02 (2000) [hereinafter Perlin, *Misdemeanor Outlaw*]; Michael L. Perlin & Meredith R. Schriver, *You Might Have Drugs at Your Command: Reconsidering the Forced Drugging of Incompetent Pre-Trial Detainees from the Perspectives of International Human Rights and Income Inequality*, 8 ALB. GOV'T L. REV. 381, 395 (2015)

consequence of flagging a defendant's competence is the potential delay between evaluation, restoration, and adjudication, resulting in excessive time in jail.[156]

Jails are noisy, chaotic, crowded, uncomfortable, and dangerous. Correctional staff lack adequate training and resources to effectively care for and protect individuals with mental illness.[157] Confinement itself exacerbates symptoms of mental illness, and the longer IST defendants are deprived of health care, the dimmer their long-term prognoses become.[158]

Justin Volpe, a Recovery Peer Specialist in Miami, described his experience as an inmate with mental illness in Miami-Dade County Jail as "anything but rehabilitative":

> I was locked up on the jail's ninth floor — infamous as the "Forgotten Floor," where the jail kept its inmates with serious mental illnesses. The conditions were so bad that I had trouble believing I was still in the United States. The lights were on day and night; it was always 60 degrees. You could smell the mold in the air. I'm still haunted by the screams of the inmates round-the-clock. I remember one guy begging for his life while I prayed the officers wouldn't take their wrath out on me. Amid the chaos of the jail, my mental health worsened, and the possibility of rejoining the outside world seemed further out of reach.[159]

In the confines of jail, IST defendants are vulnerable to a dizzying array of harm and abuse. A Human Rights Watch investigation into conditions of individuals awaiting competency evaluation and restoration found "deep-rooted patterns

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(noting that pretrial detention for competency restoration may falsely connote guilt to jurors and impact the defendant's ultimate sentence). As defense attorney Daron Morris explains:

> My office frequently represents clients who would be able to resolve their cases pretty expeditiously and on favorable terms with treatment options in the community. But, all that gets delayed while they wait in jail for months and months and months pending competency restoration, sometimes on cases where they are facing no more than 60 days in jail [if convicted]. This seems like an absolute waste.

DISABILITY RIGHTS WASHINGTON, LOST AND FORGOTTEN: CONDITIONS OF CONFINEMENT WHILE WAITING FOR COMPETENCY EVALUATION AND RESTORATION 6 (2013).

156. *See* discussion *supra* Part I.A.

157. *See, e.g.*, HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 76–78 (2003) (finding that mental health training for custodial staff is "sorely lacking" across the United States).

158. *See* Eric Balaban, *Freeing the Most Vulnerable: Litigation Tools to Reduce the Disabled Prisoner Population*, 1 UCLA CRIM. J. L. R. 1, 4 (2017) [hereinafter Balaban, *Litigation Tools*]; *see also* Judge William Wayne Justice, *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (S.D. Texas, 1999) ("It is deplorable and outrageous that this state's prisons appear to have become a repository for a great number of its mentally ill citizens. Persons who, with psychiatric care, could fit well into society, are instead locked away, to become wards of the state's penal system. Then, in a tragically ironic twist, they may be confined in conditions that nurture, rather than abate, their psychoses.").

159. Justin Volpe, *Jails are No Place for the Mentally Ill. I was Lucky to Get Out*, WASH. POST (Sept. 23, 2015), https://www.washingtonpost.com/posteverything/wp/2015/09/23/jails-are-no-place-for-the-mentally-ill-i-was-lucky-to-get-out/?utm_term=.a6f5bf30d114 [https://perma.cc/9KQ9-GTL5].

of neglect, mistreatment, and even cavalier disregard for the well-being of vulnerable and sick human beings."[160] Haunting personal anecdotes, like the following, abound.

After Tyler Haire's defense attorney requested that he receive a competence evaluation, the seventeen-year-old remained stuck in a Mississippi jail for 1,266 days.[161] While awaiting transfer to the state hospital, Tyler did not see a single psychiatrist, have access to medication, or receive a minute of educational instruction.[162] After the first few months in jail, Tyler had lost so much weight that his mother was concerned he would "dry up and blow away."[163]

Jan Green was booked into a New Mexico jail after a minor domestic violence incident.[164] Instead of being referred to a psychiatrist for refusing to wear jail clothes, the fifty-one-year-old grandmother was pepper sprayed and placed in a ten-foot-by-six-foot bathroom converted into an isolation cell.[165] Found incompetent to proceed, she spent over two years cycling in-and-out of solitary confinement before being transferred to a mental health facility where her mental health quickly stabilized.[166] While in solitary, she was repeatedly denied access to medication and basic human necessities like feminine hygiene products.[167]

Three Santa Clara correctional officers were sentenced to prison for beating an inmate with mental illness to death in 2015.[168] Michael Tyree was naked and covered in vomit and feces when he was found dead in his cell.[169] Tyree was being detained in jail on misdemeanor charges as he waited for a bed to open up at a residential treatment program.[170]

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160. HUMAN RIGHTS WATCH, *supra* note 16, at 2.

161. Sarah Smith, *What are We Going to do About Tyler?* PROPUBLICA (Dec. 28, 2017), https://features.propublica.org/tyler-haire-mississippi/tyler-haire-mississippi-mental-health-evaluations-criminal-justice/ [https://perma.cc/2333-AVMR].

162. *Id*.

163. *Id*.

164. *See* Gary A. Harki, *How One Woman Survived Her Mental Illness Isolated in Jail with Only the Voices in Her Head for Company*, THE VIRGINIAN-PILOT (Aug. 30, 2018), https://pilotonline.com/news/local/projects/jail-crisis/article_d4099ae6-975b-11e8-bc49-bb2da6c825f2.html [https://perma.cc/L2JC-M6XT]; Erin Fuchs, *The Shocking Story of a Bipolar Woman Stuck for Years in Jail Without Ever Being Convicted of a Crime*, BUSINESS INSIDER (Feb. 17, 2014, 8:46 PM), https://www.businessinsider.com/jan-greens-solitary-confinement-nightmare-2014-2 [https://perma.cc/P3FT-VDPB].

165. *See* Harki, *supra* note 164.

166. *Id*.

167. *See id*.; Fuchs, *supra* note 164.

168. *See* Annie Ma, *Guards Who Beat Santa Clara County Prisoner to Death Get Long Prison Terms*, SFGATE (Jan. 5, 2018, 3:41 PM), https://www.sfgate.com/crime/article/Guards-who-beat-Santa-Clara-County-prisoner-to-12477219.php [https://perma.cc/XHG9-27BY].

169. Julie Small, *Inmate's Brutal Beating Death Spurs Scrutiny and Reform in Santa Clara County Jails*, KQED (Jan. 25, 2017), https://www.kqed.org/news/11285099/inmates-brutal-beating-death-spurs-scrutiny-and-reform-in-santa-clara-county-jails [https://perma.cc/UXT6-XSH4].

170. Veronica Rocha, *3 Santa Clara County Deputies Arrested in Mentally Ill Inmate's Beating Death*, L.A. TIMES (Sept. 3, 2015, 8:29 PM), https://www.latimes.com/local/lanow/la-me-ln-santa-clara-deputies-arrested-20150903-story.html [https://perma.cc/LZA4-D92K].

Another California inmate now suffers from post-traumatic stress disorder after being held in a Los Angeles County jail for eight months.[171] A fellow inmate raped him repeatedly while he awaited transfer to a treatment center.[172]

Each of these cases are extremely devastating, but they cannot be written off as anomalies. Abuse of inmates with mental illness, as well as acts of self-mutilation and suicide, is widespread in jails and prisons.[173] In 2013, the New York Times documented 129 cases in which Rikers correctional officers beat inmates so severely that they required emergency medical care.[174] Seventy-seven percent of the victims had a mental health diagnosis.[175] Another more comprehensive study conducted by the Virginian Pilot and Marquette University students uncovered 404 deaths of inmates with mental illness in correctional facilities since 2010.[176] Forty-four percent of the deaths were by suicide.[177] In seventy cases, inmates had been shocked with a Taser, pepper sprayed, or restrained before dying.[178]

Nearly half of the inmates were in segregation, or or had recently been released from segregation when they died.[179] Inmates with mental illness are disproportionately ensnared in the "cruel cycle" of solitary confinement.[180] Mental illness makes it exceedingly difficult to comply with rigid correctional facility rules,[181] and officers have wide discretion to impose punishment for "broadly defined

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171. Sharon Bernstein, *California Sued for Failing to Protect Mentally Disabled Defendants*, REUTERS (July 29, 2015, 7:36 PM), https://www.reuters.com/article/us-usa-california-jails/california-sued-for-failing-to-protect-mentally-disabled-defendants-idUSKCN0Q32SS20150729 [https://perma.cc/9ZWE-PJZ7].

172. *Id*.

173. *See* Gary A. Harki, *Horrific Deaths, Brutal Treatment: Mental Illness in America's Jails*, THE VIRGINIAN-PILOT (Aug. 23, 2018), https://pilotonline.com/news/local/projects/jail-crisis/article_5ba8a112-974e-11e8-ba17-b734814f14db.html [https://perma.cc/4PHJ-RZ32].

174. Michael Winerip & Michael Schwirtz, *Rikers: Where Mental Illness Meets Brutality in Jail*, N.Y. TIMES (July 14, 2015), https://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html?module=inline [https://perma.cc/235K-8GT5].

175. *Id*.

176. Harki, *supra* note 173.

177. *Id*.

178. *Id*.

179. *Id*.

180. *See* Eric Balaban, *Time Has Come to Save Mentally Ill Inmates from Solitary Confinement*, AZ. CAP. TIMES (Feb. 27, 2018), https://azcapitoltimes.com/news/2018/02/27/time-has-come-to-save-mentally-ill-inmates-from-solitary-confinement/ [https://perma.cc/Z86R-RY3W] (describing cyclical phenomenon wherein inmates with mental illness are put in segregation for behavior that is the product of mental illness, deteriorate further in segregation, which then justifies their continued isolation) [hereinafter Balaban, *Time Has Come*]; Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY L. 104, 105 (2010).

181. Inmates with mental illness are twice as likely to be cited with rule violations than inmates without mental illness. DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 10 (2006); *see also* Metzner & Fellner, *supra* note 180 at 105 (explaining that inmates with mental illness have a harder time coping with the stress of incarceration and conforming to "highly regimented routine[s]"); ALLEN J. BECK, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, USE OF RESTRICTIVE HOUSING IN U.S. PRISONS AND JAILS, 2011-12 1 (2015) ("22% of jail inmates with current symptoms of serious psychological distress had spent time in restrictive housing units in the past 12 months.").

disciplinary charges," like disorderly conduct.[182] Even acts of self-mutilation and attempted suicide are commonly dealt with as disciplinary matters.[183] Both can be grounds for placement in segregation.[184]

Once in solitary, inmates with mental illness have a harder time complying with the unrealistic behavioral expectations required to return to general population.[185] It is widely acknowledged that mental illness deteriorates rapidly in "the hole."[186] The near total absence of human interaction in solitary confinement destabilizes an inmate's sense of self and severs their connection to social reality, exacerbating symptoms of mental illness.[187] Psychiatrist Dr. Stuart Grassian found that inmates in isolation experience "an agitated confusional state which, in more severe cases, had the characteristics of a florid delirium, characterized by severe confusional, paranoid, and hallucinatory features, and also by intense agitation and random, impulsive, often self-directed violence."[188] Attempts to provide meaningful mental health care to inmates in solitary confinement, who are likely locked-down for twenty-three hours a day, restrained in shackles, and escorted by guards at all times, are futile.[189] As Justice Sotomayor described, "solitary confinement imprints on those that it clutches a wide range of

182. Andrea C. Armstrong, *Race, Prison Discipline, and the Law*, 5 UC IRVINE L. REV. 759, 771 (2015) (explaining that vaguely worded "catchall rules" give prison guards great latitude to punish inmates' attitudes in addition to conduct).

183. HUMAN RIGHTS WATCH, *supra* note 16, at 174–88 (explaining that suicide and self-harm are linked to inadequate mental health care but are nevertheless dealt with as disciplinary issues); Haney, *supra* note 2, at 321 (arguing that the treatment of suicide and self-harm as disciplinary infractions illustrates how "a punitive mind-set now dominates over therapeutic perspectives" in correctional institutions).

184. HUMAN RIGHTS WATCH, *supra* note 16, at 179 (describing the "tragic irony" that mentally ill inmates who attempt or commit self-harm are placed in segregation, which further increases their risk of committing self-harm or suicide). In Tennessee, for example, attempted suicide may be punished by up to five days in punitive segregation. Armstrong, *supra* note 182, at 769 (citing TENN. DEP'T OF CORR. DISCIPLINARY PUNISHMENT GUIDELINES 7 (2012), https://www.tn.gov/assets/entities/correction/attachments/502-02.pdf [https://perma.cc/U4WM-R5XL]).

185. *See* Metzner & Fellner, *supra* note 180, at 105 (explaining that continued misconduct in segregation, "often connected to mental illness," can keep inmates in segregation indefinitely); Balaban, *Time Has Come*, *supra* note 180.

186. *See, e.g.*, Metzner & Fellner, *supra* note 180, at 105.

187. *See* Haney, *supra* note 2, 321. The effects of solitary confinement—anxiety, depression, confusion, hallucinations, paranoia, and violent outbursts—are similar to the effects of physical torture. International treaty bodies and human rights officials, including the Human Rights Committee and the UN Special Rapporteur on Torture, have criticized the United States for certain confinement practices that violate the UN Convention Against Torture and Other Cruel, Inhuman and Degrading Punishment. *See* Metzner & Fellner, *supra* note 180, at 104–05; Allegra M. McLeod, *Prison Abolition and Grounded Justice*, 62 UCLA L. REV. 1156, 1179 (2015).

188. Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J. L. & POL'Y 325, 328 (2006).

189. *See* Metzner & Fellner, *supra* note 180, at 105 (explaining that therapy, structured activities and other therapeutic interventions are typically unavailable to inmates in isolation because of insufficient resources and correctional facility rules). Group therapy for mentally ill prisoners in solitary confinement at Pelican Bay State Prison in northern California takes place in "a small room with six phone-booth-sized cages" with no therapist. Laura Sullivan, *At Pelican Bay Prison, a Life in Solitary*, NPR (July 26, 2003, 3:01 PM), https://www.npr.org/templates/story/story.php?storyId=5584254 [https://perma.cc/SJ33-PTTJ].

psychological scars."[190] These psychological scars can have permanent and even fatal consequences.[191]

The side-effects of antipsychotic medication may render mentally ill inmates sluggish, apathetic, and less aware of their surroundings.[192] Inmates with mental illness are thus easy targets for extortion, exploitation, and physical and sexual abuse by fellow inmates.[193] Those who resist taking medication out of a desire to keep themselves safe, to avoid stigmatization by other inmates, or to stave off adverse side effects risk being forcibly medicated by correctional facility authorities with a singular mission: maintain order.[194] A Sonoma County jail was recently accused of forcibly medicating inmates without going through proper procedures.[195] One woman was involuntarily injected seven times over a ten-week period.[196]

Even after a defendant is successfully restored to competence, there is no guarantee that his or her criminal case will come to a timely close. When IST defendants are transferred from treatment facilities back to jail, they may wait months for their cases to resume, due to substantial backlogs in the criminal court.[197] Lack of adequate medication or mental health care in jail puts IST defendants at risk of decompensating to the point of incompetency, triggering another round of inpatient restoration.[198] Practitioners refer to this phenomenon as the "shuttle process" or "riding the bus."[199] New Yorkers call it the "merry-go-round."[200]

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190. Apodaca v. Raemisch, 139 S. Ct. 5, 9 (2018) (Sotomayor, J., statement).

191. *See* Haney, *supra* note 2, 324 (explaining that the "adverse psychological consequences" of solitary confinement intensifies the risk that a mentally ill inmate will commit suicide).

192. Perlin & Schriver, *supra* note 155, at 402.

193. *See id*.; Margo Schlanger, *Prisoners with Disabilities*, *in* REFORMING CRIMINAL JUSTICE: A REPORT OF THE ACADEMY FOR JUSTICE BRIDGING THE GAP BETWEEN SCHOLARSHIP AND REFORM 298 (Erik Luna, ed. 2017), *available at* http://academyforjustice.org/wp-content/uploads/2017/10/14_Criminal_Justice_Reform_Vol_4_Prisoners-with-Disabilities.pdf [https://perma.cc/FH6U-9QSJ] [hereinafter Schlanger, *Prisoners with Disabilities*]; *see also* Haney, *supra* note 2, at 319 (explaining that inmates with mental illness are targets of abuse and exploitation because "mental illness is interpreted as a sign of weakness").

194. *See* Kathy Swedlow, *Forced Medication of Legally Incompetent Prisoners: A Primer*, 30 HUM. RTS. 3, 3 (2003); Margaret Wilkinson Smith, *Restore, Revert, Repeat: Examining the Decompensation Cycle and the Due Process Limitations on the Treatment of Incompetent Defendants*, 71 VAND. L. REV. 319, 335 (2018) (discussing various reasons why mentally ill inmates may resist taking antipsychotic medication).

195. Lisa Pickoff-White & Julie Small, *Disability Agency Blasts Sonoma County Jail's Treatment of Mentally Ill*, KQED (May 16, 2016), https://www.kqed.org/news/10953925/sonoma-county-accused-of-involuntarily-medicating-inmates [https://perma.cc/K793-HVW7].

196. *Id*.

197. *See* Smith, *supra* note 194, at 328; ROTH, *supra* note 4, at 262 (noting that court delays in New York City disproportionately impact defendants with mental illness).

198. *See* Smith, *supra* note 194, at 322; Weinstein & Perlin, *supra* note 74, at 472 (arguing that the shuttle process violates defendants' Constitutional right to continuity of care).

199. *See, e.g*., SLATE, ET AL., *supra* note 89, at 326; Weinstein & Perlin, *supra* note 74, at 472 (arguing that the shuttle process violates defendants' Constitutional right to continuity of care).

200. *See* Ben Hattem, *How New York's Mentally Ill Get Lost in Courts, Jails and Hospitals*, AL JAZEERA (July 27, 2015, 5:30 AM), http://america.aljazeera.com/articles/2015/7/27/ny-mentally-ill-get-lost-in-the-justice-system.html [https://perma.cc/9FJF-HSZF].

One analysis of two Florida counties found that nearly twenty percent of restored defendants shuttle back to the hospital for treatment after decompensating in jail.[201] Likewise, as many as two thirds of all defendants court-ordered for restoration services in New York ride the merry-go-round from treatment to jail and back again multiple times on one charge; one defendant hitched a ride for seven rounds during the course of one case.[202]

C. JAIL-BASED COMPETENCE RESTORATION: AN ENTICING BUT MISGUIDED ALTERNATIVE

Amid pressure to reduce the IST logjam, officials in Allegheny County, Pennsylvania recently proposed spending $640,000 to create a jail-based competency restoration program in the county jail.[203] Pennsylvania's response mirrors that of other jurisdictions where forensic hospital beds are scarce, the number of IST detainees is overwhelming, and the threat of litigation looms.[204] Within the emerging discussion of alternatives to traditional inpatient competence restoration treatment,[205] jail-based competence restoration (JBCR) is gaining traction.[206] Proponents characterize JBCR as a saving-grace for the criminal justice system, IST defendants, and the taxpaying public.[207] The shortcomings inherent in the model itself, however, render JBCR a chimera.

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201. *See* Smith, *supra* note 194, at 329.

202. *See* Ben Hattem, *supra* note 200.

203. Shelly Bradbury, *Allegheny County Looks Closer to Home for Jail Mental Health Care Amid Long Waits at State Hospitals*, PITT. POST-GAZETTE (Aug. 10, 2018, 6:45 PM), https://www.post-gazette.com/news/crime-courts/2018/08/10/Allegheny-County-jail-local-competency-mental-aclu-torrance-lawsuit/stories/201808100167 [https://perma.cc/GD53-KW8C].

204. *See* Felthous & Bloom, *supra* note 141, at 366 (explaining the main reasons that jurisdictions have turned to jail restoration include wait-lists for scarce hospital beds and the high cost of forensic psychiatric hospitalization).

205. Potential reforms include creating more bed space at psychiatric hospitals, modifying hospital admissions processes and wait-lists, and creating outpatient restoration programs. *See, e.g.*, WIK, ET AL., *supra* note 47, at 8; Felthous & Bloom, *supra* note 141, at 366.

206. *See, e.g.*, AMANDA WIK, ALTERNATIVES TO INPATIENT COMPETENCY RESTORATION PROGRAMS: JAIL-BASED COMPETENCY RESTORATION PROGRAMS 1 (2018) [hereinafter WIK, JAIL-BASED PROGRAMS]; Graham S. Danzer, et al., *Competency Restoration for Adult Defendants in Different Treatment Environments*, 47 J. AM. ACAD. PSYCHIATRY L. ONLINE 1, 7 (2019), *available at* http://jaapl.org/content/early/2019/02/08/JAAPL.003819-19 [https://perma.cc/7PR5-TBCA] (explaining growing interest in jail-based restoration "due to concerns about the high cost of hospitalization, the higher risk of attempting restoration in the community, and jail-based competency programs' reporting of noteworthy rates of restoration"); Jerry L. Jennings & James D. Bell, *The "ROC" Model: Psychiatric Evaluation, Stabilization and Restoration of Competency in a Jail Setting, in* MENTAL ILLNESSES - EVALUATION, TREATMENTS AND IMPLICATION 75–87 (Luciano L'Abate, ed., 2012) (discussing origins and advantages of "ROC" model of jail-based competency restoration).

207. *See* Wendelyn Pekich, *The Road to an Effective RTC Program*, CORRECTIONS FORUM 40 (2013), *available at* http://www.wexfordhealth.com/media/pdf/47_2013-0910_CORR_FORUM_The_Road_to_an_Effective_RTC_Program.pdf [https://perma.cc/FS2J-F9PY] ("Clearly, the idea of jail-based Restoration to Competency is an idea whose time has come.").

1. EMERGING JAIL-BASED COMPETENCE RESTORATION PROGRAMS

The first JBCR program was established in 1997 at the Riverside Regional Jail in Prince George County, Virginia.[208] As of 2018, at least thirteen states had jail restoration programs in operation or development, including Arizona, Arkansas, California, Colorado, Florida, Georgia, Louisiana, New York, Tennessee, Texas, Utah, Virginia, and Wisconsin.[209] The structure of JBCR programs vary widely depending on resources available to the jail. Indeed, there is no national consensus over what services a JBCR program need provide and to what extent JBCR should emulate hospital treatment.[210] Generally, though, there are three jail-based models.[211] One is a full-scale program, whereby IST defendants are detained in jail until they regain competency or are found unrestorable.[212] In a time-limited program, jails provide restoration services to IST defendants as they wait to be transferred to inpatient treatment at a psychiatric hospital.[213] Lastly, JBCR may operate as a "screening" program to stabilize IST defendants to the point where they could qualify for outpatient restoration services.[214]

Many JBCR programs are limited to certain IST defendants. For example, Colorado created a jail-based program in 2013 for non-dangerous defendants who voluntarily take their medications and do not have serious medical conditions.[215] Similarly, to be eligible for JBCR in Georgia, a defendant must not have a history of violent or aggressive behavior, a serious medical condition, or more than a mild to moderate intellectual impairment.[216] Oftentimes, a defendant who cannot be restored in jail within a certain period of time is transferred to a state hospital for more intensive restoration services.[217] Ideally, IST inmates in JBCR programs are housed in a separate and therapeutic "pod" in the jail where they meet with mental health practitioners on a regular basis.[218] Where resources are tight, however, like at the Pima County Jail in Tucson, IST inmates may be housed in the general population, administrative segregation, or in a mental

208. *See* WIK, JAIL-BASED PROGRAMS, *supra* note 206, at 7; Jennings & Bell, *supra* note 206, at 81.

209. *See* ALEXIS LEE WATTS, ROBINA INSTITUTE OF CRIM. L. AND CRIM. JUSTICE, CLOSING THE "GAP" BETWEEN COMPETENCY AND COMMITMENT IN MINNESOTA: IDEAS FROM NATIONAL STANDARDS AND PRACTICES IN OTHER STATES 20 (2018); WIK, JAIL-BASED PROGRAMS, *supra* note 206, at 3–9.

210. Felthous & Bloom, *supra* note 141, at 369.

211. *See* WIK, JAIL-BASED PROGRAMS *supra* note 206, at 2–3; Gowensmith, et al., *supra* note 48, at 298.

212. WIK, JAIL-BASED PROGRAMS *supra* note 206, at 2.

213. *Id.*

214. *See* Gowensmith, et al., *supra* note 48, at 298; *see also* Brian D. Shannon, *Competency, Ethics, and Morality*, 49 TEX. TECH L. REV. 861, 877 (2017) (describing a "hybrid" between jail and outpatient restoration where a jail would provide antipsychotic medication and a community-based program would provide competency education).

215. WIK, JAIL-BASED PROGRAMS, *supra* note 206, at 5.

216. *Id.* at 6.

217. In California, for example, a defendant is sent to the state psychiatric hospital if unrestored after seventy days. *Id.* at 4.

218. *See* Jennings & Bell, *supra* note 206, at 77.

health unit.[219] Mental health practitioners provide services to IST inmates in any of these locations.[220]

Jurisdictions that have implemented JBCR programs report shorter wait-lists for jail-to-hospital transfer and a significant reduction in forensic health care costs.[221] When the jail restoration pilot program was developed in Virginia, for example, it cost an average of $776 per day to treat an inmate at the maximum security forensic hospital, compared to $70 per day to detain an inmate in a regional jail.[222] More recently, the first nine months of a JBCR program in San Bernardino saved approximately $200,000 for the county and $1.2 million for the state of California.[223] A report from the Legislative Analyst's Office estimated that providing treatment in the jail restoration program saved approximately $70,000 per IST defendant.[224] A benefit-cost analysis of a proposed JBCR program in Travis, County, Texas found that the program would save the state over one million dollars.[225]

Proponents insist the benefits of JBCR extend beyond government coffers to IST defendants themselves. First, pre-trial detention in jail allows defendants to remain near their home communities instead of being transported to distant psychiatric hospitals.[226] Proximity facilitates access to legal counsel and family support, which can have "substantial therapeutic benefits."[227] Local restoration also eases the burden of transporting defendants between remote state hospitals and court, preserving resources and providing defendants a more "seamless transition" from restoration to adjudication.[228] Lastly, jails that are located in more populous areas than state hospitals might attract mental health clinicians with higher qualifications.[229]

According to JBCR proponents, the unique features of a correctional setting enhance, rather than hinder, the restoration process. One corporation that contracts with local jails to implement and maintain JBCR programs extolls the

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219. *See* Reena Kapoor, *Commentary: Jail-Based Competency Restoration*, 39 J. AM. ACAD. PSYCHIATRY L. 311, 312 (2011).

220. *Id*.

221. *See id*. at 314 ("[I]n the real world of budget cuts and hospital closures, it is easy to see why some states regard this as a legitimate option.").

222. *See* Jennings & Bell, *supra* note 206, at 77; *see also* WIK, JAIL-BASED PROGRAMS *supra* note 206, at 9 (acknowledging the difficulty of making cross-jurisdictional comparisons because calculations in each jurisdiction involve different factors).

223. *See* MAC TAYLOR, AN ALTERNATIVE APPROACH: TREATING THE INCOMPETENT TO STAND TRIAL 12 (2012), *available at* http://www.lao.ca.gov/reports/2012/hlth/ist/incompetent-stand-trial-010312.pdf [https://perma.cc/NC2G-JQCR].

224. *Id*.

225. *See* KRYSTAL MULLER, A BENEFIT-COST ANALYSIS OF JAIL-BASED COMPETENCY RESTORATION SERVICES IN TRAVIS COUNTY, TEXAS 55 (2018).

226. *See* Jennings & Bell, *supra* note 206, at 77.

227. *See* Pekich, *supra* note 207, at 40.

228. Jennings & Bell, *supra* note 206, at 77–78; *see also* Felthous & Bloom, *supra* note 141, at 367.

229. *See* Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921, 948 (1985) [hereinafter Winick, *Restructuring*].

benefit of having correctional officers work in conjunction with mental health staff to "handle unruly detainees," and "minimize[] the chances of detainees acting out."[230] Further, mental health professionals point out that "the increased supervision, monitoring, and relative discomfort" of jail restoration reduces incentives for defendants to malinger.[231]

2. IRREMEDIABLE DEFECTS OUTWEIGH POTENTIAL BENEFITS

More critical views of JBCR range from trepidation to scathing critique.[232] The general conclusion among mental health professionals and disability rights advocates that jails are not suited for mental health treatment, however, is essentially unanimous.[233] JBCR programs are problematic because (1) jails are designed for punishment; (2) the vast majority of jails are starved for resources; (3) it is unclear what legal standard would govern forced medication of IST inmates in JBCR programs; (4) conflicts of interest raise thorny ethical questions for the actors involved; and (5) detention is unnecessary to reduce malingering. The shortcomings of competence restoration in facilities designed for punishment outweigh the purported benefits because they inhere in the jail itself—they are irremediable. The JBCR program in Maricopa County Jail is an illustrative example.

No amount of tinkering with the therapeutic milieu could assuage the "inherent tension between the security mission of jails . . . and mental health care."[234] By design, correctional facilities are "interpersonally fragmented, physically divided, and procedurally overcontrolled."[235] This structure inhibits meaningful contact between treatment providers and inmates, compromising clinicians' ability to assess and respond to their patients' complex mental health needs.[236] Further, correctional facilities generate a culture of "machismo, toughness, gang affiliation,

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230. Pekich, *supra* note 207, at 40.

231. *See* Danzer, et al., *supra* note 206, at 8; Felthous & Bloom, *supra* note 141, at 367.

232. *See, e.g.*, Kapoor, *supra* note 219, at 314 (concluding that until long-term efficiency and viability of jail-based restoration programs are assessed, they offer "a compromise between the idealists and the realists"); *Expanding Jail-Based Competency Restoration Takes Us Farther Off Course*, THE EQUITAS PROJECT (Feb. 12, 2018), https://www.equitasproject.org/2018/02/12/expanding-jail-based-competency-restoration-takes-us-farther-off-course/ [https://perma.cc/BN39-XFPZ] ("Being held in distinctly non-therapeutic jail cells causes an already ill inmate's mental health condition to deteriorate further, and they run an elevated risk of being victimized or committing suicide.").

233. *See e.g.* Lamb & Weinberger, *Shift, supra* note 108, at 532 (asserting that "the corrections milieu is limited in its ability to be therapeutic"); Terry A. Kupers, *Mental Health Jails: A Foolhardy Solution for a Huge Problem*, PSYCHOLOGY TODAY (Dec. 9, 2017), https://www.psychologytoday.com/us/blog/prisons-and-prisms/201712/mental-health-jails [https://perma.cc/H4C5-YQL9] (arguing against the construction of special mental health units in jails because "the culture of punishment that prevails in jails is not an appropriate setting for mental health treatment"); Haney, *supra* note 2, at 311 (arguing that prisons "are the very antithesis of a treatment-oriented milieu that promotes openness, caring, and mutual concern").

234. ROTH, *supra* note 4, at 30 (quoting attorney Jamie Fellner).

235. Haney, *supra* note 2, at 317.

236. *See id.* (arguing that mental health clinicians work under correctional facility norms that are "outwardly hostile" to sensitive mental health care).

and pecking order," which interferes with mental health treatment and perpetuates abuse of inmates with mental illness.[237]

Dehumanizing by their very nature, most jails are also woefully underresourced. Despite a growing demand for mental health care, there remain too few counselors, therapists, psychologists, and psychiatrists providing essential services in jails across the country.[238] Correctional officers who interact daily with seriously mentally ill inmates lack specialized training and may not take mental illness seriously.[239] The Bureau of Justice Statistics found that only one in six jail inmates with mental health needs had received any mental health treatment since admission.[240] Adding competence restoration responsibilities could overburden thinly spread mental health professionals, to the detriment of other inmates in desperate need of mental health care.[241] Without sufficient resources, there is a grave risk that competence restoration treatment will devolve into haphazard crisis management or even gross neglect.[242] In a JBCR program in Louisiana, for example, IST inmates see mental health practitioners just once or twice per month for restoration services.[243] Data suggesting that JBCR costs less than inpatient treatment should raise a red flag; scantier bills "most surely reflect[] on the quality" of restoration services provided.[244]

The administration of psychotropic medication in JBCR is a vexing issue. In *Washington v. Harper*, the Supreme Court held that forced medication in prison may be justified if the inmate poses a danger to himself or others.[245] In *Riggins v. Nevada*, the Supreme Court held that pretrial jail detainees could also be medicated against their will if the government demonstrated that medication was medically appropriate and essential to protect the inmate's safety or the safety of

237. *See* Kapoor, *supra* note 219, at 313.

238. Felthous & Bloom, *supra* note 141, at 369; *see also* DISABILITY RIGHTS WASHINGTON, *supra* note 155, at 7 (review of eight Washington jails found that no jail had sufficient mental health treatment resources or professionals to meet the unique needs of IST inmates).

239. *See, e.g.*, HUMAN RIGHTS WATCH, *supra* note 16, at 76–78 (2003); Bandy X. Lee; Maya Prabhu, *A Reflection on the Madness in Prisons*, 26 STAN. L. & POL'Y REV. 253, 255 (2015) (explaining that some correctional officers do not take mental illness symptoms seriously); Haney, *supra* note 2, at 318 (explaining that correctional officers are not recruited to care for vulnerable mentally ill inmates and receive little training to remedy this disconnect).

240. The most common type of treatment inmates received was taking prescribed medication for a mental problem. JAMES & GLAZE, *supra* note 181, at 9.

241. Another concern is that mental health professionals will prioritize treating inmates presently in jail and neglect their responsibility to ensure continuity of treatment upon inmates' release. *See* Felthous & Bloom, *supra* note 141, at 369.

242. *See* Smith, *supra* note 194, at 333–34; Danzer, et al., *supra* note 206, at 8 (explaining that insufficient resources reduce the likelihood that jails could offer competence restoration services on par with hospitals).

243. Kapoor, *supra* note 219, at 312.

244. Felthous & Bloom, *supra* note 141, at 370 (explaining that the cost of competency restoration in public psychiatric hospitals reflects the cost of "deliver[ing] proper mental health services).

245. 494 U.S. at 227 ("[T]he Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.").

others.[246] The Supreme Court has further found that non-dangerous IST defendants may be medicated for the sole purpose of competence restoration if the government demonstrates (1) an important interest in medication; (2) that medication will significantly further that interest; (3) that medication is necessary to further that interest; and (4) that administration of drugs is medically appropriate.[247] These factors, enumerated in *Sell v. United States*, have primarily applied to forced medication in state hospitals.[248] The petitioner Charles Sell was himself detained in a Federal Medical Center.[249]

It remains uncertain what standard for forced medication would apply in a JBCR program, as the Supreme Court has not squarely addressed what constitutes a medically appropriate setting for involuntary medication.[250] Psychiatrists Alan Felthous and Joseph Bloom contend that the *Sell* test is most applicable to JBCR because it bears directly on a defendant's competency to stand trial.[251] At the same time, they caution that most jails do not have adequate staff and facilities to forcibly medicate pre-trial detainees "in accordance with professional standards."[252] On the other hand, if the correctional-specific *Harper* standard applies, jail staff may resort to forcible medication "too freely" for purportedly dangerous defendants, without scrutinizing less-invasive safety measures.[253] Forced medication in jail is disturbing under either standard because jails are "inherently coercive" and lack the therapeutic support provided to patients in a hospital setting.[254] Additionally, as described above, the side effects of antipsychotic medication could render IST inmates targets of abuse in jail.[255] The Supreme Court reiterated in *Sell* that defendants have "a constitutionally protected liberty 'interest in avoiding involuntary administration of antipsychotic drugs,'"[256] yet forced medication in a JBCR program constitutes an intrusion on an IST patient's liberty that the Supreme Court has yet to contemplate.

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246. 504 U.S. 127, 135 (1992).

247. Sell v. United States, 539 U.S. 166, 179–81 (2003) (predicting that forced medication to restore competence may occur in "rare" instances).

248. Danzer, et al., *supra* note 206, at 6.

249. *Sell*, 539 U.S. at 170–71.

250. SLATE, ET AL., *supra* note 89, at 329; Alan R. Felthous, *Enforced Medication in Jails and Prisons: The New Asylums*, 8 ALB. GOV'T L. REV. 563, 608–09 (2015) (explaining that the Supreme Court has consistently held that involuntary medication must be medically appropriate, but has not "explicitly address[ed] the nature of the facility in which enforced medication should take place").

251. *See* Felthous & Bloom, *supra* note 141, at 370.

252. *Id.*

253. *See id.*

254. *Id.* at 368 (citing Michael A. Norko, Craig G. Burns & Charles Dike, *Hospitalization*, *in* OXFORD TEXTBOOK OF CORRECTIONAL PSYCHIATRY 141–45 (Robert L. Trestman, Kenneth L. Appelbaum & Jeffrey L. Metzner eds., 2015)); *see also* Perlin & Schriver, *supra* note 155, at 398–403 (discussing forced medication to restore defendants' competence through the lens of therapeutic jurisprudence).

255. *See* discussion *supra*, Part II.B.

256. *Sell*, 539 U.S. at 178 (quoting *Riggins*, 504 U.S. at 134); *see also* Washington v. Harper, 494 U.S. 210, 237–38 (1990) (Stevens, J., dissenting) (arguing that respondent has both a physical and intellectual liberty interest in rejecting "the unwanted administration of antipsychotic drugs").

Conflicts of interest arising in correctional mental health care raise more thorny questions for JBCR. As "guests in the house of corrections," mental health practitioners in jails and prisons are mired in an ethical quagmire.[257] First, treatment providers must cede authority to correctional facility administrators and abide by restrictive facility rules, sometimes at the cost of providing satisfactory care.[258] Social Psychologist Craig Haney explains that even the most devoted mental health staff collide with "punitive prison norms, counter-therapeutically structured environments, and long-standing correctional practices" that undermine their efforts to provide care.[259] For example, treatment providers may feel pressured to engage in custodial activities that undermine an IST patient's mental health, like testifying in a disciplinary hearing that results in their patient's placement in solitary confinement.[260]

Relatedly, psychiatrist and legal scholar Reena Kapoor identifies the conflict arising when competency evaluators and treatment provides are not sufficiently separated.[261] In jail restoration programs, the evaluator who sends her conclusion to court will likely be part of the jail mental health staff, compromising her objectivity.[262] That evaluator may be unduly influenced by the jail's available mental health resources—or lack thereof—in making recommendations.[263] Lastly, if treatment providers are private contractors, they have an inherent incentive to increase their bottom lines by retaining IST patients for as long as possible, while providing the bare minimum of services.[264]

Concerns about malingering are a poor justification for detaining IST defendants in jail, because actual incidents of malingering are quite rare.[265] Research indicates that only eight to seventeen percent of pretrial defendants attempt

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257. Metzner & Fellner, *supra* note 180, at 104, 107 (explaining that physicians in prisons face an ethical quandary arising from "substandard working conditions, dual loyalties to patients and employers, and the tension between reasonable medical practices and the prison rules and culture"); Ron Bonner & Leon D. VandeCreek, *Ethical Decision Making For Correctional Mental Health Providers*, 33 CRIM. J. AND BEHAVIOR 4, 542 (2006) (identifying the ethical challenge of balancing inmates' mental health care "with the control, security, and paramilitary structure of the correctional system").

258. *See* HUMAN RIGHTS WATCH, *supra* note 16, at 27, 63; Ben-Moshe, *Not "The New Asylums," supra* note 94, at 283 (explaining that security trumps treatment in correctional facilities because medical staff are below correctional personnel in the prison hierarchy).

259. *See* Haney, *supra* note 2, at 313.

260. *See* Bonner & VandeCreek, *supra* note 257, at 546.

261. *See* Kapoor, *supra* note 219, at 312–13.

262. *Id.*

263. *See* Haney, *supra* note 2, at 317 (explaining that clinical decisionmakers face "built-in conflicts of interest" in the resource-scarce prison context).

264. *See, e.g.*, Anasseril E. Daniel, *Care of the Mentally Ill in Prisons: Challenges and Solutions*, 35 J. AM. ACAD. PSYCHIATRY L. 406, 407 (2007) (explaining that private contractors have a "profit motive" to pursue the least expensive treatment options, "potentially jeopardizing patient care"); HOGG FOUNDATION FOR MENTAL HEALTH, ISSUE BRIEF, RESTORATION OF COMPETENCY TO STAND TRIAL (2013), *available at* http://utw10282.utweb.utexas.edu/wp-content/uploads/2015/09/Competency-Restoration-Brief.pdf [https://perma.cc/G74E-8SLV] (explaining that private JBCR providers have an incentive to hold defendants in jail for longer than necessary because their compensation is based on defendants' total days in jail).

265. *See* SLATE, ET AL., *supra* note 89, at 328.

malingering; even fewer are actually successful.[266] Most defendants would prefer to deal with their charges expeditiously than spend months in jail awaiting treatment.[267] A more pressing concern cuts the other direction: inmates suffering from symptoms of mental illness may be more reluctant to seek health care for fear that self-identification would render them targets of derision and abuse by other inmates or correctional officers.[268]

The "Restoration to Competency" (RTC) program at Maricopa County Jail is but one example of a jail restoration experiment gone awry.[269] Until 2003, IST defendants in Maricopa County were transferred to the state hospital for restoration, at the cost of $670 per day.[270] When the state legislature shifted the cost of restoration treatment to counties, the Maricopa County Board of Supervisors elected to lessen the fiscal blow by restoring IST defendants in the county jail instead.[271] One year after implementing the jail-based program, the county's restoration expenditures decreased from over seven million dollars to less than three million dollars.[272]

Yet to say the RTC program fell short of expectations is a gross understatement. Former staff psychologist Gary Freitas outlined the RTC's flagrant deficiencies in an open letter in 2016.[273] He described futile attempts to provide mental health care to inmates, separated by cell doors and thick windows, or surrounded by onlookers in jail common areas.[274] Though medication is a primary component of competence restoration, the RTC program lacks a single psychiatrist to write prescriptions.[275] "There is no in-patient mental health care," he deplored, "only varying degrees of confinement."[276] Eric Balaban, ACLU's senior staff counsel in ongoing litigation over constitutionally-deficient health care in Maricopa County jails, condemns the setting of RTC as "an absolutely brutalizing environment."[277] IST inmates in the RTC program are "among the most seriously mentally ill prisoners in the jail's population," and yet, according to a

266. *Id*.
267. *Id*.
268. *See* Haney, *supra* note 2, at 319 (describing "strong disincentives" to self-report mental illness symptoms in prison).
269. *See* Michael Kiefer, *This Program for Mentally Ill Defendants Mostly Focuses on Declaring Them Fit for Trial*, AZCENTRAL, https://www.azcentral.com/in-depth/news/local/arizona-investigations/2018/12/11/restoration-competency-jail-program-defendants-mental-illness-maricopa-county-superior-court/712133002/ [https://perma.cc/LX75-NT69] (last visited Feb. 22, 2019).
270. *Id*.
271. *Id*.
272. *Id*.
273. *Id*.
274. *See* Kiefer, *supra*, note 269.
275. *Id*.
276. *Id*.
277. *Id*.

court filing, many end up "warehoused . . . in the most punitive housing units . . . living in their own squalor, and growing more symptomatic by the day."[278]

III. ARGUMENT FOR THE MOST INTEGRATED SETTING

A. THE AMERICANS WITH DISABILITIES ACT AND *OLMSTEAD V. L.C.*

The enactment of the Americans with Disabilities Act (ADA) in 1990 marked a watershed moment in the disability rights movement.[279] When President George H.W. Bush signed the bill into law, he hailed the legislation's potential to "ensure that people with disabilities are given the basic guarantees for which they have worked so long and so hard: independence, freedom of choice, control of their lives, the opportunity to blend fully and equally into the rich mosaic of the American mainstream."[280] Unlike discrimination based on race, sex, national origin, religion, or age, individuals subject to disability-based discrimination previously had no legal recourse to seek redress.[281]

The ADA was the culminating achievement of decades of grassroots organizing efforts by disability and civil rights advocates, who staged rallies, participated in direct actions, collected oral histories documenting discrimination, and lobbied members of Congress for reform.[282] Individuals with disabilities delivered moving testimonies on the Hill during ADA Congressional hearings, raising public consciousness about "the severe prejudice and disability discrimination" that permeated all facets of society.[283]

Congress internalized the advocates' message. The ADA findings acknowledge that throughout history, "society has tended to isolate and segregate individuals with disabilities," and that discrimination remained "a serious and pervasive social problem."[284] The legislative history reflects a similar recognition that segregating people with disabilities operates as a pernicious mode of discrimination

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278. Plaintiffs' Mot. to Enforce Fourth Amended Judgment and for Additional Relief, Fred Graves, et al. v. Joseph Arpaio, et al., No. CV 77-479-PHX-NVW (D. Ariz. 2016), at 1, 9.

279. *See, e.g.*, Laura L. Rovner, *Disability, Equality, and Identity*, 55 ALA. L. REV. 1043, 1044 (2004) (explaining that the ADA adopted a "socio-political model of disability" and guaranteed substantive rights to disabled people).

280. *The Americans with Disabilities Act of 1990 – ADA*, OLMSTEAD RIGHTS (last visited Feb. 25, 2019), https://www.olmsteadrights.org/about-olmstead/item.6460-The_Americans_with_Disabilities_Act_of_1990_ADA [https://perma.cc/C6NA-EZJH].

281. 42 U.S.C. § 12101(a)(4).

282. *See The Americans with Disabilities Act of 1990 – ADA*, *supra* note 280; Am. Assoc. of People with Disabilities, *Ed Roberts, the Disability Rights Movement and the ADA*, GOOGLE ARTS & CULTURE (last visited Feb. 25, 2019), https://artsandculture.google.com/exhibit/VwLy4PBo_Ty9Jg [https://perma.cc/MX45-QHVW].

283. *See* Timothy Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 408; Hon. Donovan W. Frank & Lisa L. Beane, *How the ADA Was Passed*, 62 THE FED. LAWYER 65 (2015), *available at* http://www.fedbar.org/Resources_1/Federal-Lawyer-Magazine/2015/June/Features/How-the-ADA-Was-Passed.aspx?FT=.pdf [https://perma.cc/FA9Y-7GJM].

284. 42 U.S.C.A. § 12101(a)(2).

and perpetuates negative stereotypes about those who are segregated.[285] In passing the ADA, Congress declared an unambiguous policy goal: "to provide individuals with disabilities opportunities to live their lives like individuals without disabilities."[286] The ADA is often described as the "Emancipation Proclamation for those with disabilities" because of its two main statutory purposes.[287] First, it establishes "a clear and comprehensive national mandate" to eliminate all forms of discrimination against individuals with disabilities, including segregation.[288] Second, it provides the tools to do so, through "clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities."[289]

The statute characterizes individuals with disabilities as a "discrete and insular minority," placing the burden on the Government to prove that policies that discriminate against individuals with disabilities are narrowly tailored to serve a compelling government interest.[290] Invoking "footnote 4" of *United States v. Carolene Products*[291] reflects Congress' recognition that historical discrimination against individuals with disabilities is as invidious as racial discrimination.[292] Both are systemic and can only be ameliorated through structural change.[293] Congress explicitly identified "segregation," and "institutionalization" as distinct forms of discrimination.[294] As Congressman Miller explained, "it has been our unwillingness to see all people with disabilities that has been the greatest barrier to full and meaningful equality. Society has made them invisible by shutting them away in segregated facilities. . . ."[295] Fully integrating individuals with disabilities into community settings is thus "fundamental to the purposes of the ADA."[296]

Title II of the ADA prohibits disability-based discrimination by state and local government entities and pertains to institutionalized individuals. It states, "no qualified individual with a disability shall, by reason of such disability, be

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285. *See* Cook, *supra* note 283, at 398 (explaining that the legislative history indicates Congress' intention to eradicate "the vestiges" of this historical regime).

286. U.S. DEP'T OF JUSTICE, CIVIL RIGHTS DIVISION, STATEMENT OF THE DEPARTMENT OF JUSTICE ON ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND *OLMSTEAD V. L.C.* (2011), *available at* https://www.ada.gov/olmstead/q&a_olmstead.htm [https://perma.cc/3SWN-23YM] [hereinafter CIVIL RIGHTS DIVISION, STATEMENT]; PERLIN, THE HIDDEN PREJUDICE 175 (2003) [hereinafter PERLIN, HIDDEN PREJUDICE].

287. *See* PERLIN, HIDDEN PREJUDICE, *supra* note 286, at 175 (quoting Americans With Disabilities Act of 1990: Summary and Analysis, Special Supplement (BNA), at S-5); Cook, *supra* note 283, at 417.

288. Cook, *supra* note 283, at 417 (quoting 42 U.S.C.A § 12101(b)(1)).

289. *Id*. (quoting 42 U.S.C.A. § 12101(b)(2)).

290. *See* PERLIN, HIDDEN PREJUDICE, *supra* note 286, at 175–76; Cook, *supra* note 283, at 397, 434 (explaining that the ADA makes "classifications that segregate persons with disabilities . . . presumptively illegal").

291. *See* United States v. Carolene Products Co., 304 US 144, 152 n.4 (1938).

292. Cook, *supra* note 283, at 410.

293. *See* Fischer, *supra* note 110, at 177 (2005).

294. Cook, *supra* note 283, at 419 (quoting 42 U.S.C.A. §§ 12101(a)(2),(3), (5)).

295. *Id*. at 424 (quoting 136 CONG. REC. H2447 (daily ed. May 17, 1990) (statement of Rep. Miller)).

296. *Id*.

excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[297] The ADA defines disability broadly as "a physical or mental impairment that substantially limits one or more major life activities," including "a record of such impairment" or "being regarded as having such an impairment."[298] A "qualified individual with a disability" is one who:

> [W]ith or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.[299]

The Attorney General's implementing regulations instruct public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (the "integration mandate").[300] The "most integrated setting" is one that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[301] To comply with the ADA, a public entity must "make reasonable modifications" (the "reasonable modification" requirement) to prevent disability-based discrimination, unless it demonstrates that modifications would "fundamentally alter the nature of the service, program, or activity" (the "fundamental alteration" defense).[302]

The Supreme Court's decision in *Olmstead v. L.C.* cemented the ADA as the cornerstone of disability rights. *Olmstead* was the first Supreme Court case to consider whether the "proscription of discrimination" contained in Title II of the ADA affords institutionalized persons the right to treatment in community-based settings.[303] *Olmstead* plaintiffs L.C. and E.W., both diagnosed with mental health conditions and intellectual disabilities, challenged their continued institutionalization in a Georgia state hospital.[304] They argued that Title II of the ADA entitled them to access mental health services in "the most integrated setting appropriate to [their] needs," of which the hospital was not.[305] Both women desired

297. 42 U.S.C. § 12132.

298. 42 U.S. Code § 12102(1).

299. 42 U.S.C. § 12131(2).

300. 28 C.F.R. § 35.130(d); CIVIL RIGHTS DIVISION, STATEMENT, *supra* note 286. The Title II implementing regulations "are controlling authority 'unless they are arbitrary, capricious, or manifestly contrary to the statute.'" Balaban, *Litigation Tools*, *supra* note 158, at 4 (quoting *Cohen v. City of Culver City*, 754 F.3d 690, 695 (9th Cir. 2014)).

301. CIVIL RIGHTS DIVISION, STATEMENT, *supra* note 286 (quoting 28 C.F.R. Pt. 35, App. A (2010)).

302. 28 C.F.R. § 35.130(b)(7).

303. *See* Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 587 (1999).

304. *Id*. at 593–94.

305. *See* L.C. by Zimring v. Olmstead, 138 F.3d 893, 895 (11th Cir. 1998), *aff'd in part, vacated in part, remanded sub nom.* Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999); *Olmstead*, 527 U.S. at 594.

community treatment and their treatment providers agreed that with sufficient support, they were perfectly capable of living outside of an institutional setting.[306]

The district court granted summary judgement to the plaintiffs and the Eleventh Circuit affirmed. Considering the statutory text, legislative history, and the implementing regulations promulgated by the Attorney General, the Court found that Georgia engaged in disability-based discrimination in violation of the ADA by confining L.C. and E.W. in a segregated institution when "a more integrated setting would be appropriate."[307] Community placement is an integrated treatment setting, the Court reasoned, because it fosters interaction with nondisabled persons—interaction that is permitted only "in limited circumstances" to individuals with disabilities segregated "within the walls of" state institutions.[308] Georgia's duty to make a "reasonable accommodation" to place L.C. and E.W. in a community setting aligned with the purpose of the ADA, "'to ensure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner that shunts them aside, hides, and ignores them.'"[309]

The Court rejected the notion that the State's "lack of funds" justified the plaintiffs' continued isolation, declaring that the ADA requires public entities to make additional expenditures to provide integrated services.[310] Under the ADA, the Court explained, a cost defense is only viable when the "additional expenditures would be so unreasonable" that they would "fundamentally alter" the mental health services the state provides.[311] The Court remanded the case for further findings on whether treating L.C. and E.W. in community-based care would fundamentally alter Georgia's system for providing mental health care.[312]

In a divided opinion by Justice Ginsberg, the Supreme Court affirmed the Eleventh Circuit with qualifications.[313] The Court found that Title II of the ADA required public entities to provide community-based treatment for individuals with disabilities instead of unnecessarily segregating them in institutions.[314] The Court endorsed the Department of Justice's implementing regulations characterizing "undue institutionalization" as discrimination "by reason of . . . disability."[315] "Unjustified isolation," the Court held, "is properly regarded as

306. *See Olmstead*, 527 U.S. at 593–94, 602–603; *Olmstead v. L.C. History and Current Status*, OLMSTEAD RIGHTS (last visited Feb. 25, 2019), https://www.olmsteadrights.org/about-olmstead/ [https://perma.cc/347S-BDEA].

307. *See L.C. by Zimring*, 138 F.3d at 895.

308. *Id.* at 897.

309. *Id.* at 899–900 (quoting *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1 995), *cert. denied*, 516 U.S. 813 (1995)).

310. *See id.* at 902, 905.

311. *Id.* at 905.

312. *Id.*

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

314. *See id.* at 607.

315. *See id.* at 596–98.

discrimination based on disability."[316] This holding reflects two judgments: first, needless institutionalization "perpetuates unwarranted assumptions" that people with disabilities "are incapable or unworthy of participating in community life," and second, institutional confinement severely curtails daily life activities for individuals with disabilities, "including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[317]

Yet the *Olmstead* majority also recognized public entities' obligation to maintain a range of services for individuals with diverse disabilities.[318] The Eleventh Circuit's instructions on remand were "unduly restrictive," according to the Court, because they failed to consider the state's "obligation to administer services with an even hand."[319] To evaluate whether providing community-based care would constitute a fundamental alteration of state services, lower courts must consider the cost of community-based care, the range of services provided to other individuals with disabilities, and the state's obligation to deliver services equitably.[320] Expanding community services might constitute a fundamental alteration if it impedes on the state's ability to serve other persons with disabilities.[321]

The Court further emphasized that the ADA does not mandate deinstitutionalization for all patients.[322] In particular, transition to a less restrictive setting would not be required for individuals "unable to handle or benefit from community settings" or for "patients who do not desire it."[323] The majority explained that "the reasonable assessments" of the state's own treatment professionals may inform whether institutionalized individuals "meet[] the essential eligibility requirements" for community living.[324] Even if treatment providers conclude that community placement is appropriate, the state may not impose such placement against an individual's wish.[325]

To summarize, the *Olmstead* Court found that Title II of the ADA requires public entities to provide services to a person with a mental disability in a less restrictive setting than an inpatient facility when (1) the state's treatment professionals determine that community placement is appropriate; (2) the individual affected does not oppose transfer to a more integrated setting; and (3) the state can reasonably provide community services, considering available resources and

316. *Id*. at 597.
317. *Id*. at 600–01.
318. *Olmstead*, 527 U.S. at 597.
319. *Id*.
320. *Id*.
321. *Id*. at 604.
322. *Id*.
323. *Olmstead*, 527 U.S. at 601–602.
324. *Id*. at 602.
325. *Id*.

the diverse needs of other persons with disabilities.[326] The Supreme Court remanded the case to the Eleventh Circuit to further contemplate the appropriate relief, taking into account the facilities that Georgia maintains "for the care and treatment of persons with diverse mental disabilities," and its duty to administer services equitably.[327]

If the ADA took a "sledgehammer" to the "shameful wall of exclusion" segregating individuals with disabilities from their communities,[328] the *Olmstead* decision laid the bricks to bridge the divide. The Court reaffirmed that public entities have an affirmative obligation under the ADA to provide services in a setting that is as least restrictive as practicable.[329]

Although the *Olmstead* plaintiffs were segregated in a civil institution, neither the opinion nor the ADA preclude application of the integration mandate to correctional facilities.[330] In *Pennsylvania Department of Corrections v. Yeskey*, the Supreme Court extended the ADA's protections to state prison inmates.[331] Because he suffered from hypertension, plaintiff Ronald Yeskey was denied admission to a program that could have accelerated his eligibility for parole.[332] The Supreme Court unanimously held that "no public entity" under Title II of the ADA "unmistakably" includes state prison programs.[333]

Further, Attorney General Eric Holder signed revised regulations implementing the ADA that went into effect on March 15, 2011.[334] The regulations expound upon the "integration mandate" in the prison and jail context. Specifically:

> (b)(2) Public entities shall ensure that inmates or detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals. Unless it is appropriate to make an exception, a public entity–
>
> (i) Shall not place inmates or detainees with disabilities in inappropriate security classifications because no accessible cells or beds are available; [and] . . .
>
> (iii) Shall not place inmates or detainees with disabilities in facilities that do not offer the same programs as the facilities where they would otherwise be housed. . . .[335]

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326. *Id*. at 587.

327. *See id*.

328. *Remarks of President George Bush at the Signing of the Americans with Disabilities Act*, EEOC 35TH ANNIVERSARY (last visited Feb. 25, 2019), https://www.eeoc.gov/eeoc/history/35th/videos/ada_signing_text.html [https://perma.cc/M3L9-7S64].

329. *See* Margo Schlanger, *Anti-Incarcerative Remedies for Illegal Conditions of Confinement*, 6 U. MIAMI RACE & SOC. JUST. L. REV. 1, 24 (2016) (explaining that the ADA under *Olmstead* "bolster[s] alternatives to institutions") [hereinafter Schlanger, *Remedies*].

330. Perlin, *Misdemeanor Outlaw*, *supra* note 155, at 221.

331. *See* 524 U.S. 206, 209–10 (1998).

332. *Id*. at 208.

333. *Id*. at 209–10.

334. *Revised ADA Regulations Implementing Title II and Title III* (last visited Feb. 25, 2019), https://www.ada.gov/regs2010/ADAregs2010.htm [https://perma.cc/BN8G-HAS6].

335. 28 C.F.R. § 35.152.

Courts have applied an *Olmstead* analysis to the categorical segregation of HIV-positive prison inmates from the general population,[336] a claim by the surviving spouse of an inmate who committed suicide in isolation,[337] and IST defendants stuck in jail awaiting inpatient restoration treatment.[338] One court found that a county violated the ADA by automatically placing pre-trial detainees with disabilities in a jail complex with inferior programming and services compared to those offered in other facilities housing individuals without disabilities.[339]

Scholars have persuasively argued that the ADA under *Olmstead* precludes excessive segregation of prisoners with mental illness in solitary confinement[340] and guarantees prisoners' right to continuity of care.[341] One student note contends that "reasonable modifications" include investment in mental health treatment, police training, and diversion programs to prevent the rampant criminalization of individuals with mental illness in the first place.[342]

Legal scholar Michael Perlin asserts that blanket policies mandating "confinement in maximum security facilities" for criminal defendants subject to competency evaluations violate the integration mandate.[343] To comply with *Olmstead*, he explains, judges must make individualized determinations about the location of competency evaluations based on the nature of a defendant's charge, potential dangerousness, and the necessity of institutionalization.[344]

Discriminatory segregation of individuals with mental illness does not have to be purposeful or malicious to violate the ADA under *Olmstead*; the focus is on "state resource allocation decisions."[345] When public entities provide services in

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336. *See* Jessica Knowles, *The Shameful Wall of Exclusion: How Solitary Confinement for Inmates with Mental Illness Violates the Americans with Disabilities Act*, 90 WASH. L. REV. 893, 924 (2015) (citing *Henderson v. Thomas*, 913 F. Supp. 2d 1267 (M.D. Ala. 2012) (holding that segregation in isolated housing without an individualized risk assessment violated the ADA and Rehabilitation Act)).

337. *See id*. at 925 (citing *Stiles v. Judd*, No. 8:12-cv-02375-T-27EAJ, 2013 WL 6185404 (M.D. Fla. Nov. 25, 2013) (denying motion to dismiss ADA claim because the deceased inmate had been "unjustifiably isolated from other prisoners on the basis of his mental illness")).

338. *See Geness v. Cox*, 902 F.3d 344, 362 (3rd Cir. 2018) (finding that IST defendant detained for nine years cycling in-and-out of treatment and jail "stated cognizable ADA and due process claims"); *Cooper v. Kliebert*, No. 15-751-SDD-RLB, 2016 WL 3892445, at *6 (M.D. La. July 18, 2016) (denying motion to dismiss ADA claims brought by pretrial detainees with mental disabilities who were denied "prompt transfer" from local jails to mental health facilities).

339. *See* Pierce v. Cty of Orange, 526 F.3d 1190, 1221 (9th Cir. 2008).

340. *See* Knowles, *supra* note 336, at 936; Brittany Glidden & Laura Rovner, *Requiring the State to Justify Supermax Confinement for Mentally Ill Prisoners: A Disability Discrimination Approach*, 90 DENV. U. L. REV. 55, 70 (2012).

341. Weinstein & Perlin, *supra* note 74, at 474–75 (arguing that prisoners with disabilities have the right to continuity of care if the ADA applies to both community integration and prison inmates).

342. *See* Fischer, *supra* note 110, at 160.

343. *See* Perlin, *Misdemeanor Outlaw*, *supra* note 155, at 195 (limiting his argument to misdemeanants and petty felons, as a practical first step); *see also* Perlin & Schriver, *supra* note 155, at 403 (2015) (arguing that courts must acknowledge the ADA's application to pre-trial incompetent defendants).

344. *See* Perlin, *Misdemeanor Outlaw*, *supra* note 155, at 232.

345. *See* Bagenstos, *supra* note 84, at 32.

a manner that produces the needless segregation of individuals with disabilities, the integration mandate provides a remedy: funds must be re-allocated to services that prevent segregation.[346]

The active promotion of community-based services by the United States Department of Justice is instructive on this point.[347] Settlement agreements arising from two statewide lawsuits—*U.S. v. Georgia* and *U.S. v. Delaware*—address the unnecessary institutionalization of individuals with mental illness in jail.[348] Both agreements require states to expand services that enable individuals with mental illness to thrive in the community, including multi-disciplinary Assertive Community Treatment (ACT) teams to provide ongoing support, intensive case management, peer support services, supportive housing, and supportive employment.[349] This "continuum of support" has proven effective at reducing the unjustified institutionalization of mentally ill individuals in jails.[350]

B. JAIL-BASED COMPENTENCE RESTORATION VIOLATES THE INTEGRATION MANDATE

The degree of isolation experienced by incarcerated individuals is absolute. By design, correctional institutions erase "undesirable" members of society from the public sphere and the public consciousness. Compounding the deleterious effects of extreme isolation, incarceration is maximally restrictive. Confinement in correctional institutions "entails caging or imposed physical constriction," and "minute control of prisoners' bodies and most intimate experiences."[351] Inmates with mental illness who face a greater likelihood of being locked in solitary confinement may spend twenty-three to twenty-four hours a day in a closet-sized, windowless cell, deprived of mental stimulation, human contact, and meaningful mental health care.[352]

The harm created by isolating IST defendants in correctional facilities is precisely the harm that Congress and the *Olmstead* Court intended to address:

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346. *See* Margo Schlanger, *Prisoners with Disabilities*, *supra* note 193, at 312.

347. *See id*. at 312–13; *see also* ACLU OF SOUTHERN CALIFORNIA & THE BAZELON CENTER FOR MENTAL HEALTH LAW, A WAY FORWARD: DIVERTING PEOPLE WITH MENTAL ILLNESS FROM INHUMANE AND EXPENSIVE JAILS INTO COMMUNITY-BASED TREATMENT THAT WORKS 2 (2014).

348. *See* BERNSTEIN, ET AL., *supra* note 88, at 14–15 (citing *U.S. v. Georgia*, No. 10-249 (N.D. Ga. Oct. 19, 2010); *U.S. v. Delaware*, No. 11-591 (D. Del. July 15, 2011)).

349. *See id*. at 16.

350. Schlanger, *Prisoners with Disabilities*, *supra* note 193, at 312–13 (quoting Settlement Agreement, *United States v. Delaware*, 1:11-cv-00591-LPS (D. Del. July 6, 2011), at 3, http://www.clearinghouse.net/chDocs/public/PB-DE-0003-0002.pdf); *see also* BERNSTEIN, ET AL., *supra* note 88, at 18 (noting the low arrest rate of individuals receiving Assertive Community Treatment in Georgia and Delaware).

351. McLeod, *supra* note 187, at 1184; *see also* Craig Haney, *Prison Effects of in the Age of Mass Incarceration*, THE PRISON JOURNAL 5 (2012) ("Prisoners generally have no choice over when they get up in the morning or turn their lights out, when, what, or where they eat, whether and for how long they shower or make a phone call, or how much toilet paper they are permitted in their cells.").

352. *See, e.g*., DISABILITY RIGHTS WASHINGTON, *supra* note 155, at 9 (describing a typical day in isolation in a Washington jail).

discrimination via segregation. As the Senate Report acknowledged, "[o]ne of the most debilitating forms of discrimination is segregation imposed by others," which "destroys healthy self-concepts and slowly erodes the human spirit."[353] The *Olmstead* Court re-iterated that isolating individuals with disabilities in segregated institutions, when those individuals could benefit from community placement, "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."[354]

Jail-based competency restoration programs facilitate the needless segregation of IST individuals, denying patients the benefits of restoration treatment in a more integrated setting and perpetuating negative stereotypes about mental illness. JBCR programs are unjustified because (1) many IST defendants do not need to be detained in a maximum-security facility for competence restoration, and (2) community-based restoration is a viable less restrictive alternative to JBCR. By pouring resources into jail restoration programs, public entities violate the plain text of the ADA's integration mandate and contravene the *Olmstead* decision.[355]

1. COMMUNITY RESTORATION IS APPROPRIATE FOR MANY IST DEFENDANTS

A considerable number of IST defendants can be treated in a less restrictive setting than jail. From a medical perspective, many IST defendants do not require inpatient treatment to be restored to competency.[356] The advent of antipsychotic medications in the 1950s, which facilitated deinstitutionalization, makes community treatment feasible for even the most serious mental illness.[357] Research indicates that court-mandated and monitored community treatment can be effective for defendants with chronic and severe mental illness.[358]

With regards to public safety, many IST defendants would almost certainly be eligible for pre-trial release but for exhibiting symptoms of mental illness.[359] Despite popular perceptions that most mentally ill defendants are booked into jail for violent behavior, a considerable percentage of IST defendants are charged

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353. Cook, *supra* note 283, at 410–411 (quoting SENATE COMM. ON LABOR AND HUMAN RESOURCES, REP. ON THE AMERICANS WITH DISABILITIES ACT, S. REP. NO. 116, 101ST CONG., 1ST SESS. 6, 16 (1989)).

354. 527 U.S. at 583.

355. By mandating detention for IST defendants, JBCR programs also raise Constitutional concerns. *See* Kaufman, *supra* note 152 (arguing that inpatient competency evaluation and restoration violates the Due Process and Equal Protection Clauses, and a defendant's speedy trial right); Orihuela, *supra* note 44 (arguing that competency detention violates substantive and procedural due process, as compared to pretrial detention, federal civil commitment, and commitment after verdict of not guilty by reason of insanity).

356. *See, e.g.*, Gowensmith, et al., *supra* note 48, at 295 ("Many individuals do not require an inpatient setting to be restored to competency.").

357. *See* McMahon, *supra* note 19, at 33–34.

358. H. Richard Lamb, Linda E. Weinberger & Bruce H. Gross, *Mentally Ill Persons in the Criminal Justice System: Some Perspectives*, 75 PSYCHIATRIC Q. 2, 117 (2004).

359. *See* McMahon, *supra* note 19, at 43–44 (advocating for outpatient competency restoration for IST defendants when "a similarly situated healthy defendant would be released pending trial").

with misdemeanors or non-violent felonies.[360] According to one estimate, one in five IST defendants awaiting competency restoration in jail are charged with low-level misdemeanors or petty offenses.[361] Another study found that thirty percent of defendants hospitalized for competency evaluations were charged with "disturbing the peace."[362] A recent analysis of Florida criminal cases from 2004 to 2013 found that sixty-three percent of IST defendants were charged with nonviolent offenses and many more were criminalized for mere scuffles with police.[363]

How can this be? For one, civil codes and administrative regulations have gradually fused with criminal laws, greatly expanding the tentacles of the carceral state.[364] Even mundane activity like sleeping in public or jingling a change jar on the street corner can be punished as a criminal offense.[365] Relatedly, police disproportionately arrest mentally ill people for behavior that should not fall under the purview of the criminal justice system—behavior that stems from illness, lack of treatment, lack of structure, and lack of community support.[366] Individuals with mental illness are four times more likely to be charged with minor crimes than those without mental illness.[367] A 1992 study found that the most common charges filed against defendants with mental illness include disorderly conduct and trespassing.[368] When a person acts irregularly in public, they become a prime target for police intervention.[369] One study found that a person exhibiting signs of mental illness was likely to be arrested forty-seven percent of the time, compared with twenty-eight percent of individuals in similar situations who did not exhibit these signs.[370] Even more serious criminal behavior may be an outgrowth of untreated mental illness, thus some IST defendants charged with violent crimes would not pose any public safety risk if provided adequate community support.[371] Plus, underlying criminal charges are just that—charges. Mental illness should not abrogate the presumption of innocence.

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360. Winick, *Restructuring, supra* note 229, at 941–42.

361. *See* THE EQUITAS PROJECT, *supra* note 232.

362. Winick, *Restructuring*, *supra* note 229, at 941–942.

363. *See* Michael Braga, Anthony Cormier & Leonara LaPeter Anton, *Insane. Invisible. In Danger.'Definition of Insanity,'* TAMPA BAY TIMES (Dec. 18, 2015), http://www.tampabay.com/projects/2015/investigations/florida-mental-health-hospitals/competency/ [https://perma.cc/W9JM-ZKPG].

364. Ben-Moshe, *Not "The New Asylums," supra* note 94, at 278–79; McMahon, *supra* note 19, 34–35 (explaining how the "overcriminalization of arrest" disproportionately impacts individuals exhibiting signs of mental illness).

365. *See* Ben-Moshe, *Not "The New Asylums," supra* note 94, at 278–79.

366. H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVS. 4, 485 (1998) [hereinafter Lamb & Weinberger, *A Review*].

367. SLATE, ET AL., *supra* note 89, at 45.

368. McMahon, *supra* note 19, at 35 (citing E. FULLER TORREY, ET AL., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 46 (1992)).

369. *See* SLATE, ET AL., *supra* note 89, at 44–45.

370. *Id*. at 44.

371. *See* Lamb & Weinberger, *A Review*, *supra* note 366, at 484 ("[I]t should be acknowledged that many mentally ill persons who commit serious crimes and enter the criminal justice system might not have engaged in such behavior if they had been receiving adequate and appropriate mental health treatment.").

The state has a significant interest in restoring IST defendants to competence quickly and efficiently while maintaining public safety. This is an interest in treatment, not punishment. For the vast majority of IST defendants, the state's interest in competence restoration can be effectuated (perhaps more quickly and more efficiently) in a less restrictive setting than jail.

2. COMMUNITY BASED COMPETENCE RESTORATION IS A VIABLE ALTERNATIVE

At first blush, competence restoration in psychiatric hospitals appears less restrictive than jail. The stated mission of hospitals is mental health treatment, not punishment.[372] As such, hospitals typically allow patients greater freedom of movement, access to programs, and therapy.[373] In addition to competence restoration, hospital patients receive "intensive and multi-faceted services," like medication to address other psychiatric conditions, resources to ensure adherence to treatment, rehabilitative interventions, and discharge planning.[374] In a report on conditions of confinement for IST defendants awaiting restoration, Disability Rights Washington contrasts local jails with a psychiatric hospital in Washington.[375] The hospital is fully staffed by a psychiatrist, a psychologist, a social worker, mental health technicians, and nurses.[376] IST patients receive individual and group therapy in addition to legal skills training, and those with co-occurring mental health issues or developmental disabilities may receive individualized treatment in a specialized unit.[377] Patients are free to roam around and congregate in common areas.[378] A physician's order is required for isolation or seclusion, which are used sparingly.[379]

Nevertheless, locking IST defendants in maximum-security forensic hospitals infringes deeply on their basic liberties—much like it does in jail. Hospital wards designated for forensic patients operate more like correctional facilities than hospitals: barred cells, restraints, and overuse of confinement are common.[380] A 2006 Department of Justice investigation into the Oregon State Hospital—where "One Flew Over the Cuckoo's Nest" was filmed—uncovered rampant abuse, inadequate nursing and mental health care, and excessive use of seclusion and restraint.[381] Though the hospital has since implemented sweeping reforms, a

372. Kapoor, *supra* note 219, at 311.
373. *Id*.
374. Danzer, et al., *supra* note 206, at 6.
375. DISABILITY RIGHTS WASHINGTON, *supra* note 155, at 14.
376. *Id*.
377. *Id*.
378. *Id*.
379. *Id*.
380. *See* June Resnick German & Anne C. Singer, *Punishing the Not Guilty: Hospitalization of Persons Acquitted by Reason of Insanity*, 29 RUTGERS L. REV. 1011, 1036 (1976) (describing the "prison-like" environment of state hospitals, where "abasements and degradation abound").
381. *See* Joseph D. Bloom, "*The Incarceration Revolution" : The Abandonment of the Seriously Mentally Ill to Our Jails and Prison*s, 38 J. of L., MED. & ETHICS 727, 730–31 (2010); Mac McClelland, *When 'Not Guilty'*

staggering 1,908 incidents of seclusion and restraint among 937 forensic patients were reported in 2014.[382]

Forensic units also tend to be more restrictive than civil units in the same hospitals.[383] For example, in Pennsylvania, the patients being treated in forensic units have limited privileges to make outgoing calls, receive visitors, or wear their own clothes.[384] The civil units in the same hospital offer a greater array of activities and allow patients more meaningful contact with the outside world.[385] Further, maximum-security hospitals tend to be located considerable distances from IST patients' defense attorneys, family members, and social support network.[386] Physical and social isolation hinders an IST defendant's criminal case, triggers shame and stigmatization, and could hamper treatment.[387] Finally, inpatient restoration programs are functionally unavailable to the vast majority of IST defendants logjammed in jail until a forensic bed becomes available.[388]

Community-based competence restoration (CBCR) is the least restrictive solution to the IST logjam crisis. At present, CBCR is astonishingly underutilized: only thirty-five states currently have statutes on the books allowing for outpatient restoration, and only fifteen states and the District of Columbia have functioning CBCR programs.[389] The programs vary widely in terms of size, patient composition, inclusion criteria, location of treatment, and the range of services provided, making cross-state comparisons difficult.[390] Preliminary data, however, suggests that for many IST defendants, community-based treatment is a viable alternative to restoration in institutional settings.[391]

A typical IST patient in a community-based program has been charged with a misdemeanor or nonviolent felony offense, does not have a lengthy criminal history or history of substance abuse, does not present a risk for serious violence, is

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is a Life Sentence, N.Y. TIMES (Sept. 27, 2017), https://www.nytimes.com/2017/09/27/magazine/when-not-guilty-is-a-life-sentence.html [https://perma.cc/9GKX-SY6W].

382. McClelland, *supra* note 388.

383. *See* German & Singer, *supra* note 380, at 1037.

384. Gullapalli, *supra* note 64.

385. *Id*.

386. *See* German & Singer, *supra* note 380, at 1036–37.

387. *See id*. at 1038–39 (1976) (describing the general consensus that maximum security institutions "sacrifice therapeutic standards" and "contribute to longer terms of confinement for patients caged within").

388. *See* discussion *infra*, Part I.A.

389. Community-based programs have been developed in Arkansas, California, Colorado, Connecticut, DC, Florida, Georgia, Hawaii, Louisiana, Nevada, Ohio, Oregon, Tennessee, Texas, Virginia, and Wisconsin. AMANDA WIK, ALTERNATIVES TO INPATIENT COMPETENCY RESTORATION PROGRAMS: COMMUNITY-BASED COMPETENCY RESTORATION PROGRAMS 5 (2018) [hereinafter WIK, COMMUNITY-BASED PROGRAMS]; *see also* Gowensmith, et al., *supra* note 48, at 294 (explaining that the development of outpatient competency restoration is stagnant compared to outpatient evaluations).

390. WIK, COMMUNITY-BASED PROGRAMS, *supra* note 389, at 14.

391. *See* Gowensmith, et al, *supra* note 48, at 293, 300 (concluding that community-based competency restoration programs generally achieve positive results, including substantial cost savings, high restoration rates, low program failure, maintenance of public safety, and increased inpatient bed capacity).

psychiatrically stable, and takes medications voluntarily.[392] Oftentimes, the CBCR participant is first admitted to a state hospital and screened for suitability in an outpatient program, and the local criminal court determines if the defendant meets program qualifications.[393] The community restoration program may be operated by a state agency or a private contractor, and programming might take place in an outpatient center at the state hospital, a community mental health center, or a specialized residential facility.[394] In some programs, the IST patient will receive holistic psychosocial services in addition to competence restoration treatment.[395]

The CBCR program in Wisconsin has one of the highest restoration rates in the country at seventy-nine percent.[396] Eligible participants are non-dangerous (though no crimes are per se excluded), psychiatrically stable enough for community placement, willing to actively participate in treatment, and have stable living circumstances.[397] Participants meet with treatment providers multiple times per week for one-on-one competency education sessions and case management services.[398] If at any point a participant becomes unstable, uncooperative, or poses a safety risk, they will be transferred to an inpatient facility.[399] The majority of patients in the outpatient program are restored in less than four months, at the cost of approximately three thousand dollars per client per month.[400] In comparison, the total cost per client for inpatient restoration in Wisconsin is approximately eighty to one hundred thousand dollars.[401]

CBCR has myriad advantages over jail-based programs for IST defendants who do not require treatment in an in-patient setting. In contrast to confinement, CBCR is a modest encroachment on personal liberty and poses a slighter risk of severely destabilizing defendants' lives.[402] IST defendants receiving treatment in their communities are likely to be closer to social anchors like friends and family members, and face fewer obstacles to communicate with their attorneys. They are

392. *See id*. at 297–98 (in a survey comparing community-based competency restoration programs across the country, finding that approximately half of patients were charged with misdemeanors and half were charged with nonviolent felonies).

393. *See id*. at 298 (noting that a small subset of patients are admitted directly from court or jail).

394. *See id*.

395. *See id*.

396. *See* WIK, COMMUNITY-BASED PROGRAMS, *supra* note 389, at 11; Johnson & Candilis, *supra* note 139, at 229.

397. *See* WIK, COMMUNITY-BASED PROGRAMS, *supra* note 389, at 10–11; DISABILITY RIGHTS CALIFORNIA, PLACEMENT OF INDIVIDUALS FOUND INCOMPETENT TO STAND TRIAL: A REVIEW OF COMPETENCY PROGRAMS AND RECOMMENDATIONS 24 (last visited Feb. 24, 2019), *available at* https://www.disabilityrightsca.org/system/files?file=file-attachments/CM5201.pdf [https://perma.cc/F2TX-BPKD].

398. *See* Johnson & Candilis, *supra* note 139, at 229.

399. DISABILITY RIGHTS CALIFORNIA, *supra* note 397, at 24.

400. *See id*.; WIK, COMMUNITY-BASED PROGRAMS, *supra* note 389, at 11.

401. DISABILITY RIGHTS CALIFORNIA, *supra* note 397, at 24. According to the Wisconsin Department of Health Services, the daily cost per patient in community-based restoration is $199 compared to $674 for inpatient treatment, saving a total of $41,290 per patient. Gowensmith, et al., *supra* note 48, at 299.

402. *See* Johnson & Candilis, *supra* note 139, at 230.

also less likely to be improperly medicated during the course of treatment.[403] A consistent treatment regime reduces the risk that IST defendants will decompensate shortly after restoration; a near-certainty for patients "shuttled" from the hospital back to jail without access to psychiatric services or medication.[404] Further, an IST defendant receiving comprehensive mental health services in their home community may continue receiving services from the same treatment providers after their criminal case resolves, which could reduce recidivism.[405] Lastly, the potential for successful restoration is higher when an IST defendant engages in treatment voluntarily rather than being coerced (or forcibly medicated) into treatment in a forensic facility.[406]

Jurisdictions with robust CBCR programs report high restoration rates, in short time spans, at a low cost.[407] The public health system and criminal justice system would thus benefit from implementing CBCR. One survey of forensic administrators found that the average daily cost per patient in community-based restoration programs was $215, compared to $603 for inpatient treatment.[408] The data does not suggest that community-based programs compromise public safety, likely because participants are carefully screened and placed in programs with high levels of structure and support.[409] Finally, by freeing up hospital beds for inmates with acute mental health needs, community-based treatment relieves the logjam for other defendants in jail awaiting transfer to state hospitals.[410]

The *Olmstead* Court emphasized that Title II of the ADA does not mandate deinstitutionalization.[411] In particular, the Court acknowledged that for some individuals with mental disabilities, "no placement outside the institution may

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403. *See* ROTH, *supra* note 4, at 211; Danzer, et al., *supra* note 209, at 10; 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, 1051 (2000) (advocating for community-based treatment for civilly committed patients).

404. *See* Amber Beard, *Competency Restoration in Texas Prisons: A Look at Why Jail-Based Restoration Is a Temporary Fix to a Growing Problem*, 16 TEX. TECH. ADMIN. L.J. 179, 189–90 (2014).

405. *See id*. at 189–90, 195; Gowensmith, et al., *supra* note 48, at 301 (noting low recidivism among participants in community-based restoration programs).

406. *See* Bruce J. Winick, *Reforming Incompetency to Stand Trial and Plead Guilty: A Restated Proposal and a Response to Professor Bonnie*, 85 J. CRIM. L. & CRIMINOLOGY 571, 616 (1995).

407. A review of community-based restoration programs based on available state data found that most programs restored over sixty percent of participants within half the time of inpatient programs. WIK, COMMUNITY-BASED PROGRAMS, *supra* note 389, at 15.

408. Gowensmith, et al., *supra* note 48, at 299; *see also* Johnson & Candilis, *supra* note 139, at 231 (reporting that the cost to run an outpatient program in Washington, DC is $2006 per week, compared to $6307 per week for inpatient restoration).

409. *See* Gowensmith, et al., *supra* note 48, at 301.

410. *See* Gowensmith, et al., *supra* note 48, at 301; KELLEN RUSSONIELLO, ACLU CALIFORNIA, THE TURNING POINT: GETTING ON THE ROAD TO ENDING THE OVER-INCARCERATION OF PEOPLE WITH MENTAL HEALTH AND SUBSTANCE USE NEEDS 25–27 (last visited Feb. 25, 2019), *available at* https://www.aclusandiego.org/wp-content/uploads/2018/06/The-Turning-Point-FINAL.pdf [https://perma.cc/8SCH-K8TE] (recommending that California expand community-based competency restoration options to reduce the need to send IST inmates to state hospitals).

411. 527 U.S. at 601–04.

ever be appropriate."[412] For a small subset of IST defendants, community-based restoration will not be the most integrated setting according to their treatment needs.[413] The ADA thus requires public entities to expand the availability of hospital beds and improve the quality of care in inpatient treatment facilities in conjunction with CBCR.

According to the Court, the state may rely on a "reasonable assessment of its own professionals" to assess whether a patient is eligible for community placement.[414] Crucially, placement in an inpatient facility must not be based primarily on the defendant's prior criminal history or an assessment of an IST defendant's potential dangerousness. Scholars have raised the alarm that both expert and judicial evaluations of a defendant's dangerousness are rooted in unsubstantiated fears and obscured by stereotypes.[415] Nor should prior criminal history preclude participation in community treatment, because mentally ill individuals are more likely to be arrested for minor crimes.[416] A reasonable assessment by the state's treating professional must therefore take the totality of a defendant's circumstances into account, including for example, specific symptoms, potential for treatment compliance, and co-occurring substance abuse.[417]

3. ANTICIPATING THE STATE'S FUNDAMENTAL ALTERATION DEFENSE

Public entities will surely cast CBCR programs as a fundamental alteration of restoration services. Under the ADA, the state may deny integration accommodations when the cost is so substantial, it compromises the state's obligation to provide services to other individuals with disabilities.[418] As the *Olmstead* Court made clear, this tradeoff would constitute a fundamental alteration of services.[419] In response to a prima facie discrimination case, however, the government bears

412. 527 U.S. at 584.

413. *See* Shannon, *supra* note 214, at 875 (advocating for a residential component in conjunction with outpatient restoration services, to meet the needs of individuals experiencing acute symptoms of mental illness); Barry W. Wall, *State Hospitals as "the Most Integrated Setting According to Their Needs,"* 41 J. AM. ACAD. PSYCHIATRY L. 484, 487 (2013) (asserting that improving the quality of care and increasing the number of beds in state hospitals is compatible with expanding outpatient services); Lamb & Weinberger, *Shift, supra* note 108, at 533 (advocating for the expansion of psychiatric hospital beds for "the relatively small group" of individuals with severe mental illness who need full-time, structured mental health care).

414. *Olmstead*, 527 U.S. at 602.

415. *See e.g.*, Michael L. Perlin, *Everything's a Little Upside down, as a Matter of Fact the Wheels Have Stopped: The Fraudulence of the Incompetency Evaluation Process*, 4 HOUS. J. HEALTH L. & POL'Y 239, 246 (2004) (reviewing research suggesting that an expert's analysis of a defendant's dangerousness often relies on the alleged crime); Kaufman, *supra* note 152, at 485 (noting that judicial evaluation of dangerousness is "founded on subjective impressions"); McMahon, *supra* note 19, at 29–33 (debunking two "staunchly held" myths that individuals with mental illness are more dangerous than those without, and that experts "can easily and accurately spot dangerousness in defendants"); *see also* Heller v. Doe, 509 U.S. 312, 324 (1993) ("[M]any psychiatric predictions of future violent behavior by the mentally ill are inaccurate.").

416. *See supra*, Part I.B., III.B.

417. *See* SLATE, ET AL., *supra* note 89, at 76.

418. *See* discussion *infra*, Part. III.A.

419. *See Olmstead*, 527 U.S. at 604; 28 C.F.R. § 35.130(b)(7).

a hefty burden of proving that providing services in a more integrated setting would fundamentally alter the government program.[420] The ADA requires that treatment accommodations be "specific and individualized."[421] Thus, the government must demonstrate that modifications would be unreasonable for each particular plaintiff requesting services in a more integrated setting.[422] The determination is "a fact-intensive" one, for which "there is no clear test."[423] However, courts are more likely to regard only those modifications that would impose a substantial economic burden or "radically change the essential nature" of a program as fundamental alterations.[424]

By pouring resources into JBCR, public entities are already "altering" the traditional service of providing inpatient restoration in state hospitals. This first proves that changing the setting of competence restoration does not compromise the essential nature of the service. The defining difference between institutional restoration and community-based restoration is the integrated treatment setting—the primary treatment components remain the same. Nor would the patient population of a CBCR program be fundamentally different, as many jail-based programs are already limited to non-violent defendants who are amenable to outpatient treatment.[425] The essential nature of CBCR is more like traditional inpatient restoration than a jail-based program because the underlying mission of CBCR accords with treatment in a hospital setting. The primary purpose of community-based restoration is treatment to protect an IST defendant's due process rights. In contrast, punishment supersedes therapeutic aims in jail.

Second, public entities must expend considerable resources to construct and maintain jail-based programs. If the investment of time and money required to build a JBCR program from the ground up does not constitute a fundamental alteration of traditional inpatient restoration, nor would the creation of a community restoration option. As noted, many jurisdictions with CBCR report significant cost savings compared to inpatient treatment.[426] Nor would community restoration detract from the services provided to other individuals with disabilities. On the contrary, CBCR will free up precious hospital bed space for the

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420. *See* Knowles, *supra* note 336, at 919 (explaining that a correctional facility must offer "detailed and legitimate justifications" to prevail over "the ADA's presumption of integration"); Glidden & Rovner, *supra* note 340, at 69.

421. Glidden & Rovner, *supra* note 340, at 69; Schlanger, *Prisoners with Disabilities*, *supra* note 193, at 305 (explaining that the "reasonable modification" under Title II of the ADA requires a high degree of individualization) (citing Wright v. N.Y. St. Dep't of Corr., 831 F.3d 64, 78 (2d Cir. 2016) ("Title II of the ADA, therefore, requires that once a disabled prisoner requests a non-frivolous accommodation, the accommodation should not be denied without an individualized inquiry into its reasonableness.")).

422. Glidden & Rovner, *supra* note 340, at 69.

423. *See* Jefferson D.E. Smith & Steve P. Calandrillo, *Forward to Fundamental Alteration: Addressing ADA Title II Integration Lawsuits After Olmstead v. L.C.*, 24 HARV. J.L. & PUB. POL'Y 695, 726 (2001).

424. *See id.* at 768–69.

425. *See* discussion *infra*, Part II.C.1.

426. *See* Gowensmith, et al., *supra* note 48, at 299; WIK, COMMUNITY-BASED PROGRAMS, *supra* note 389, at 14.

small subset of forensic patients who require inpatient care, alleviating the logjam crisis. Moreover, a well-run community-based program that reduces recidivism would save local governments untold future resources. These resources could be reinvested in prevention or diversion programs to better address the root of the logjam crisis.

Finally, an analysis of whether CBCR programs constitute a fundamental alteration of the competence restoration process must not overlook the reality that individuals with mental illness are substantially burdened by systemic subordination and ableism.[427] Many IST defendants are victims of public prejudice against mental illness and neoliberal social policies that have allowed the criminal justice system to eclipse the mental health system.[428] In this regard, CBCR is not an unreasonable accommodation; it is only a minor remedy for rectifying the broader "structural hostility and inaccessibility" that facilitates mentally ill people's involvement in the criminal justice system to begin with.[429]

If state and local governments have an interest in allocating resources wisely, preserving public safety, maintaining the integrity of the criminal justice system, and addressing structural discrimination against individuals with mental illness, expanding CBCR for qualified patients is a reasonable and necessary modification.

IV. A PRISON ABOLITION ETHIC SUPPORTS COMMUNITY-BASED ALTERNATIVES

The benefits of community integration, for individuals with disabilities and society alike, propelled the deinstitutionalization movement, inspired the ADA, and influenced the *Olmstead* decision. Yet despite the ADA's integration mandate and the Supreme Court's affirmation that segregation is discrimination, IST defendants remain isolated in jails. A prison abolition ethic provides a framework through which to critically re-examine our relegation of individuals with mental illness to the criminal justice system. The abolition lens exposes the inhumanity of incarceration and advances an alternative vision, consistent with the integration mandate articulated in the ADA and *Olmstead*. Prison abolition lends support to community-based restoration because it frames integration as an ethical imperative.

A true reckoning with the futility of confinement and the harm it causes forces us to consider alternatives. As the discussion above elucidates,[430] the violence of

427. *See* Beth Ribet, *Surfacing Disability through a Critical Race Theoretical Paradigm*, 2 GEO. J. L. & MOD. CRITICAL RACE PERSP. 209, 244 (2010).

428. *See, e.g.*, Marta Russell & Jean Stewart, *Disablement, Prison & Historical Segregation*, MONTHLY REV. (2002), https://monthlyreview.org/2001/07/01/disablement-prison-and-historical-segregation/ [https://perma.cc/Q3VV-P4BF].

429. *See* Ribet, *supra* note 427, at 244.

430. *See infra*, Part II.C.

incarceration inheres in the institution itself.[431] Confining humans in cages imposes severe psychological, emotional, and physical harm, and is uniquely devastating for inmates with existing mental health conditions.[432] If the criminal justice system is truly aimed at crime reduction, incarceration is untenable. Confinement is generally ineffective at deterring or preventing crime;[433] rather, jails and prisons create adverse social conditions allowing crime to flourish[434] or simply move crime to a new location (within the prison walls).[435] As evidence that incarceration is a particularly fruitless means of addressing mental illness, one study found that nearly a quarter of state prison and jail inmates with a mental health condition had been incarcerated three or more times prior, compared to one fifth of those without.[436]

Much like the ADA and *Olmstead* advance a vision of community integration and equal access for individuals with disabilities, prison abolitionists dare to envision a society where "coercion, repression, oppression, and forced disappearance and segregation" cease to exist.[437] The ADA and *Olmstead* mandate systemic change to root out the prejudice against individuals with disabilities that has been baked into social institutions. Prison abolitionists advocate for similar structural

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431. *See* McLeod, *supra* note 187, at 1173, 1180 (explaining that the basic structure of prison society produces violence).

432. *See* Haney, *supra* note 2, at 314. Isolating inmates in solitary confinement, for example, "almost guarantees the creation of a mental disability." Ben-Moshe, *Not "The New Asylums," supra* note 94, at 280–82; *see also* Syrus Ware, Joan Ruzsa & Giselle Dias, *It Can't Be Fixed Because It's Not Broken: Racism and Disability in the Prison Industrial Complex, in* DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA 257 (Liat Ben-Moshe, Chris Chapman & Allison C. Carey, eds. 2014) (noting that the hostile environment in prisons "is designed to effect the mental health of prisoners") (citing MICHAEL FOUCAULT, DISCIPLINE AND PUNISH: THE BIRTH OF THE PRISON (1977)); Beth Ribet, *Naming Prison Rape as Disablement: A Critical Analysis of the Prison Litigation Reform Act, the Americans with Disabilities Act, and the Imperatives of Survivor-Oriented Advocacy*, 17 VA. J. SOC. POL'Y & L. 281, 306 n.102 (2010) ("[T]he brutalities of the incarceration context, combined with the lack of legal remedies, and a paucity of medical or recuperative resources, both within and external to the incarceration context (i.e., on re-entry) make disablement very predictable."); Russell & Stewart, *supra* note 428 ("Inadequate or absent medical care, poor nutrition, violence, and extremes of heat, cold, and noise inside prison, not to mention the lack of sensory, emotional, intellectual, and physical stimuli, all lead directly to acute or chronic physical and psychological disabilities.").

433. *See, e.g.*, Chapman, et al., *Reconsidering Confinement: Interlocking Locations and Logics of Incarceration*, *in* DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA 13 (Liat Ben-Moshe, Chris Chapman & Allison C. Carey, eds. 2014).

434. *See* Dorothy E. Roberts, *The Social and Moral Cost of Mass Incarceration in African American Communities*, 56 STAN. L. REV. 1271, 1285 (2004) (explaining that mass incarceration distorts social norms and "reproduces the very dynamics that sustain crime").

435. McLeod, *supra* note 187, at 1204 ("[P]rison itself is a place where interpersonal violence, theft, and abuse are rampant and largely unreported.").

436. Chapman, et al., *supra* note 434, at 13; *see also* Jacques Baillargeon, et al., *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door*, 166 AM. J. PSYCHIATRY 1, 105 (2009) (finding that "inmates with major psychiatric disorders were far more likely to have had previous incarcerations compared with inmates without a serious mental illness").

437. *See* Liat Ben-Moshe, *Alternatives to (Disability) Incarceration*, *in* DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA 257 (Liat Ben-Moshe, Chris Chapman & Allison C. Carey, eds. 2014) [hereinafter Ben-Moshe, *Alternatives*].

and attitudinal change, geared toward displacing the punitive arm of the state with an array of social substitutes.[438] Legal scholar Allegra McLeod presents abolition as a "gradual project of decarceration," aimed at creating a robust system of alternative "institutions, forms of empowerment, and regulatory approaches" to "supplant criminal law enforcement."[439] McLeod imagines investing in human welfare, decriminalizing minor infractions, redesigning spaces and products to reduce opportunities for offending, urban redevelopment, expanding restorative justice, creating safe harbors, and generating alternative livelihoods for at-risk individuals.[440] Likewise, pioneering civil rights activist and legal scholar Angela Davis advances a vision of abolition involving a "radical transformation[] of many aspects of our society."[441] The prison walls do not simply get bulldozed in this vision; they are replaced by new social institutions and attitudes that restore equality, peace, and justice.[442]

Through the abolition lens, the protracted detention of individuals with mental illness in jail is a "morally unsustainable" response to society's failure to address human beings' legitimate health care needs.[443] The pursuit of humane alternatives, like expanding community-based restoration to keep a subset of individuals with serious mental illness out of jail, is thus a pressing ethical demand. Creating robust CBCR programs can be considered a (very) preliminary step within the transformational abolition project—the first link on a chain of reforms laying the groundwork for investment in substitutive social projects that will ultimately diminish the need for criminal law enforcement in the first place.[444]

Abolitionists do not seek to reform the carceral state—they strive for a more just, equitable, and humane society where caging human beings is unthinkable.[445] Advocating for community-based restoration within the abolitionist framework injects a sense of urgency into the discourse surrounding competence restoration and necessarily calls the legitimacy of the entire carceral state into question.[446] It

438. *See* McLeod, *supra* note 187, at 1161; ANGELA Y. DAVIS, ARE PRISONS OBSOLETE? 20–21 (2003).

439. *See* McLeod, *supra* note 187 at 1161, 1208.

440. *See id*. at 1224–32.

441. DAVIS, *supra* note 438, at 108.

442. *See* Chapman, et al., *supra* note 433, at 13 (citing W.E.B. DU BOIS, BLACK RECONSTRUCTION IN AMERICA, 1860–1880 (New York: S.A. Russell, 1956)).

443. *See* Mcleod, *supra* note 187, at 1161; *see also* Roberts, *supra* note 434, at 1304 ("By damaging social networks, distorting social norms, and destroying social citizenship, mass incarceration serves a repressive political function that contradicts democratic norms and is itself immoral.").

444. *See* Ben-Moshe, *Alternatives*, *supra* note 437, at 257.

445. *See id*. at 256.

446. *See* Liat Ben-Moshe, *Dis-epistemologies of Abolition*, 26 CRITICAL CRIMINOLOGY 3, 345 (2018) (explaining that the word "abolition" activates scholarship with "urgency, relevance, or potential for the future"); Mcleod, *supra* note 187, at 1208 ("[I]n its radical call for change [abolition] appropriately captures the intensity that ought to be directed to transforming the regulation of myriad social problems through punitive policing and incarceration.").

is a radical idea,[447] but then so was deinstitutionalization.[448]

CONCLUSION

In *Memorial to the Legislature*, Dix excerpted letters from county sheriffs who agreed that housing individuals with mental illness in jail was utterly senseless.[449] As one sheriff explained, "jails and houses of correction *cannot* be so managed as to render them suitable places of confinement for that unfortunate class of persons who are the subject of your inquiries."[450] Nearly two centuries later, society has developed a sophisticated understanding of the particular vulnerabilities individuals with mental illness experience in jails and prisons. Yet we continue to confine people with mental illness in metal cages, instead of investing in social services to facilitate their community integration. We continue to view individuals with mental illness as barely human, as dangerous criminals who deserve to be isolated and punished, as social outcasts unworthy of our sustained attention and care.

Now, at the intersection between an under-realized deinstitutionalization project and a fully entrenched carceral state, communities across the country are at a crossroads. Enticed by potential cost-savings and the supposed efficiency of treating IST defendants in jail, a handful of jurisdictions are investing in jail-based competency restoration programs. It is foreseeable that many more communities will follow suit. The Americans with Disabilities Act and *Olmstead v. L.C.*, however, mandate that public entities allocate their resources differently—to facilitate integration instead of discrimination against individuals with mental illness. To comply with the integration mandate, legislatures should expand community-based restoration programs. Courts should order restoration in community settings as a default, reserving spots in psychiatric hospitals for the small sub-set of IST defendants who would not be successful in community programs.[451]

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447. The prison abolition ethic is "radical" in the sense that it aims to address the root causes of social issues. *See, e.g.*, Vasilios Ioakimidis, *A Guide to Radical Social Work*, THE GUARDIAN (May 24, 2016, at 5:03 PM), https://www.theguardian.com/social-care-network/2016/may/24/radical-social-work-quick-guide-change-poverty-inequality [https://perma.cc/4H62-QXV3].

448. *See* Ben-Moshe, *Not "The New Asylums," supra* note 94, at 274 (describing deinstitutionalization as "a radical anti-segregationist philosophy" and "an ideological shift in the way we react to difference among us").

449. *See* Dix, *Memorial to the Legislature of Massachusetts*, *supra* note 8.

450. *Id.*

451. This accords with the American Bar Association model standards, which prohibit involuntary hospitalization of IST defendants if a less restrictive alternative is available. *See* CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, std. 7-4.10(b)(iii)(B) (Am. Bar Ass'n 2016) ("A defendant should be evaluated in jail only when the defendant is ineligible for release to the community").

Jail-based competency restoration programs keep IST defendants out of sight and mind, fostering prejudice and fear toward individuals with mental illness. This is precisely the type of stigma that Congress intended to eradicate upon passing the Americans with Disabilities Act. Disability rights litigation aimed at implementing the ADA's vision has demonstrated that "it is possible and practicable" to require public entities to reallocate resources in a way that facilitates integration rather than isolation.[452] It is also an ethical imperative.

452. *See* Glidden & Rovner, *supra* note 340, at 74.