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DISCRIMINATION AND DISPARITY: VIOLATING OLMSTEAD V. L.C. DISCRIMINATES AGAINST THE PSYCHIATRICALLY VULNERABLE AND FOSTERS RACIAL/ETHNIC AND SOCIOECONOMIC MENTAL HEALTH DISPARITIES

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DISCRIMINATION AND DISPARITY: VIOLATING *OLMSTEAD V. L.C.* DISCRIMINATES AGAINST THE PSYCHIATRICALLY VULNERABLE AND FOSTERS RACIAL/ETHNIC AND SOCIOECONOMIC MENTAL HEALTH DISPARITIES

McKenna Stone Cloud[*]

Mississippi is one of several states still in violation of federal laws by unnecessarily institutionalizing individuals with serious mental illness and intellectual and developmental disabilities ("psychiatric vulnerabilities") and by failing to offer sufficient community-based mental health services. This Comment uses Mississippi's broken mental healthcare system as a case study to reveal how violating the Americans with Disabilities Act ("ADA") and Olmstead v. L.C. ex rel Zimring, 527 U.S. 581, 597 (1999), *not only discriminates against the psychiatrically vulnerable but also fosters racial/ethnic and socioeconomic mental health disparities. Complying with these federal mandates will provide individuals with psychiatric vulnerabilities with the least-restrictive treatment possible, ensuring such individuals are not unnecessarily institutionalized against their will. Furthermore, expanding access to affordable community-based services will increase racial/ethnic and socioeconomic mental healthcare parity. Therefore, this Comment implores states to heed the following call to action: stop violating people's rights, and put an end to discrimination and disparity.*

To comply with the ADA and Olmstead *and address these disparities, states such as Mississippi must increase access to community-based mental health services and decrease reliance on institutional care. The following five actions can aid compliance efforts: (1) create an* Olmstead *plan with measurable goals; (2) increase and reallocate funding for community-based services; (3) improve patient discharge plans and collaboration among state actors; (4) increase telehealth accessibility for mental health services; and (5) expand Medicaid mental health coverage and eligibility.*

[*] McKenna Stone Cloud is a 2022 graduate of Mississippi College School of Law. The author would like to sincerely thank Associate Dean Jonathan Will for his guidance and expertise throughout the research and drafting of this Comment. Additionally, the author would like to express gratitude to her parents, Retired Air Force Colonels Jay and Lynn Stone, and her husband, Cameron Cloud, for devoting their careers to serving Mississippi's mental health consumers.

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I. INTRODUCTION

When asked how to improve Mississippi's mental healthcare system, Melody Worsham's response was simple: "Stop violating people's rights. Start there. The current system is designed to violate people's rights."[1] Melody speaks from experience, not just as a certified peer support specialist for the State, but also as a mental health consumer who has struggled with serious mental illness ("SMI").[2] As a visitor, she has seen firsthand the conditions of Mississippi's psychiatric institutions and hospitals.[3] Patients have little to no rights or privacy, as they are inundated with drugs, forced to share community bathrooms, and prevented from resting in their rooms during the day.[4] In fact, during menstruation, women are forced to publicly carry feminine hygiene products in their hands, stripping them of even the most basic dignity and privacy.[5] After witnessing these deplorable conditions, Melody was determined never to be institutionalized.[6]

Unfortunately, thousands of Mississippians with SMI and intellectual and developmental disabilities (hereinafter "psychiatric vulnerabilities")[7] are unable to escape these institutional settings due to

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[1] Interview with Melody Worsham, Peer Support Specialist and Mental Health Consumer (Dec. 28, 2020) (notes on file with *Mississippi College Law Review*).

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] The population of impacted individuals includes, but is not limited to, those with SMI, developmental disabilities, and intellectual disabilities. While these three conditions differ in definition, for purposes of this Comment, the collective term "psychiatric vulnerabilities" will refer to all three categories. The U.S. Substance Abuse and Mental Health Services Administration defines SMI as, "adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities." *Behavioral Health Barometer: Mississippi, 2015*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, https://www.samhsa.gov/data/sites/default/files/2015_Mississippi_BHBarometer.pdf (last visited May 5, 2022). The current Diagnostic and Statistical Manual of Mental Disorder ("DSM-V") defines an intellectual disability (intellectual developmental disorder) as, "a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains." AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013). An intellectual disability is categorized as a developmental disability. *Id.* The Centers for Disease Control and Prevention defines developmental disabilities as, "a group of conditions due to an impairment in physical,

insufficient community-based services throughout the State.[8] Unnecessarily institutionalizing individuals with psychiatric vulnerabilities *violates people's rights*, and Mississippi is not alone; states across the nation are similarly guilty of such violation.

Dubbed "the *Brown v. Board of Education* for Disability Rights,"[9] the landmark United States Supreme Court case *Olmstead v. L.C. ex rel Zimring* held that institutionalizing individuals with psychiatric vulnerabilities who are capable and desirous of community-based treatment is a form of unlawful discrimination that violates the Americans with Disabilities Act ("ADA").[10] Violating the ADA and *Olmstead* does more than just discriminate against people with psychiatric vulnerabilities; it fosters racial/ethnic and socioeconomic mental health disparities.

More than twenty years after *Olmstead*'s publication, numerous states remain in violation of the federal mandate through failure to provide the least restrictive treatment to individuals with psychiatric vulnerabilities. In 2019, Mississippi was the subject of one of the most recent federal court decisions expressly finding a state in violation of *Olmstead*,[11] but it is merely one of several states that continues to unnecessarily institutionalize individuals with psychiatric vulnerabilities due to a lack of community-based mental health services. States' failures to fund and implement ample community-based treatment not only discriminates against individuals with psychiatric vulnerabilities, but it also disproportionately impacts those in lower socioeconomic statuses and people of color. Data shows that oftentimes community-based mental health services are ample in wealthy cities comprised of majority-white residents, while such services are sparse in lower-income areas in which the majority of the population consists of people of color. Such racial/ethnic and socioeconomic mental health

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learning, language, or behavioral areas. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime." *Developmental Disabilities*, CENTERS FOR DISEASE CONTROL AND PREVENTION (updated Nov. 12, 2020), https://www.cdc.gov/ncbddd/developmentaldisabilities/facts.html#ref (citing I. Leslie Rubin and Allen C. Crocker, *Developmental Disabilities: Delivery of Medical Care for Children and Adults*, Philadelphia, PA, Lea & Febiger, 1989).

[8] *See* United States v. Mississippi, 400 F. Supp. 3d 546 (S.D. Miss. 2019).

[9] *See* Amy Tidwell, *Deinstitutionalization: Georgia's Progress in Developing and Implementing an "Effectively Working Plan" as required by* Olmstead v. L.C. ex rel, 25 GA. ST. U. L. REV. 699 (2009) (citing Mary C. Cerreto, Olmstead: The Brown v. Board of Education *for Disability Rights: Promises, Limits, and Issues*, 3 LOY. J. PUB. INT. L. 47 (2001)).

[10] Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 597 (1999).

[11] *See Mississippi*, 400 F. Supp. 3d at 546.

disparities can be addressed through compliance with *Olmstead*, which requires states to fund and implement community-based treatment.[12]

Using the recent holding against Mississippi as a focal point, this Comment advocates for states to "stop violating people's rights" by increasing access to community-based mental health alternatives. While Mississippi is used as a case study, the application for findings and recommendations has a much broader scope, extending to states across the nation. Part II of this Comment discusses the history of the deinstitutionalization movement in the United States, a trend which led to the enactment of the ADA, its interpretation in *Olmstead*, and states' responses to the federal mandates. Part III highlights Mississippi's violation of the ADA and *Olmstead* and the resulting socioeconomic and racial/ethnic implications. Finally, using Mississippi as a case study, Part IV offers a path forward by exploring proposals for complying with the ADA and *Olmstead* and the larger implications of expanding community-based services—improving socioeconomic and racial/ethnic mental health parity.

II. THE MOVEMENT TOWARD DEINSTITUTIONALIZATION IN THE UNITED STATES

Nearly six decades ago, a significant portion of the nation campaigned for deinstitutionalization, a movement to transition individuals with psychiatric vulnerabilities from state psychiatric hospitals to community settings.[13] Advocates for deinstitutionalization sought to protect the civil rights of individuals with psychiatric vulnerabilities, improve conditions within institutions, close certain asylums, and expand community-based care and services.[14] Due to the movement's traction of

[12] It is important to note that compliance with the ADA and *Olmstead*, alone, is insufficient to alleviate the racial and economic disparities that individuals face across the U.S. Even if more community-based treatment facilities are opened to ensure those of color and from lower socioeconomic backgrounds have access to care, other inequities such as the prison system, drug prosecutions, and access to healthcare services, to name a few, still infect the country. All such inequities are beyond the scope of this article. This Comment recognizes that complying with the ADA and *Olmstead* by increasing community-based services is one necessary step out of many toward achieving racial/ethnic and socioeconomic parity.

[13] *See* Catherine Ryan Gawron, *Funding Mental Healthcare in the Wake of Deinstitutionalization: How the United States and the United Kingdom Diverged in Mental Health Policy After Deinstitutionalization, and What We Can Learn from Their Differing Approaches to Funding Mental Healthcare*, 9 NOTRE DAME J. INT'L & COMP. L. 85, 86 (2019).

[14] *Id.*

public support, Congress enacted the ADA; shortly thereafter, the U.S. Supreme Court interpreted the Act in *Olmstead*.

A. Public Attention

Throughout much of the nineteenth and twentieth centuries, psychiatric facilities were the primary mode of treatment for those with psychiatric vulnerabilities.[15] As those facilities became overcrowded, however, adequate staffing was limited, leading to deteriorating and unsanitary conditions.[16] In the early to mid-twentieth century, widespread awareness of these issues grew and the nation realized that psychiatric institutions were "warehousing" and abusing individuals rather than appropriately treating their mental illnesses.[17] The need for reform swiftly became clear.[18]

Beginning in the 1960s, the deinstitutionalization movement sought to close large state hospitals that housed individuals with psychiatric vulnerabilities.[19] In 1955, approximately 560,000 individuals were confined in public psychiatric hospitals in the U.S.[20] Advocates' efforts were not in vain; from 1955 to 1994, there was a nearly ninety-percent reduction in the number of individuals living in public psychiatric institutions.[21] Deinstitutionalization advocates fought to achieve two goals: (1) to prevent people from entering into, and move people out of, state institutions; and (2) to implement services and support in community settings so as to enable individuals with psychiatric vulnerabilities to flourish in the least-restrictive environment possible.[22] Many viewed involuntary commitment in these public psychiatric institutions as a form of incarceration, a perception fueled by media attention to deplorable conditions in several institutions such as Willowbrook.[23]

Willowbrook was one of many institutions that sparked national attention to issues surrounding state-operated psychiatric institutions.[24] In 1972, a New York television station exposed Willowbrook's horrific living conditions in a special report entitled *Willowbrook: The Last Great*

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[15] *Id.* at 89.
[16] *Id.*
[17] *Id.* at 90.
[18] *Id.*
[19] Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 7 (2012).
[20] *Id.* at 9.
[21] *See* Gawron, *supra* note 13, at 91.
[22] *See* Bagenstos, *supra* note 19, at 14-16.
[23] *Id.*
[24] *Id.*

Disgrace.[25] The report, which featured a journalist sneaking into the wards, displayed shocking footage of patients' living conditions, including residents lying naked on the floor covered in feces.[26] The journalist, Geraldo Rivera, compared Willowbrook to a Nazi concentration camp, emphasizing the smell of death and the rampant neglect and abuse by staff.[27] Shortly after this report was broadcast, a lawyer for the New York Civil Liberties Union challenged the conditions in the Willowbrook State School in a lawsuit, alleging a right to treatment and decent care under the First, Eighth, and Fourteenth Amendments.[28] The plaintiff's attorney affirmed that the goal of the litigation was to promote community-based options in order to eliminate institutions like Willowbrook.[29] The landmark Willowbrook suit was one of many that contributed to the rise of the deinstitutionalization movement, particularly leading up to the passage of the ADA.[30]

Following the nationwide closing of state psychiatric hospitals, state governments began to decrease spending for mental health services.[31] In response to the movement and the need for alternative services to supplement the closing of hospitals, Congress passed the Community Mental Health Centers Act of 1963 to provide inpatient, outpatient, and partial hospitalization services to individuals with psychiatric vulnerabilities.[32] Unfortunately, due to insufficient funding, this program did not meet expectations.[33] However, mental health directors across the nation proceeded to build community mental health centers ("CMHCs"), funded by states' Medicaid programs.[34] The Community Mental Health Centers Act of 1963 was one of several legislative initiatives by the federal government to protect the rights of individuals with disabilities. The ADA was the most notable of such federal action.

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[25] *See* Herbert A. Eastman, *Speaking Truth to Power: The Language of Civil Rights Litigators*, 104 YALE L.J. 763, 784 (1995).

[26] *See id.* at 784-85.

[27] *See id.*

[28] *See id.* at 782 (citing New York State Ass'n for Retarded Children v. Carney, 393 F. Supp. 715 (E.D.N.Y. 1975)).

[29] *See* Bagenstos, *supra* note 19, at 16.

[30] *See id.*

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

[32] *See* Johnathan Fish, *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. HEALTH L. & POL'Y 181, 201 (2012).

[33] *See id.*

[34] *See* Bridgette Stasher-Booker, *An Evaluative Look: Mississippi's Response to the* Olmstead v. L. C. *Case Twenty-one Years Later*, 1 J. REHAB. PRACT. RES. 1, 1 (2020).

B. The Americans with Disabilities Act

Since the late 1960s, Americans with disabilities have become empowered by antidiscrimination protections.[35] Between 1968 and 1990, Congress expanded protections for people with disabilities through a series of civil rights statutes.[36] In 1990, Congress passed the ADA,[37] which prohibits discrimination against individuals with mental or physical disabilities in a broad variety of public and private settings.[38] The most far-reaching federal civil rights legislation to protect people with disabilities, the ADA's purpose is to implement "a national mandate to end discrimination against individuals with disabilities and to bring those individuals into the economic and social mainstream of American life."[39] Its protections for individuals with disabilities are comparable to those protections afforded to citizens of color in the Civil Rights Acts of the 1960s.[40]

In the legislation's language, Congress acknowledged that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[41] The Act explicitly recognizes that discrimination "persists in such critical areas as . . . institutionalizations" and "health services."[42] Congress also noted that "individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion . . . failure to make modifications to existing facilities and practices . . . segregation, and relegation to lesser services."[43]

Title II of the ADA is the most important title pertaining to institutionalized individuals with psychiatric vulnerabilities.[44] Barring discrimination by public entities, Title II states, "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or

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[35] *See* Michael E. Waterstone, Michael Ashley Stein & David B. Wilkins, *Disability Cause Lawyers*, 53 WM. & MARY L. REV. 1287, 1331 (2012).

[36] *See id.*

[37] 42 U.S.C. §§ 12101-12213 (1990).

[38] *See* Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?*, 8 J.L. & HEALTH 15, 24 (1994).

[39] *See id.* at 15; H. Comm. on Energy and Commerce, H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 4, at 25 (1990).

[40] *See* Perlin, *supra* note 38, at 15.

[41] 42 U.S.C. § 12101(a)(2) (2020).

[42] *Id.* § 12101(a)(3).

[43] *Id.* § 12101(a)(5).

[44] *See* Michael L. Perlin, *"Make Promises by the Hour": Sex, Drugs, the ADA, and Psychiatric Hospitalization*, 46 DEPAUL L. REV. 947, 960 (1997).

activities of a public entity, or be subjected to discrimination by any such entity."[45] Through its authority granted by the ADA, the Attorney General promulgated regulations to implement Title II.[46] Pursuant to those regulations, public entities must "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[47] This type of setting "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[48] Furthermore, public entities must "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."[49]

In the landmark case *Olmstead v. L.C. ex rel. Zimring*, the U.S. Supreme Court interpreted Title II of the ADA in an opinion authored by civil rights proponent Justice Ruth Bader Ginsburg.[50]

C. Interpreting the ADA: Olmstead

In 1999, the Supreme Court held in *Olmstead* that the unjustified confinement of persons with psychiatric vulnerabilities in institutions qualifies as discrimination under the ADA.[51] In that case, the plaintiffs were two women with SMI who remained confined in a Georgia institution despite treating professionals' conclusions that community-based treatment was appropriate for them.[52] The plaintiffs brought suit against Georgia state officials, alleging the State's failure to place them in community-based programs, once their treating professionals determined that such placement was proper, violated Title II of the ADA.[53]

First, the Court concluded that unjustified institutionalization qualifies as discrimination based on disability.[54] The Court reasoned that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and such confinement "severely diminishes the everyday-life activities of

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[45] 42 U.S.C. §§ 12131-12165 (2020).
[46] 28 C.F.R. § 35.130 (2020).
[47] *Id.* § 35.130(d).
[48] 28 C.F.R. Pt. 35, App. B (2020).
[49] 28 C.F.R. § 35.130(b)(7)(i) (2020).
[50] *Olmstead*, 527 U.S. at 581.
[51] *Id.* at 607.
[52] *Id.* at 593-94.
[53] *Id.*
[54] *Id.* at 597.

individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[55] Justice Ginsburg recognized in the plurality portion of her opinion that for some individuals, "no placement outside the institution may ever be appropriate."[56]

However, the Court acknowledged that the requirement to provide community-based treatment is not limitless. Recognizing states' need to maintain a range of facilities to treat people with diverse psychiatric vulnerabilities, the Court provided a cost-based "fundamental-alteration defense" pursuant to the statute.[57] Under the fundamental-alteration defense, a court must consider, in light of the State's mental-health budget, the cost of providing community-based care to the plaintiffs, the range of services the State provides others with psychiatric vulnerabilities, and the State's duty to equitably distribute those services.[58] In other words, this defense permits the State to demonstrate that immediate relief for the litigants would be inequitable, considering the allocation of available resources and the responsibility of the State to care for and treat a large and diverse population of individuals with psychiatric vulnerabilities.[59]

The fundamental alteration defense, however, does not simply permit a state to claim it lacks the financial resources to provide necessary community-based services. Rather, the State must show the requested modification would fundamentally alter its service system, and the availability of financial resources is one factor to consider.[60] Absent a showing of fundamental alteration, states must comply with *Olmstead*'s final holding, often referred to as the "integration mandate,"[61] which provides:

> States are required to provide community-based treatment for persons with [psychiatric vulnerabilities] when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available

[55] *Id.* at 600-01.
[56] *Id.* at 605.
[57] *Id.* at 600-01.
[58] *Id.* at 597.
[59] *Id.* at 604.
[60] *Id.* at 603.
[61] *See, e.g.*, Disability Advocates, Inc. v. Paterson, 653 F. Supp. 2d 184, 190-91 (E.D.N.Y. 2009).

> to the State and the needs of others with [psychiatric vulnerabilities].[62]

Currently, when determining whether a state has violated the ADA's integration mandate, courts look to both the language of the regulations interpreting Title II and *Olmstead*'s holding as the proper standard.[63] In response to *Olmstead*, many states began to adjust their mental healthcare systems. Those that did not adequately attempt to comply with the holding were targeted by the federal government.

D. States' Responses to Olmstead

Following *Olmstead*, states struggled to promptly take action, particularly because the opinion's guidance as to what action was required appeared ambiguous. The *Olmstead* Court acknowledged that states required "leeway" to accommodate individuals who needed to remain institutionalized and attempted not to "impel States to phase out institutions."[64] However, immediately following *Olmstead*, states faced a clear requirement to begin providing community-based services to those with psychiatric vulnerabilities who did not need to remain in institutions.[65] The *Olmstead* decision has been criticized for providing inadequate guidance on how states should take action to comply with the direction to avoid discriminating against individuals with psychiatric vulnerabilities through institutionalization.[66] Justice Ginsburg suggested that a state would satisfy its obligation by "demonstrat[ing] that it had a comprehensive, effectively-working plan for placing qualified persons with [psychiatric vulnerabilities] in less-restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated."[67] While the Supreme Court failed to address what constitutes an "effectively-working plan" or a waiting list that moves at a "reasonable pace," U.S. circuit courts of appeals have interpreted these requirements.[68]

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[62] *Olmstead*, 527 U.S. at 607.

[63] *See, e.g.*, *Disability Advocates, Inc.*, 653 F. Supp. 2d at 191.

[64] *Olmstead*, 527 U.S. at 604-05.

[65] *See* Megan Chambers, *Integration as Discrimination Against People with Disabilities? Olmstead's Test Shouldn't Work Both Ways*, 46 CAL. W.L. REV. 177, 201-02 (2009).

[66] *See id.* at 202.

[67] *See id.* at 203 (quoting *Olmstead*, 527 U.S. at 605-06).

[68] *See* Tidwell, *supra* note 9, at 700 (identifying interpretations by the Ninth and Third Circuits).

The federal government deems the implementation of an effectively-working plan as an essential component of *Olmstead* compliance.[69] For instance, within months of the decision, the U.S. Center for Medicaid and State Operations Health Care Financing Administration distributed letters to State Medicaid Directors highlighting the gravity of *Olmstead* and providing recommendations on how states could comply with the holding.[70] Justice Ginsburg's "comprehensive plan" portion of the opinion has been implemented by several states; nearly all states and the District of Columbia have published documents described as either "*Olmstead* plans" or "alternative strategies."[71] Despite these plans to move people out of institutions, some have criticized the slow pace of deinstitutionalization after *Olmstead*.[72]

The Supreme Court's holding in *Olmstead* resulted in presidential initiatives and a plethora of litigation challenging the institutionalization of people with psychiatric vulnerabilities.[73] The Clinton and Bush administrations created initiatives to advance deinstitutionalization following the decision.[74] President Bush's New Freedom Initiative in 2001 aimed to implement *Olmstead* and eliminate barriers to community living for people with disabilities.[75] By 2003, forty-two states had developed a legislative *Olmstead* taskforce or committee.[76] Yet, the actual rate of deinstitutionalization in the decade preceding *Olmstead* was greater than in the decade following it.[77]

In 2009, on *Olmstead*'s tenth anniversary, President Obama announced the Year of Community Living, an initiative aimed at increasing access to community-based care for persons with disabilities and to enable federal agencies to enforce the civil rights of such persons.[78] The President's Community Living Initiative sparked the U.S. Department of Justice ("DOJ") to file, join or participate in *Olmstead* suits in at least twenty-one states and obtain significant settlements.[79] At the time of this Comment's publication, the DOJ has found the following states to be in

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[69] *See id.* at 706.

[70] *See* Chambers, *supra* note 65, at 203.

[71] *See id.*

[72] *See id.* (citing Samantha A. DiPolito, Olmstead v. L.C. – *Deinstitutionalization and Community Integration: An Awakening of the Nation's Conscience?*, 58 MERCER L. REV. 1381 (2007)).

[73] *See* Bagenstos, *supra* note 19, at 5.

[74] *See* Laura Sloan & Chinmoy Gulrajani, *Where We are on the Twentieth Anniversary of* Olmstead v. L.C., 47 J. AM. ACAD. PSYCHIATRY & LAW 408, 409 (2019).

[75] *See id.*

[76] *See id.*

[77] *See id.*

[78] *See id.*

[79] *See* Chambers, *supra* note 65, at 203.

violation of the ADA and *Olmstead*: California, Nebraska, Connecticut, North Carolina, Illinois, Arkansas, New Jersey, Florida, Georgia, Alabama, Missouri, Louisiana, Pennsylvania, Delaware, Washington, New Hampshire, Virginia, Texas, Rhode Island, Indiana, Oregon, South Dakota, Ohio, New York, West Virginia, Maine, North Dakota, the District of Columbia, Colorado, and, recently, Mississippi.[80]

III. MISSISSIPPI VIOLATES THE ADA AND *OLMSTEAD*

In 2019, on the twentieth anniversary of *Olmstead*'s publication, the United States District Court for the Southern District of Mississippi found Mississippi to be in violation of the ADA and *Olmstead*.[81] Mississippi is among many states still violating the federal mandate by unnecessarily institutionalizing individuals and having inadequate community mental health services. Violating *Olmstead* does not merely discriminate against people with psychiatric vulnerabilities; insufficient community-based services also fosters racial/ethnic and socioeconomic mental health disparities.

A. United States v. Mississippi

As a twentieth-birthday present, Mississippi gifted *Olmstead* with two decades of noncompliance. In September 2019, Judge Carlton W. Reeves, U.S. District Court Judge for the Southern District of Mississippi, issued an opinion in which he found the State in violation of the ADA and *Olmstead*.[82] This litigation began when the DOJ published a findings letter in 2011 summarizing the results of its investigation into Mississippi's mental health system.[83] The DOJ determined that Mississippi was violating the ADA's integration mandate by unnecessarily institutionalizing individuals with psychiatric vulnerabilities.[84] When attempts to negotiate failed over the years, the United States filed suit in 2016, pursuant to Title II of the ADA.[85] The United States claimed that Mississippi was in violation of *Olmstead* by relying too heavily on state psychiatric hospitals.[86] In accordance with its investigation, the DOJ found that adults with psychiatric vulnerabilities were being denied access to the most integrated

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[80] *Olmstead Enforcement*, ADA.GOV, https://www.ada.gov/olmstead/olmstead_cases_list2.htm (last visited June 10, 2022).

[81] *Mississippi*, 400 F. Supp. 3d at 546.

[82] *Id.*

[83] *Id.* at 551-52.

[84] *Id.*

[85] *Id.* at 552.

[86] *Id.*

setting in which to receive services, because they were confined in segregated hospitals instead of receiving treatment in community-based settings.[87]

In assessing whether Mississippi was in violation of the ADA's integration mandate, Judge Reeves first painted a vivid picture of Mississippi's current mental health system.[88] He set the scene by citing one of the United States' experts, Dr. Robert Drake.[89] Dr. Drake testified that while Mississippi's community-based system looks good on paper, in practice, it is nothing more than a recurring cycle of hospitalizations—"the hallmark of a failed system."[90] Next, Judge Reeves broke down how this system is dispersed over Mississippi's fourteen regional CMHCs.[91]

The State's mental healthcare system is controlled and operated by two entities: the Mississippi Department of Mental Health ("DMH"), which provides services across all regions, and the Mississippi Division of Medicaid, which compensates services for Medicaid-enrolled persons.[92] There are various categories of community-based services offered throughout the State: programs of assertive community treatment ("PACT"); mobile crisis response services; crisis-stabilization units; community-support services; peer-support services; supported employment; and permanent supported housing.[93] After analyzing each of these services, considering their quantity, quality, and locations, Judge Reeves concluded, "[t]he problem is that the descriptions do not match the reality of service delivery, in terms of what is actually provided and where it is provided."[94]

Judge Reeves assessed each community-based service individually.[95] First, he determined that "PACT is unavailable and under-enrolled," finding that PACT services are nonexistent in sixty-eight of the State's eighty-two counties, and that many of Mississippi's most-hospitalized individuals live in areas lacking PACT services.[96] Next, he concluded, "mobile crisis services are illusory," CSUs "are not available," "peer support services are not billed," "supported employment is miniscule," and the CHOICE housing program "is far too small."[97] Finally,

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[87] *Id.*
[88] *Id.* at 555.
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] *Id.* at 552.
[93] *Id.* at 555-58.
[94] *Id.* at 557.
[95] *Id.* at 557-63.
[96] *Id.* at 557-60.
[97] *Id.*at 560-63.

Judge Reeves addressed management concerns in the State, determining that the lack of data-driven management contributes to the underutilization of community services in Mississippi.[98] Furthermore, he was concerned by DMH's relationship with community health providers, since CMHCs operate as independent, autonomous organizations with little State oversight.[99] DMH, after all, is supposed to be responsible for overseeing the expansion of the CMHCs' community-based services.[100]

After examining Mississippi's inadequate community-based services, Judge Reeves then evaluated the four State Hospitals funded and operated by DMH.[101] Judge Reeves emphasized that "Mississippi has relatively more hospital beds and a higher hospital bed utilization rate than most states," and its "hospital utilization rate is higher than the national and regional rates."[102] He also acknowledged that Mississippi allocates substantially more money to institutional settings and less to community-based services than other states do.[103]

In addition to concerns regarding the State's over-reliance on institutional settings, Judge Reeves also addressed his distress with transition planning when patients are discharged from hospitals.[104] For instance, there is neither a follow-up nor a consistent connection to local services when individuals are discharged, and some patients have no access to post-discharge medication; consequently, many persons with psychiatric vulnerabilities end up re-hospitalized, some several times.[105] Along with inadequate community-based services and an over-reliance on State hospitals, Judge Reeves also highlighted the lack of a qualified workforce for mental healthcare employers in the state.[106] A prominent factor contributing to this issue is a lack of competitive compensation.[107]

After tackling Mississippi's mental health system, Judge Reeves concluded that due to the more than one-hundred Mississippians with psychiatric vulnerabilities who would prefer to receive community-based treatment, "the State's mental health system depends too much on segregated hospital settings and provides too few community-based services that would enhance the liberty of persons with [psychiatric

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[98] *Id.* at 563-64.
[99] *Id.*
[100] *Id.* at 564.
[101] *Id.* at 564-66.
[102] *Id.* at 564.
[103] *Id.* at 565.
[104] *Id.* at 566.
[105] *Id.*
[106] *Id.* at 566-67.
[107] *Id.* at 567 n.20.

vulnerabilities]."[108] As such, Judge Reeves held that Mississippi is in violation of the ADA and *Olmstead*'s integration mandate by unlawfully discriminating against people with psychiatric vulnerabilities.[109]

To guide the State forward, he appointed a Special Master to help the parties craft an appropriate remedy.[110] Judge Reeves also ordered the appointment of a Monitor who will report to him whether services are actually performed as described "on paper," ensuring that Mississippians with psychiatric vulnerabilities obtain "the help they so desperately need."[111] Despite the challenges related to Mississippi's rural geography and lack of funding, Judge Reeves remained hopeful that Mississippi can eventually come into compliance with *Olmstead*.[112] After all, the evidence in this case revealed that it would likely cost the system *less* in the long run to fund community-based services than to fund institutional settings.[113]

Since publication of this 2019 opinion, the State has continued ongoing conversations regarding Mississippi's mental healthcare system, specifically focusing on how to expand community-based services.[114] In October 2020, the Mississippi Department of Finance and Administration appointed an attorney from the Mississippi Attorney General's Office to serve as the State's coordinator of mental health accessibility, a new governmental position.[115] In this role, the coordinator is tasked with evaluating the State's mental healthcare and proposing changes to improve the system.[116] Hopefully these state-level conversations will help Mississippi not only to finally comply with the ADA and *Olmstead*, but also to shed light on the socioeconomic and racial/ethnic mental health disparities that Mississippians face.

B. Racial/Ethnic and Socioeconomic Mental Health Disparities

The implications of violating and ADA and *Olmstead* do not stop with discriminating against people with psychiatric vulnerabilities; the

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[108] *Id.* at 575.

[109] *Id.* at 576.

[110] *Id.* at 579.

[111] Order, 6, July 14, 2021, Case 3:16-cv-00622-CWR-FKR.

[112] *Mississippi*, 400 F. Supp. 3d at 578.

[113] *Id.* at 572.

[114] *See Olmstead*, www.DMH.MS.GOV (last updated Oct. 13, 2020), http://www.dmh.ms.gov/olmstead/.

[115] *See* Taylor Vance, *Assistant State Attorney General Chosen to Evaluate Status of State's Mental Health*, DAILY JOURNAL (Oct. 21, 2020), https://www.djournal.com/news/state-news/assistant-state-attorney-general-chosen-to-evaluate-status-of-states-mental-health/article_e75c8a74-3f43-5156-a959-8ba68eba0927.html.

[116] *See id.*

ripple effect of such a violation disparately reaches minority racial/ethnic populations and poor communities. For instance, Mississippi's mental healthcare system not only violates the rights of individuals with psychiatric vulnerabilities, but it also fosters healthcare disparities among people of color and lower-income areas.

1. Relationships Between Race/Ethnicity, Socioeconomic Status, and Mental Health Parity

Health disparities can be defined as specific health differences at the population level that are connected to histories of economic, environmental, or social disadvantage.[117] While this term typically refers to variances in health status or outcomes—including an increased burden of injury, mortality, or illness—the term can also indicate differences in access to healthcare and the quality of care received.[118] Viewed by many as a form of discrimination and social injustice, health inequities across gender, race, and disability persist.[119] One scholar paints a vivid picture of health equity and what it takes to achieve such an ambitious goal:

> Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[120]

Clearly, the health of individuals and communities is greatly influenced by equal access to care.[121]

Studies reveal that people of color are disparately affected by mental health inequities.[122] Such disparities can be attributed primarily to healthcare inaccessibility and socio-economic factors, placing such individuals in sub-categories including homelessness, incarceration, and

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[117] Barry R. Furrow et al., HEALTH LAW: CASES, MATERIALS AND PROBLEMS, 8 (West Acad. Pub., 8th ed.) (2018).

[118] *Id.*

[119] *Id.*

[120] *Id.* at 8-9 (citing Paula Braveman et al., *What is Health Equity? And What Difference Does a Definition Make?*, PRINCETON, NJ: ROBERT WOOD JOHNSON FOUNDATION, 2017).

[121] *See* Furrow, *supra* note 117, at 9.

[122] *See, e.g.*, Camille A. Nelson, *Starting Anew: The ADA's Disability with Respect to Episodic Mental Illness*, 75 MISS. L.J. 1039, 1050 (2006).

institutionalization.[123] Individuals in these sub-categories also face higher rates of psychiatric vulnerabilities.[124]

One study found that residing in lower-income neighborhoods generally decreases access to community mental health services and increases utilization of emergency and in-patient services.[125] Individuals with psychiatric vulnerabilities, and particularly members of racial/ethnic minority populations, are concentrated disproportionately in areas of high poverty.[126] Impoverished communities containing high populations of minority residents typically lack access to community mental health treatment, exacerbating psychiatric vulnerabilities for minority and other residents.[127] Thus, safety net providers, such as state hospitals and community health centers,[128] remain the primary source of care for such communities.[129] Yet, these providers are overburdened and often unable to provide the best quality of care to the most vulnerable populations.[130] The increasing rates of hospitalization and lengths of stay are influenced by failure to receive outpatient care at the outset of episodes of mental illness.[131]

The research indicates that a leading factor in racial/ethnic and socioeconomic mental health disparities is inaccessibility to community mental health services and overreliance on public hospitals and community health centers. This problem is particularly prevalent in Mississippi.

2. Mississippi's Racial/Ethnic and Socioeconomic Mental Health Inequities

Mississippians face socioeconomic and racial/ethnic mental healthcare disparities due to inequities in funding and geography. First, it is imperative to understand the geographic and socioeconomic makeup of Mississippi. The State's population is comprised of approximately thirty-eight percent African American residents and fifty-nine percent white

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[123] *Id.*

[124] *Id.*

[125] Julian C. Chow et al., *Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas*, 93 AM. J. PUB. HEALTH 792, 792 (2003) (citations omitted).

[126] *Id.*

[127] *Id.*

[128] A community health center offers primary healthcare services to patients, regardless of patients' ability to pay. Mental health services may be offered as well, although this is not always the case. *See What is a Health Center*, HRSA HEALTH CENTER PROGRAM (Nov. 2018), https://bphc.hrsa.gov/about/what-is-a-health-center/index.html.

[129] Chow, *supra* note 125.

[130] *See id.*

[131] *Id.*

residents.[132] Some of the wealthiest parts of the State are located in the Jackson Metropolitan area, including Rankin County.[133] Rankin County also happens to be one of the whitest counties in the State, with white residents accounting for approximately eighty-one percent of its population, while only seventeen percent is black.[134] Similarly, the City of Madison, another suburb of the State Capital, is comprised of nearly eighty-five percent white and ten percent black residents, and Madison is also one of the wealthiest areas in Mississippi.[135] Madison's poverty rate is about three percent, and the city has a home ownership rate of nearly one-hundred percent. [136] From 2012 to 2016, Madison's median household income was approximately $103,000, and the median home value was $250,200.[137] During that same time period, the remainder of Mississippi's income and median home value were $42,900 and $109,300, respectively.[138]

In contrast to these majority-white, affluent urban areas, the Mississippi Delta is filled with predominantly African American, rural communities described as "areas of chronic or persistent poverty."[139] Two such impoverished, rural areas include Humphreys County and Noxubee County, which consist mostly of African American residents (approximately seventy-two to seventy-five percent of these populations is black).[140] These statistics illustrate that many of Mississippi's higher

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[132] *See Quick Facts Mississippi*, UNITED STATES CENSUS BUREAU, https://www.census.gov/quickfacts/MS (last visited July 1, 2022).

[133] *See* Ashton Pittman, *Poor Mississippi Counties Are Top IRS Targets in Hunt for Tax Cheats*, JACKSON FREE PRESS (April 2, 2019, 12:40 PM), https://www.jacksonfreepress.com/news/2019/apr/02/poor-mississippi-counties-are-top-irs-targets-hunt/.

[134] *See id.*

[135] *See* Desiree C. Hensley, *Affirmatively Furthering Fair Housing in the Deep South: Obama's AFFH Rule Won't Make Rural America Less Segregated*, 26 VA. J. SOC. POL'Y & L., 92, 124-27 (2019) (citing Madison Miss., Population: Census 2010 and 2000 Interactive Map, Demographics, Statistics, Quick Facts, http://censusviewer.com/city/MS/Madison (last visited July 22, 2018)).

[136] *See* Hensley, *supra* note 135, at 124-27 (citing U.S. Census Quickfacts Madison Mississippi, https://www.Census.gov/quickfacts/fact/table/madisoncitymississippi/INC1102 16 (last visited July 22, 2018)).

[137] *See* Hensley, *supra* note 135, at 126-27 (citing In 2017 dollars. U.S. Census Quickfacts Madison, Miss., https://www.census.gov/quickfacts/fact/table/madisoncitymississippi/AFN1202 12 (last visited July 22, 2019)).

[138] *See* Hensley, *supra* note 135, at 127 (citing In 2016 dollars. U.S. Census Quickfacts Miss., https://www.Census.gov/quickfacts/ms (last visited July 22, 2018)).

[139] *See* Hensley, *supra* note 135, at 109-110 (quoting Daniel T. Lichter, Domenico Parisi & Michael C. Taquino, *Emerging Patterns of Hispanic Residential Segregation*, 81 RURAL SOC. 483 (2016)).

[140] *See* Pittman, *supra* note 133.

socioeconomic communities—located in larger, urban cities—are disproportionately white, while the State's most impoverished areas—located in rural communities, particularly in the Mississippi Delta—are disproportionately African American.[141]

Next, an investigation into Mississippi's CMHCs reveals funding and geographic disparities. The State is currently comprised of thirteen regional CMHCs.[142] A few years ago, the State operated fifteen regional CMHCs, but at least one of them closed due to financial difficulties.[143] Unfortunately, not all CMHCs receive funding for services such as crisis diversion due to inequities in the funding provided by the counties they serve.[144] One such CMHC is Region Seven, located in Northeast Mississippi, with more than a fifth of its families—a third of whom live in one county alone—living in poverty.[145] Some CMHCs struggle to remain viable and provide essential mental health services due to revenue shortfalls and disparities in government funding, coupled with limited resources in rural areas throughout the State.[146]

These funding and geographic disparities result in a significant quantity of Mississippians with psychiatric vulnerabilities cycling through jails, emergency rooms, and psychiatric hospitals because of nonexistent or insufficient community-based services.[147] It is imperative to break this cycle, not only to adequately treat those with psychiatric vulnerabilities, but also to improve communities and family environments by creating stability; increasing employment; and decreasing homelessness, incarceration, hospitalization, and the need for public benefits.[148] Breaking the cycle requires adequate community infrastructures, particularly in lower-income regions.[149]

Mississippi's Region Eight CMHC is frequently viewed as a model center that provides such an infrastructure.[150] Not surprisingly, this Region

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[141] *See* Hensley, *supra* note 135, at 112 ("[M]any towns in the Mississippi Delta have been predominantly African American for decades.").

[142] *See Community Mental Health Centers*, MISSISSIPPI DEPARTMENT OF MENTAL HEALTH, https://www.dmh.ms.gov/service-options/community-services/ (last visited June 15, 2022).

[143] *See* Shirley L. Smith, *Mental Health Care: It's the Haves vs. the Have-Nots in Mississippi*, CLARION LEDGER (Oct. 14, 2019, 3:57 AM), https://www.clarionledger.com/story/news/politics/2019/10/14/mental-health-system-care-mississippi-funding-fragmented-community-centers/3931991002/.

[144] *See id.*

[145] *See id.*

[146] *See id.*

[147] *See id.*

[148] *See id.*

[149] *See id.*

[150] *See id.*

is located in the Jackson Metropolitan area, serving eighteen-thousand people[151] and including two of the wealthiest and fastest-growing counties in the State: Madison and Rankin.[152] Unlike other counties in the State, Region Eight contains a Crisis Stabilization Unit and contracts with local, private acute care facilities.[153] Furthermore, Region Eight offers intellectual and developmental disability services, while many other regions do not.[154] While Region Eight might be providing the most efficient and extensive care in Mississippi,[155] other CMHCs will not be able to emulate Region Eight until they receive the same access to resources, services, and funding.[156]

By providing insufficient community-based services across the State, Mississippi is not only discriminating against individuals with psychiatric vulnerabilities, but it is also fostering racial/ethnic and socioeconomic mental health disparities. But there is hope for Mississippi and other states that are not in compliance with the ADA and *Olmstead*. Such states must diligently look to the path forward to end discrimination against individuals with psychiatric vulnerabilities and combat racial/ethnic and socioeconomic inequities. It is not enough for the affluent to have absolute access to health; when the disadvantaged and marginalized are denied access to this necessity, there is a fundamental flaw in the healthcare system.[157] Mental healthcare should not be a privilege; it is a basic need that should be prioritized by the government.[158]

IV. THE PATH FORWARD: MISSISSIPPI AS A CASE STUDY FOR COMPLIANCE

This section identifies five proposals for complying with the ADA and *Olmstead* and the positive implications of achieving this goal, namely, socioeconomic and racial/ethnic mental healthcare parity. While Mississippi is used as a case study, the findings and proposals are applicable

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[151] Compare this to Region Two, which serves 13,000 people in six rural counties. *See id.*

[152] *See* Smith, *supra* note 143.

[153] *See id.*

[154] *See Community Mental Health Centers*, *supra* note 142.

[155] Access to private insurance likely influences these inequities as well. For instance, residents in high-income counties such as Region Eight are more likely to have access to private insurance, thereby increasing pay for these services. Thus, such regions receive private funding in addition to public funding. In contrast, lower-income regions likely depend heavily on Medicaid reimbursement, thereby subjecting them to more state control.

[156] *See* Smith, *supra* note 143.

[157] *See* Anita B. Pereira, Comment, *Live and Let Live: Healthcare is a Fundamental Human Right*, 3 CONN. PUB. INT. L.J. 481 (2004).

[158] *See id.*

to all states in violation of the federal mandates, as well as states that face barriers to mental health inequities.

A. What will it Take for Mississippi to Comply with the ADA and Olmstead*?*

As Judge Reeves has highlighted, it is insufficient for the State to have an attractive mental healthcare system on paper when the system *in practice* is broken.[159] So what will it take for Mississippi to comply with the ADA and *Olmstead* and improve socioeconomic and racial/ethnic mental healthcare parity? There are five proposals to effect change: (1) create an *Olmstead* plan with measurable goals; (2) increase and reallocate funding for community-based services; (3) improve patient-discharge plans and collaboration among state actors; (4) increase telehealth accessibility; and (5) expand Medicaid mental health coverage and eligibility.

1. Create an *Olmstead* Plan with Measurable Goals

While Mississippi has not created an *Olmstead* plan, the adoption of one would help guide the State toward compliance with the federal mandates and address mental health parity by expanding community-based services. One way in which a state can claim the "fundamental alteration defense" set out in *Olmstead* is by demonstrating "a comprehensive, effectively-working plan for placing qualified persons with [psychiatric vulnerabilities] in less-restrictive settings, and a waiting list that move[s] at a reasonable pace."[160] While the Supreme Court did not mandate that states adopt an *Olmstead* plan, the federal government clarified that such a plan is a key component of complying with the Court's holding when CMS issued a series of letters to states directly following the decision.[161] According to the Third Circuit's interpretation of *Olmstead*, a sufficient plan must "set forth reasonably specific and measurable targets for community placement" and demonstrate a "commitment to implement" its terms.[162]

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[159] *See Mississippi*, 400 F. Supp. 3d at 549.

[160] *Olmstead*, 527 U.S. at 605-06.

[161] *See A Compendium of Current Federal Initiatives in Response to the* Olmstead *Decision*, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (July 9, 2001), https://aspe.hhs.gov/reports/compendium-current-federal-initiatives-response-olmstead-decision-0.

[162] Frederick L. v. Dep't of Pub. Welfare of Pa., 422 F.3d 151, 158 (3d Cir. 2005) (rejecting Pennsylvania's fundamental-alteration defense).

Developing an *Olmstead* plan, however, is just the initial step; fully implementing *Olmstead* requires both logistic and budgetary commitments.[163] Unfortunately, Mississippi has yet to take even this first step. Nearly two decades after *Olmstead* and the federal government's clear expectation for states to develop an effectively-working plan, Mississippi lacks such a plan and persists to unnecessarily institutionalize individuals with psychiatric vulnerabilities.

Regardless of whether a state has some sort of *Olmstead* plan in place, case law suggests that states are to be held accountable under *Olmstead* for dragging their feet on deinstitutionalization.[164] In *Frederick L.*, the Third Circuit held that "[g]eneral assurances and good-faith intentions neither meet the federal laws nor a patient's expectations."[165] Pursuant to the Third Circuit's interpretation, *Olmstead* mandates that "verifiable benchmarks or timelines" are "necessary elements of an acceptable plan," and that a plan must "demonstrate a commitment to community placement in a manner for which [the state government] can be held accountable by the courts."[166] Specifically, the Third Circuit clarified that an effective plan should:

> [Specify] the time-frame or target date for patient discharge, the approximate number of patients to be discharged each time period, the eligibility for discharge, and a general description of the collaboration required between the local authorities and the housing, transportation, care, and education agencies to effectuate integration into the community.[167]

According to the DOJ and Judge Reeves, Mississippi's current "strategic plan"[168] does not pass muster. During the trial of *United States v. Mississippi*, DMH executives conceded that the State does not have an *Olmstead* plan in place.[169] The Deputy Executive Director, who has worked for DMH for thirty years, testified that he had never seen an *Olmstead* plan for Mississippi.[170] He concluded that even if the State had

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[163] *See* Sloan, *supra* note 74.

[164] *Mississippi*, 400 F. Supp. 3d at 554.

[165] *Frederick L.*, 422 F.3d at 158.

[166] *Id.* at 155-56.

[167] *Id.* at 160.

[168] *Strategic Plan*, MISSISSIPPI DEPARTMENT OF MENTAL HEALTH, http://www.dmh.ms.gov/what-we-believe/strategic-plan/ (last visited June. 7, 2022).

[169] *Mississippi*, 400 F. Supp. 3d at 575-76.

[170] *Id.* at 576.

such a plan, it would be "useless."[171] In contradiction to this testimony, the DMH Executive Director contended that DMH's *Olmstead* plan consists of "a collection of documents" including annual strategic plans and budget requests.[172] Judge Reeves found the latter testimony unpersuasive and concluded the State likely lacks an *Olmstead* plan.[173]

Furthermore, the federal government pointed out that DMH's strategic plans "still do not include measurable goals."[174] Regardless, the State has not shown that the strategic plans result in fewer people being hospitalized, as the number of inpatients has remained at nearly three-thousand for the past six years.[175] Judge Reeves agreed with the federal government, finding that the State's existing documents do not effectively satisfy the State's own goals.[176]

Judge Reeves listed a few examples illustrating how the State's "scattered, ineffective assemblage of documents" do not satisfy *Olmstead*.[177] First, PACT failed to expand over 2017-2018 as planned.[178] Second, supported employment falls below DMH's recommendation from 2011.[179] Finally, the number of state hospital beds has been consistent since 2014, despite Mississippi's intentions to shift to community-based care.[180] While the State may have good intentions, "[t]he fact remains that neither Congress nor the Supreme Court [has] made a state's good intentions a defense to an *Olmstead* claim."[181] As such, Mississippi not only lacks a formal *Olmstead* plan, but its strategic plan also fails to satisfy the *Olmstead* requirements. Perhaps the State could benefit from modeling an *Olmstead* plan after another state with an effective plan.

One such state is Minnesota. Minnesota began to develop its *Olmstead* plan in 2009 as a result of a lawsuit similar to Mississippi's.[182] This settlement resulted in moving Minnesotans with psychiatric vulnerabilities to the least restrictive settings by expanding community

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[171] *Id.*

[172] *Id.* 576-77.

[173] *Id.*

[174] *See* Jeff Amy, *Analysis, Mississippi Says Mental Health Demands Exceed Law*, AP NEWS (June 2, 2019), https://apnews.com/article/fa4df6600e774f07a6082ae9c71c9a1a.

[175] *See id.*

[176] *Mississippi*, 400 F. Supp. 3d at 577.

[177] *Id.*

[178] *Id.*

[179] *Id.*

[180] *Id.*

[181] *Id.* at 578.

[182] *See* Sloan, *supra* note 74 (citing Jensen v. Minn. Dept. of Human Services, No. 09-1775 (DWF.FLN), 2012 WL 1409283 (D. Minn. May 21, 2012)).

support services.[183] The settlement agreement required that the State create an *Olmstead* plan within eighteen months, but it took four years for the State to develop its plan.[184]

Minnesota's *Olmstead* plan aims to achieve fifty measurable goals which can be allocated into four groups: (1) moving individuals with disabilities from segregated to integrated settings; (2) moving persons from waiting lists; (3) measuring quality of life; and (4) increasing system capacity and options for integration.[185] Additionally, the *Olmstead* plan focuses on full integration into the community by targeting not only housing but employment and education as well.[186] Within four years of implementing its plan, Minnesota had moved thousands of individuals from segregated to integrated settings, eliminated its waiting list for community housing disability waivers, and decreased the number of people waiting for developmental disability waivers.[187] Despite these vast strides toward complete integration, as of 2019 Minnesota still faces a shortage of more affordable community housing.[188]

Mississippi should model its *Olmstead* plan after Minnesota's approach to holistic community integration. Mississippi's *Olmstead* plan certainly needs to identify measurable goals, and perhaps those goals could align with Minnesota's four categories. In addition to finding guidance within Minnesota's plan, Mississippi should research and adopt effective *Olmstead* plans from other states, perhaps with challenges similar to those faced by Mississippi. For instance, in order to identify measurable goals, the State should better utilize its *Olmstead* task force as other states have done.

While Mississippi did not develop its strategic plan until nearly a decade after *Olmstead* in 2008,[189] Georgia swiftly began implementing *Olmstead*'s holding in 1999 with the creation of its Blue Ribbon Taskforce.[190] This task force consisted of consumers (people with disabilities), parents, advocates, and various professionals.[191] The group was tasked with several initiatives: (1) advising the State on the status of and future need for community-based services in Georgia; (2) identifying barriers to accessing such services; (3) making funding suggestions; (4)

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[183] *See id.* at 410.
[184] *See id.*
[185] *See id.*
[186] *See id.*
[187] *See id.*
[188] *See id.*
[189] *See Strategic Plan*, *supra* note 168.
[190] *See* Tidwell, *supra* note 9, at 714.
[191] *See id.*

advising how to prioritize services; and (5) pinpointing potential waiting list criteria.[192]

After this task force provided its recommendations in 2001, the Georgia Department of Human Resources received a grant from the Center for Health Care Strategies to develop an *Olmstead* plan, and the State established an *Olmstead* Planning Committee.[193] This committee consisted of consumers, family members, service providers, state hospital representatives, advocates, and state-agency staff members.[194] After eight meetings over a series of months, the committee issued a final report containing recommendations for transitioning individuals from institutions to communities by increasing community system capacity.[195] These recommendations were incorporated into Georgia's *Olmstead* Strategic Plan, which contains measurable goals and the actions required to achieve them.[196]

Mississippi would benefit greatly from establishing an *Olmstead* advisory committee similar to Georgia's *Olmstead* Planning Committee. While Mississippi currently has a mental health planning and advisory council, this council could be improved to better utilize its potential for impact.[197] Unlike Georgia's transparent *Olmstead* task force and committee, which has its own web page and publicly-published recommendations, Mississippi's council operates under the radar.[198] For instance, a simple Google search generates no mention of this council or its recommendations. Melody Worsham, a member of the council, echoed the need for improvements to this group.[199] For example, she revealed that the council has been operating without a manual until recently.[200] It was not until DMH sent an operating manual—which was drafted in 2012—to Ms. Worsham in 2020 that the entire council received a copy, upon *her* distribution to other members.[201] Additional documentation and information concerning and/or governing the council is virtually

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[192] *See id.*

[193] *See id.* at 715.

[194] *See id.*

[195] *See id.*

[196] *See State of Georgia* Olmstead *Strategic Plan*, GOVERNOR SONNY PERDUE, file:///Users/mckennastone/Downloads/31848286olmstead_plan%20(2).pdf (last visited June 8, 2022).

[197] Worsham, *supra* note 1.

[198] *Id.*

[199] *Id.*

[200] *Id.*

[201] *Id.*

nonexistent.[202] The council also fails to collaborate with residents and councils of other states to gather external guidance.[203]

Mississippi's State Board of Mental Health is required to form advisory councils "to assist the board and department in the performance and discharge of their duties,"[204] but the current council is not being utilized effectively to assist DMH. Implementing simple changes to this already-formed group could significantly enhance the State's mission to achieve *Olmstead* compliance. For instance, the council could operate more publicly, perhaps by holding open meetings, publishing meeting minutes, collaborating with similar advisory groups from other states, and creating a website detailing the council's members and outlining recommendations for change. If such changes were implemented, this group could be a catalyst not only for forming an effective *Olmstead* plan like Georgia but also for addressing racial/ethnic and socioeconomic mental health disparities throughout Mississippi.

After creating an *Olmstead* plan with the guidance of the State's mental health planning and advisory council, the second step toward compliance requires every "red" state's worst nightmare: increased funding, at least in the near term.[205]

2. Increase and Reallocate Funding for Community-Based Services

As is true with many divisive political issues, implementation boils down to funding. State governments have continued to decrease spending for mental health services since deinstitutionalization began in the 1960s.[206] By 2006, combined state spending on mental health had plummeted to less than twelve percent of the total amount spent in 1955.[207] Furthermore, the 2007 recession prompted additional cuts to state mental health budgets, straining the systems even further.[208]

Complying with *Olmstead* and expanding community-based services requires a substantial monetary investment—at least up front.

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[202] *Id.*

[203] *Id.*

[204] Miss. Code Ann. § 41-4-9 (2013).

[205] *See infra* notes 216-17 and accompanying text (explaining how economic analyses suggest that proper care in community-based settings generates substantial cost savings down the road).

[206] *See* Redfern, *supra* note 31, at 1284 (citing Bazelon Ctr. For Mental Health Law, *Funding for Mental Health Services and Programs* (2011), https://perma.cc/W6Q7-Y6QA).

[207] *See id.*

[208] *See id.*

Since Mississippi is one of the poorest states in the nation,[209] funding such an initially expensive goal can be problematic, but it is not impossible. Considering that Mississippi's *Olmstead* litigation with the DOJ began over a decade ago, one would imagine the State would make every effort to decrease reliance on institutional settings and appropriate more funding to community-based resources. Surprisingly, however, that does not seem to be the case.

Judge Reeves determined that Mississippi is *still* increasing institutionalization through policy changes, such as by increasing hospital beds at some of its facilities.[210] Meanwhile, the ADA and *Olmstead* "protect persons trapped in a snail's-pace deinstitutionalization" by integrating them into mainstream life through the use of community-based services.[211] During the trial of *United States. v. Mississippi*, the federal government conceded that the State has effective community-based services but argued that Mississippi fails to offer such services in enough places.[212] Judge Reeves agreed with the Federal Government's position.

As Judge Reeves recognized, funding is a prominent factor contributing to the State's violation of the ADA and *Olmstead*, including both an inadequate mental health budget and misallocation of the existing money.[213] Mississippi allocates substantially more money to institutional settings and less to community-based services, particularly compared to other states.[214] In 2011, the DOJ found that Mississippi spent fifty-five percent of its mental health budget on institutional services, yet other states on average allocated twenty-seven percent of their budgets toward institutional care.[215] In order to provide patients with the least restrictive treatment options pursuant to the ADA and *Olmstead*, the Mississippi Legislature and DMH must allocate more funding toward expanding community-based treatment options. In fact, these short-term costs will lead to long-term savings.

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[209] *See Top 10 Poorest States in the U.S.*, FRIENDS COMMITTEE ON NATIONAL LEGISLATION (Oct. 5, 2020), https://www.fcnl.org/updates/2020-10/top-10-poorest-states-us.

[210] *Mississippi*, 400 F. Supp. 3d at 554.

[211] *Id.*

[212] *See* Amy, *supra* note 174.

[213] *Mississippi*, 400 F. Supp. 3d at 578.

[214] *Id.* at 565.

[215] *Mississippi Department of Mental Health Findings Letter*, U.S. DEPARTMENT OF JUSTICE, CIVIL RIGHTS DIVISION, 3 (last updated, Dec. 22, 2011), https://www.justice.gov/sites/default/files/crt/legacy/2012/01/26/miss_findletter_12-22-11.pdf.

Ironically, Mississippi's lack of community-based services costs the government more money overall.[216] According to Debbie Plotnick, Mental Health America's vice president for mental health and systems advocacy, "[t]he most expensive ways to deal with mental health are emergency departments, inpatient hospitalization and the criminal justice system including using the police as first responders. So, if you can keep people from repeating that cycle, it saves the state and county money and it makes for healthier communities."[217] Research demonstrates that community-based treatment is cost-effective and generates substantial savings when implemented.[218]

Not only should community-based services be viewed as cost-effective strategies for states—particularly when compared to institutional treatments—but community-based treatment is also more effective and preferred for many individuals with psychiatric vulnerabilities.[219] For instance, in contrast to living in institutional settings, supported housing for such individuals has increased housing stability, improved mental health systems, reduced hospitalization, and heightened satisfaction with the quality of life.[220] Research also indicates that patients highly prefer community-based treatment to institutional treatment.[221]

DMH and the Mississippi Legislature have focused on increasing funding for community-based services over the past few years. In Fiscal Year 2019, DMH reallocated funding from institutional budgets to the "Service Budget" in order to increase community-based services and reduce reliance on institutional care.[222] For the past five years, the State Legislature has appropriated $16.1 million each year to DMH to expand community-based services.[223] DMH requested $1 million for community-based treatment expansion in its Fiscal Year 2020 legislative budget request.[224] While these numbers sound promising, the Federal Government and Judge Reeves have determined they are not enough. If the State is to

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[216] *See* Smith, *supra* note 143.

[217] *Id.*

[218] *See* Redfern, *supra* note 31, at 1289 (citations omitted).

[219] *Id.* at 1287-88.

[220] *Id.* at 1287 (citation omitted).

[221] *Id.* at 1288 (citing Bazelon Ctr. For Mental Health Law, *A Place of My Own: How the ADA is Creating Integrated Housing for People with Mental Illnesses*, 6 (2014), https://perma.cc/D3Y7-TW55).

[222] *See DMH Fiscal Year 2020 Legislative Budget Request*, MISSISSIPPI DEPARTMENT OF MENTAL HEALTH (Dec. 2, 2020), http://www.dmh.ms.gov/dmh-fiscal-year-2020-legislative-budget-request/.

[223] *See id.*

[224] *See id.*

comply with *Olmstead* and adequately expand community-based services, a more significant monetary commitment will be necessary.

Unfortunately, appropriating money toward community-based services will require sacrifices elsewhere, particularly for state hospitals. Mississippi's psychiatric hospitals already face difficulties with adequate staffing due to an underfunded mental healthcare system.[225] Judge Reeves noted,

> "[i]t should come as no surprise that when the State underfunds its large systems, whether schools, social service agencies, prisons, or mental health providers, the systems become ripe for constitutional violations. If it remains uninterested in fixing this problem, the State will be doomed to repeat it—and repeatedly have to defend it in federal court."[226]

Thus, while reallocating funds away from institutional settings and toward community-based services may be necessary at the outset in order to comply with *Olmstead*, the State's mental healthcare system and the individuals it serves will still suffer in the long run if underfunded. The State Legislature needs to continue increasing the mental health budget to address the holistic mental health needs of Mississippians.

While increasing and reallocating funding to expand community-based services are certainly necessary steps to achieving compliance with the ADA and *Olmstead*, they form merely one piece of the puzzle. Without improved collaboration and patient discharge plans, the cyclical, broken system will persist regardless of how much money is poured into it.

3. Improve Collaboration and Patient Discharge Plans

In order to comply with the ADA and *Olmstead* and address racial/ethnic and socioeconomic mental healthcare parity, it is essential for State agencies to better collaborate and to improve patient-discharge plans. First, DMH must restructure internally and provide more state-wide oversight, as well as better collaborate with other State agencies. DMH proudly displays its mission of "[s]upporting a better tomorrow by making a difference in the lives of Mississippians with a mental illness, substance use disorder and/or intellectual and developmental disability one person at

[225] *Mississippi*, 400 F. Supp. 3d at 578 n.54.
[226] *Id.*

a time."[227] In order to more effectively achieve this mission, DMH must collaborate with other State agencies with similar objectives, such as the Mississippi Division of Medicaid and the Mississippi Department of Finance and Administration ("DFA").[228] Currently, these entities operate separately within their own silos, missing the chance to form a strong alliance for consumers with psychiatric vulnerabilities.[229]

There is a tremendous opportunity for cross-agency collaboration with the recent appointments of two new positions. In October 2020, DFA created a new governmental position and appointed an attorney from the Mississippi Attorney General's Office to serve as the State's coordinator of mental health accessibility.[230] This coordinator is not a mental health or systems expert but rather an attorney who has previously advocated to make it easier for family members and judges to force institutionalization.[231] According to Melody Worsham, DFA did not collaborate with DMH when making this appointment, despite the fact that the coordinator is tasked with evaluating the State's *mental healthcare* and proposing changes to improve the system.[232] However, this new coordinator is directed to consult with the Special Master appointed in *United States v. Mississippi*, DMH, the Division of Medicaid, and other State agencies to "perform a comprehensive review of Mississippi's mental-health system to determine whether the mental-health services, to include community mental-health services," are adequately accessible to Mississippians.[233] If these appointees and State agencies collaborate to address the same goal, then perhaps the State can create a plan of action to finally comply with *Olmstead* and address racial/ethnic and socioeconomic mental health disparities.

This type of collaboration is needed not just among various State agencies, but also within DMH. As Judge Reeves has noted, DMH is not providing sufficient oversight to state-run CMHCs; rather, CMHCs operate as independent, autonomous organizations.[234] This is concerning because

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[227] *Mission, Vision, and Values*, MISSISSIPPI DEPARTMENT OF MENTAL HEALTH, http://www.dmh.ms.gov/what-we-believe/mission/#:~:text=We%%2020envision%20a%20better%20tomorrow,provision%20of%20services%20and%20supports.&text=All%20Mississippians%20have%20equal%20access,and%20supports%20in%20their%20communities%20(last%20visited%20Jan.%208,%202021 (last visited June. 8, 2022).

[228] *See* Booker, *supra* note 34, at 3.

[229] *Id.*

[230] *See* Vance, *supra* note 115.

[231] Worsham, *supra* note 1.

[232] *Id.*

[233] S. 2610, 2020 Leg. Sess., (Miss. 2020).

[234] *See Mississippi*, 400 F. Supp. 3d at 563-64.

DMH is responsible for overseeing and expanding community-based services throughout the State.[235] This issue has also been confirmed by mental health professionals who have worked for the system.

According to Dr. Julie Teater, a Forensic Psychologist who has served as a mental health professional in Mississippi for over twenty years, there are discrepancies in care across the system due to insufficient oversight at the State level.[236] The various CMHCs across the State operate independently in their own silos; this perpetuates a lack of accountability, collaboration, and equitable distribution of care.[237] Dr. Teater insists that the key to fixing this broken system is for DMH to do more than just fund the CMHCs; DMH must increase its involvement with the regional centers and set consistent standards and guidelines.[238]

The recent closure of one particular CMHC illustrates the product of the current siloed system. Gulf Coast Mental Health, a multi-county mental health provider in South Mississippi, shut its doors in 2019 due to lack of funding.[239] Dr. Teater revealed that this closure was the result of mismanagement which, despite having been brought to the attention of DMH in advance, persisted for an extensive period of time.[240] The center fell into financial crisis due to "billing problems" when the center's billing department ceased billing insurance companies for services provided.[241] Such neglect demonstrates the consequences of DMH allowing CMHCs to operate as autonomous organizations. Judge Reeves and Dr. Teater both suggest it is necessary for DMH to increase oversight and hold the CMHCs more accountable.

In addition to providing more oversight and accountability, DMH also needs to restructure its current system for providing patient-discharge plans. An effective discharge plan will better secure a strong continuum of care for individuals with psychiatric vulnerabilities.[242] The process of

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[235] *Id.*

[236] Telephone interview with Julie Teater, Clinical and Forensic Psych., (Oct. 2, 2020) (notes on file with *Mississippi College Law Review*).

[237] *Id.*

[238] *Id.*

[239] *See* Lindsay Knowles, *Gulf Coast Mental Health Center to Close its Doors at Clinics in Four South Mississippi Counties*, WLOX (July 18, 2019), https://www.wlox.com/2019/07/18/gulf-coast-mental-health-center-close-its-doors-clinics-four-south-ms-counties/#:~:text=SOUTH%20MISSISSIPPI%20(WLOX)%20%2D%20A,11%20%2C%20%202019%20WLOX.

[240] Teater, *supra* note 236.

[241] *See* Anita Lee, *'There's Going to be People Dying.' Can Gulf Coast Mental Health Overcome Financial Ruin?*, SUN HERALD (July 19, 2019), https://www.sunherald.com/article232857862.html.

[242] *See* Booker, *supra* note 34, at 3.

discharging consumers from psychiatric hospitals and developing a plan for care is an essential tool for successfully transitioning individuals to their next healthcare setting.[243] A weak transition can have devastating effects not only for the patient but also for the family and can present a barrier for individuals who seek to live independently in the community.[244] Improving discharge planning can benefit both the individual and the system, as doing so may reduce readmission rates.[245]

After investigating the State's mental health system, the DOJ determined that Mississippi's current system fosters a risk of reinstitutionalization.[246] When patients are discharged from hospitals, the State often fails to ensure there are adequate services and supports in the community to meet the patient's needs.[247] This failure to consistently coordinate between the institutions and community providers creates a risk of re-institutionalization on an already over-burdened system.[248] CMHCs play a core role in supporting individuals with psychiatric vulnerabilities when they return home to their community. Unfortunately, however, the CMHCs are currently not involved in treatment and discharge planning.[249] While the State may attempt to ensure that an individual has sufficient medication to make it to the next appointment with his psychiatrist, this is merely one component of the necessary post-discharge support.[250] Thus, in order to prevent and decrease reinstitutionalization, the State must improve its patient discharge plans by consistently creating *individualized* plans and facilitating collaboration between institutions and community-based care. This will help ensure that patients are connected to appropriate community-based treatment after discharge.

The State could also improve patient discharge plans by developing a state-wide electronic medical records system.[251] Currently, patients' medical records are not shared between CMHCs and hospitals, preventing providers from developing "a cohesive plan."[252] A state-wide records system would allow emergency room providers to access patients' medical

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[243] *See id.*
[244] *See id.* at 3-4.
[245] *See id.*
[246] *Mississippi Department of Mental Health Findings Letter*, *supra* note 215, at 21.
[247] *Id.*
[248] *Id.*
[249] *Id.*
[250] *Id.*
[251] *See* Smith, *supra* note 143.
[252] *See id.*

histories, view their past and current medications, and contact their regional CMHC to connect them with necessary support systems.[253]

By improving collaboration between State agencies and CMHCs and implementing patient-centered discharge plans, Mississippi would come one step closer to complying with the ADA and *Olmstead* and combatting mental health disparities. Another proposal to expanding access to mental healthcare is by increasing the utilization of telehealth.

4. Increase Telehealth Accessibility

Expanding access to telehealth and telemedicine[254] can help Mississippi come into compliance with the ADA and *Olmstead* and better achieve racial/ethnic and socioeconomic mental health parity. Telehealth can be defined as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration."[255] Telehealth has transformed access to care by allowing underserved populations and rural communities to receive services remotely.[256] By allowing patients to virtually access psychiatric providers at their homes and local community health centers, increasing telehealth programs within communities could reduce unnecessary institutionalization as well as increase access to mental health parity.[257]

Astonishingly, on the thirtieth anniversary of the passage of the ADA, the country saw an unprecedented use of telehealth in 2020. Access to telehealth expanded nationwide in response to the 2020 COVID-19 pandemic.[258] For instance, the U.S. Department of Health and Human Services temporarily relaxed telemedicine HIPAA regulations—allowing healthcare providers to utilize popular apps for telehealth and telemedicine services even if the application does not fully comply with HIPAA rules.[259] Furthermore, the Centers for Medicare and Medicaid Services issued

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[253] *See id.*

[254] Telehealth differs from telemedicine, as telehealth "refers to a broader scope of remote health-care related services than telemedicine." Telemedicine refers only to remote clinical services, while telehealth encompasses remote non-clinical services as well. *Advances in Telehealth*, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, https://aspe.hhs.gov/advances-telehealth (last visited June 8, 2022).

[255] *Advances in Telehealth*, *supra* note 254.

[256] *Id.*

[257] *See* James A. McClure IV, *Psychiatric Boarding in New Hampshire: Violation of a Statutory Right to Treatment*, 14 U.N.H.L. REV. 197, 223 (2016).

[258] *See Telehealth: Delivering Care Safely During COVID-19*, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, https://www.hhs.gov/coronavirus/telehealth/index.html (last visited Dec. 3, 2020).

[259] *See id.*

temporary measures to make it easier for people to receive care through telehealth and telemedicine during the pandemic.[260] These federal changes sparked a national increase in the use of telehealth services, particularly in mental healthcare.[261] Similarly, states made telehealth rules and regulations more flexible during the pandemic.

Mississippi expanded the use of telehealth in response to the global outbreak. In March 2020, Governor Tate Reeves announced the expansion of Mississippi's telehealth coverage to increase care and slow the spread of COVID-19.[262] The Mississippi Division of Medicaid issued an Emergency Telehealth Policy that expanded its coverage of telemedicine and telehealth services throughout the State in alignment with Governor Reeves's recommendations.[263] Similarly, private health insurance companies, such as Blue Cross and Blue Shield of Mississippi and United Healthcare, temporarily expanded telemedicine and telehealth coverage.[264] Additionally, various healthcare licensure boards, including the Mississippi Board of Medical Licensure and the Mississippi Board of Nursing, temporarily lifted licensing restrictions to permit more out-of-state providers to practice and treat patients across borders with ease.[265]

Dr. Jay Stone, a Licensed Clinical Psychologist who has provided mental healthcare for the State for nearly a decade, attests to the need for making telehealth flexibility permanent.[266] Dr. Stone conveyed that prior to the emergency telehealth policies, he was unable to utilize telehealth with his patients due to existing barriers.[267] However, once telehealth policies were alleviated to allow professionals and patients to utilize such services with ease, Dr. Stone began to treat many patients via video and phone.[268] He swiftly acquired temporary licensure in other states, such as Tennessee,

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[260] *See id.*

[261] *See* Jeff Lagasse, *Behavioral Health Providers Embracing Telehealth During the COVID-19 Pandemic*, HEALTHCARE FINANCE (Sept. 24, 2020), https://www.healthcarefinancenews.com/news/behavioral-health-providers-embracing-telehealth-during-covid-19-pandemic.

[262] *Governor Tate Reeves Expands Telehealth to Further Care in COVID-19 Response*, OFFICE OF GOVERNOR TATE REEVES (March 19, 2020), https://mailchi.mp/39eaa3625e61/governor-tate-reeves-expands-telehealth-to-further-care-in-covid-19-response?e=950aca5a2d.

[263] *Id.*

[264] *See Telehealth Policy Updates Related to COVID-19*, MISSISSIPPI TELEHEALTH ASSOCIATION, https://www.mstelehealth.org/telehealth-policy-updates-related-to-covid-19/ (last visited Dec. 3, 2020).

[265] *See id.*

[266] Interview with Jay Stone, Retired Air Force Colonel and Licensed Clinical Psych., (Nov. 8, 2020) (video and notes on file with *Mississippi College Law Review*).

[267] *Id.*

[268] *Id.*

in order to continue treating his patients who had to travel out-of-state for the pandemic.[269]

Dr. Stone is a proponent for making the telehealth emergency policies permanent for patients' convenience and needs, particularly in Mississippi—a state that faces mental healthcare challenges due to a rural geography, a shortage of mental health professionals, and insufficient community-based services.[270] He believes telehealth is an excellent alternative for many patients, particularly those who live in rural areas and have to travel long distances for appointments, as well as those who lack access to transportation.[271] With the use of telehealth, these remote patients have more efficient and affordable access to mental healthcare.[272] Dr. Stone relayed that he can treat many patients just as effectively via telehealth as he can in person and hopes to continue providing care in this manner after the pandemic subsides.[273]

The COVID-19 crisis showed the nation the positive implications of increasing telehealth use. However, the pandemic is not the only justification for expanding telehealth; Mississippi is one of several states that has faced a mental healthcare crisis since long before the pandemic. The emergency telehealth policies should be permanent while expanding their scope in order to aid the ongoing and critical mental healthcare crisis in Mississippi and other states. By alleviating telehealth restrictions in the State, expanding Medicaid and other insurance coverage for these services, and relaxing the licensure requirements for mental health professionals, there will be increased access to necessary mental health services for Mississippians with psychiatric vulnerabilities. By bringing virtual mental healthcare into individuals' homes and community health centers, unnecessary institutionalization could be reduced and mental health parity could be improved.

5. Expand Medicaid Mental Health Coverage and Eligibility

Pursuant to the Affordable Care Act ("ACA"), Mississippi should expand Medicaid to ensure that more individuals with psychiatric vulnerabilities have access to healthcare—particularly *mental* healthcare.[274]

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[269] *Id.*

[270] *Id.*

[271] *Id.*

[272] *Id.*

[273] *Id.*

[274] *See Medicaid Expansion*, NATIONAL ALLIANCE ON MENTAL ILLNESS, https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Medicaid-Expansion#:~:text=Medicaid%20expansion%20removes%20barriers%20for,need%2C%20when%20they%20need%20them. (last visited June 19, 2022).

After all, "as the nation's largest payer of mental health and substance use disorders," Medicaid is the lifeline for many individuals burdened with psychiatric vulnerabilities and lower socioeconomic status.[275] By increasing access to affordable community-based mental healthcare, Mississippi will better achieve *Olmstead* compliance and mental health parity.

The Supreme Court did not provide guidelines or criteria for states to comply with *Olmstead*; rather, it directed states to create a "comprehensive, effectively-working plan" for implementation.[276] In response to *Olmstead*, the Centers for Medicare and Medicaid Services ("CMS") ordered state Medicaid agencies to develop such a plan.[277] In the years which followed, the Department of Health and Human Services ("HHS") placed an emphasis on expanding community-based services by offering support to states through the Medicaid program.[278] In the wake of *Olmstead*, CMS administered a series of letters to State Medicaid Directors emphasizing the decision and providing guidance on how to comply with it.[279] In the first letter, dated January 14, 2000, CMS recognized that both institutional and community-based services for persons with disabilities are primarily funded by Medicaid, and that *Olmstead* will significantly impact state Medicaid programs.[280] More than twenty years after *Olmstead*, Medicaid funding, which finances the majority of long-term care for persons with developmental disabilities, is still a barrier to community integration, as it does not fully align with *Olmstead*'s vision.[281]

A step toward *Olmstead* compliance can be found in the Home and Community-Based waiver program.[282] This state-run program "meet[s] the needs of people who prefer to get long-term care services and supports in their community, rather than in an institutional setting."[283] The program strives to slow the growth of Medicaid spending and prevent increases in

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[275] *Id.*

[276] *See Gateway to Community Living: State of Alabama Long Term Care Rebalancing Initiatives*, ALABAMA MEDICAID AGENCY, 1 (Jan. 2012), https://medicaid.alabama.gov/documents/6.0_LTC_Waivers/6.1_HCBS_Waivers/6.1_Olmstead_Plan_4-8-12.pdf.

[277] *See id.*

[278] *See id.*

[279] *See A Compendium of Current Federal Initiatives in Response to the* Olmstead *Decision*, *supra* note 161.

[280] *See id.*

[281] *See* Sloan, *supra* note 74.

[282] *See* Booker, *supra* note 35, at 1.

[283] *See Home & Community-Based Services 1915(c)*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html (last visited June 19, 2022).

cost for community integration.[284] Mississippi currently has five home and community-based waiver programs: (1) the Elder and Disabled Waiver; (2) the Independent Living Waiver; (3) the Mentally Retarded/Developmentally Disabled Waiver; (4) the Assisted Living Waiver; and (5) the TBI/SCI Waiver.[285] Home and community-based waivers provide both home healthcare and services in the community.[286] Seventy-five percent of all home and community-based waiver spending in Mississippi is for services for persons with psychiatric vulnerabilities.[287] Studies indicate that the intellectual and developmental disability population of those eligible for Mississippi Medicaid is predicted to increase in terms of population and expenditure.[288]

The ACA of 2010 gave states the option to expand Medicaid eligibility and receive significant funding from the federal government for doing so.[289] Accordingly, states that adopt the Medicaid expansion can secure federal funding through Medicaid to cover the costs of community-based mental health treatments.[290] Medicaid states can cover services including assertive community treatment, peer-support services, mobile crisis teams, personal-care services, supported employment, and supported housing.[291] Thus, Medicaid expansion substantially alleviates the financial burden on states associated with providing community-based services.[292]

Despite its high demand for Medicaid services, Mississippi is one of only twelve states that has not expanded Medicaid as allowed under the ACA.[293] Expanding Medicaid coverage for mental health services could not only better serve individuals with psychiatric vulnerabilities, but it could also combat socioeconomic and racial/ethnic mental healthcare disparity. One of the primary reasons people experience a mental health crisis is because they are uninsured or underinsured and cannot afford their medication.[294] The majority of people served by CMHCs are of low socioeconomic status and either have insurance through Medicaid or are uninsured because they do not qualify for Medicaid.[295] When states expand

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[284] *See* Booker, *supra* note 35, at 1 (citations omitted).

[285] *See id.* at 2 (citing 42 CFR § 433.32 (2020)).

[286] *See* Booker, *supra* note 35, at 3.

[287] *See id.* at 2.

[288] *See id.*

[289] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 584-585 (2012).

[290] *See* Redfern, *supra* note 31, at 1290-91 (citation omitted).

[291] *See id.* at 1291.

[292] *See id.*

[293] *See* Louise Norris, *Mississippi and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (last updated Dec. 14, 2021), https://www.healthinsurance.org/medicaid/mississippi/.

[294] *See* Smith, *supra* note 143.

[295] *See id.*

Medicaid, there is an increase in individuals—particularly those who are low-income—served by community-based services.[296] By expanding Medicaid, Mississippi would render an additional 231,000 adults eligible for healthcare.[297] While Judge Reeves determined that Medicaid expansion is not necessary for *Olmstead* compliance,[298] it would certainly improve compliance efforts and healthcare parity.

Inadequate Medicaid coverage not only negatively impacts individuals with psychiatric vulnerabilities, but it also affects CMHCs that absorb the cost of people with no insurance.[299] In 2018, Region Fifteen provided almost $1 million worth of uncompensated indigent services to the 3,600 adults and youth served that year.[300] By expanding Medicaid to allow more people to obtain insurance and increasing reimbursement rates, the State can connect more Mississippians to adequate mental healthcare.[301]

Even if Mississippi chose not to adopt Medicaid expansion to ensure more individuals are eligible for Medicaid, Mississippi could increase access to affordable community-based mental healthcare by expanding the services covered by Medicaid. The Mississippi Division of Medicaid provides limited coverage for mental health services. For instance, Medicaid will not cover certain services such as Day Treatment if it is provided on the same day as another service that Medicaid classifies as duplicative.[302] Additionally, while Medicaid provides non-emergency transportation, it is not readily available in all rural areas and mileage is not reimbursed.[303] Most recently, the Mississippi Division of Medicaid informed mental health providers across the State that Licensed Clinical Social Workers, Licensed Professional Counselors, and Licensed Marriage and Family Therapists can no longer be reimbursed for adults with Medicaid coverage, despite Mississippi's shortage of mental health services and providers.[304]

In essence, by expanding those eligible for Medicaid and the services covered by Medicaid, Mississippi can better achieve *Olmstead* compliance and improve racial/ethnic socioeconomic mental health parity. The five aforementioned proposals are recommendations to help Mississippi and other states comply with *Olmstead* and the ADA. But what

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[296] *See Mississippi*, 400 F. Supp. 3d at 574 n.51.
[297] *Id.*
[298] *Id.*
[299] *See* Smith, *supra* note 143.
[300] *See id.*
[301] *See id.*
[302] *See id.*
[303] *See id.*
[304] Interview with Lynn Stone, Partner and Off. Manager, Bridgewater Psychiatry (Jan. 15, 2021) (notes on file with *Mississippi College Law Review*).

are the implications of adopting these proposals and coming into compliance with the federal mandates?

B. Compliance Implications

Mississippi can be used as a case study for other states that are in violation of the ADA and *Olmstead* or that face similar barriers with racial/ethnic and socioeconomic mental healthcare inequities. While Mississippi confronts unique challenges such as a rural geography, a less populous citizenry, and a general lack of monetary resources, the findings and proposals contained herein are transferable to other states across the nation. For instance, the general pattern for states over the past six decades has been to disinvest in mental health and decrease funding for associated services.[305] Thus, there is a nationwide need to prioritize and invest in mental healthcare on the state levels. Similarly, as the country has already made a unanimous shift toward the temporary expansion of telehealth during the COVID-19 pandemic, each state has the autonomy to make the emergency telehealth policies permanent.[306]

There are two primary reasons why states should adopt these proposals. First, states in violation of *Olmstead* should adopt these recommendations in order to, in the words of Melody Worsham, "stop violating people's rights." By expanding access to community-based services through funding, collaboration, and more, states will ensure that individuals with psychiatric vulnerabilities are provided with the least-restrictive treatment possible. Such individuals can thereby live among their peers, contribute to society, and experience the limitless joys of community living. Additionally, the expansion of community-based services alleviates pressure from overburdened public institutional settings, decreases rates of institutionalization, and ultimately costs less. Consumers win, providers win, and the system wins.

Second, regardless of whether a state is in violation of *Olmstead*, adoption of these recommendations positively addresses racial/ethnic and socioeconomic mental healthcare disparities. By expanding access to community mental health services, hospitalization and emergency rates will decrease among lower-income communities and people of color who are more likely to experience untreated mental illnesses or disabilities. Such mental health equity should be a goal for all states.

Further research is necessary to identify ways in which states can better comply with the ADA and *Olmstead*, particularly states with limited monetary resources and rural geographies. Moreover, while increasing

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[305] *See supra* notes 206-08 and accompanying text.

[306] *See supra* notes 258-61 and accompanying text.

access to affordable community-based services increases mental health parity, there are significantly more steps that must be taken to combat racial/ethnic and socioeconomic inequities in the United States. Ending discrimination and disparity requires additional research and action to protect and defend our most vulnerable populations.

V. CONCLUSION

Happy twentieth birthday, *Olmstead*; you've been violated, *again*. In 2019, on the twentieth anniversary of the publication of *Olmstead v. L.C. ex rel Zimring*, Mississippi was found to be in violation of the Americans with Disabilities Act and *Olmstead* due to unnecessarily institutionalizing individuals with psychiatric vulnerabilities. The federal mandate is simple: "Stop violating people's rights." However, Mississippi's lack of community-based services not only violates the rights of people with psychiatric vulnerabilities, but it also fosters racial/ethnic and socioeconomic mental health disparities. There are five recommendations to achieve *Olmstead* compliance and address racial/ethnic and socioeconomic mental health disparities: (1) create an *Olmstead* plan with measurable goals; (2) increase and reallocate funding for community-based services; (3) improve patient-discharge plans and collaboration among state actors; (4) increase telehealth accessibility; and (5) expand Medicaid mental health coverage and eligibility.

Complying with the ADA and *Olmstead* will provide individuals with psychiatric vulnerabilities with the least-restrictive treatment possible, ensuring such individuals are not unnecessarily institutionalized against their will. Furthermore, expanding access to affordable community-based services will increase racial/ethnic and socioeconomic healthcare parity. This Comment implores states to heed the following call to action: put an end to discrimination and disparity.