

# **MADNESS AND MAYHEM: REFORMING THE MENTAL HEALTH CARE SYSTEM IN ARIZONA**

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*Neither state nor federal laws adequately protect the mentally ill in Arizona. Although the Arizona Supreme Court ordered the state to establish a comprehensive mental health system in 1989, this vision has never been fully realized. When the state plays multiple roles as the lawmaker, provider, and financer of mental health services, state courts have limited power to compel the financially distressed state to live up to statutory obligations. On the federal level, the U.S. Supreme Court instructed the judiciary to defer to states' distributive decisions with respect to their resources, thus permitting states to commit minimally to the mentally ill. Because litigation under the current legal framework is not an effective vehicle to advance the interests of the mentally ill, an alternative solution is to integrate Arizona's carve-out mental health services into the primary care system. An integrated mental health system has the potential to improve patients' overall well-being and reduce the long-term social and medical costs associated with inadequate mental health services.*

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## INTRODUCTION

There was no sign of trouble in Tucson, Arizona. Like a typical Saturday morning, Doris and Jim Tucker left home early and headed to Safeway, a local grocery store.<sup>1</sup> At the entrance of the store's bustling parking lot, a frame sign directed the Tuckers to their destination: Congresswoman Gabrielle Giffords' meet-and-greet event, "Congress on Your Corner." The January air was still brisk, but a feeling of upbeat anticipation warmed the Tuckers. Jim had never met the Congresswoman; but this time, he was the third in line to speak to her.

The Tuckers waited in good spirits, greeting the campaign staff and nodding to other constituents. Shortly afterwards, it was the Tuckers' turn, and a photographer was ready to capture the couple's moment with the Congresswoman. Yet, little did the Tuckers know that what would happen next could only be reconstructed from shattered memories and the limited angles of surveillance cameras.

Just when the Tuckers were starting to chat with Congresswoman Giffords, a hooded young man emerged from behind and unleashed a barrage of

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1. Interview with Doris Tucker, Project Coordinator, Univ. of Ariz. Steward Observatory, in Tucson, Ariz. (Oct. 11, 2011).

bullets, striking Giffords in the head, wounding Jim in the leg and chest, killing six other people, and injuring eleven more.

The Tuckers did not see this coming. But to those who had prior encounters with the 22-year-old gunman, Jared Loughner, his descent into violence was not a total surprise. In the community college Loughner attended, his bizarre and disruptive behaviors raised mounting concerns from students, teachers, and the campus police.<sup>2</sup> Loughner never sought an assessment from a mental health professional.<sup>3</sup> Only after the fatal shooting did Loughner receive an overdue mental health examination and diagnosis: He suffered from schizophrenia.<sup>4</sup>

The Tucson shooting appalled the nation. While the media immediately seized upon Loughner's mental illness, the less-covered story is the alarming state of Arizona's mental health system. To help close a billion-dollar budget gap, the state slashed mental health funding by \$108.4 million and reduced services to about 14,000 mentally ill Arizonans between 2008 and 2011.<sup>5</sup> For fiscal year 2012–2013, the state further proposed to cut 5,200 people with serious mental illness from the Medicaid program.<sup>6</sup> After years of mental health budget cuts and service elimination, the prospect for the mentally ill to receive proper, affordable care in Arizona appears increasingly dim.

The lives lost from Jared Loughner's shooting cannot be restored, but there is still hope of improving the mental health system and preventing further human and social losses. As Loughner's case has taught us, the costs of leaving the mentally ill untreated are catastrophic. This Note analyzes the history of Arizona's mental health system in the hope of finding effective ways to offer treatment to the mentally ill.

Historically, the mentally ill were segregated in a state-run insane asylum.<sup>7</sup> Beginning in the 1970s, Arizona started to remove patients from the

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2. *PBS NewsHour: In Loughner Case, Missed Signals and a Troubled Mental Past* (PBS television broadcast Jan. 11, 2011) (transcript available at [http://www.pbs.org/newshour/bb/health/jan-june11/mental\\_01-11.html](http://www.pbs.org/newshour/bb/health/jan-june11/mental_01-11.html)).

3. Brigid Schulte, *Jared Loughner's Behavior Never Reported to Mental Health Authorities: Official*, WASH. POST (Jan. 10, 2011, 4:56 PM), <http://voices.washingtonpost.com/44/2011/01/jared-loughners-behavior-never.html>.

4. See Carol J. Williams, *Loughner Loses Bid to Stay out of Missouri Prison Hospital*, L.A. TIMES (Oct. 7, 2011, 3:42 PM), <http://latimesblogs.latimes.com/nationnow/2011/10/loughner-can-return-to-missouri-prison-hospital-appeals-court-rules.html>.

5. RON HONBERG ET AL., NAT'L ALLIANCE ON MENTAL ILLNESS, STATE MENTAL HEALTH CUTS: A NATIONAL CRISIS 5 (2011), available at <http://il.nami.org/NAMISateBudgetCrisis2011.pdf>; see also Stephanie Innes, *Mental-Health Cuts Are Life-Threatening for Some*, ARIZ. DAILY STAR (Dec. 5, 2010, 12:00 AM), [http://azstarnet.com/news/science/health-med-fit/article\\_1404e540-646e-5155-90d0-5b6274f1068d.html](http://azstarnet.com/news/science/health-med-fit/article_1404e540-646e-5155-90d0-5b6274f1068d.html).

6. JANICE K. BREWER, OFFICE OF THE ARIZ. STATE GOVERNOR, THE EXECUTIVE BUDGET: FISCAL YEARS 2012 AND 2013, at 22 (2011), available at [http://azgovernor.gov/documents/AZBudget/2012/FY2012\\_ExecBudget\\_Summary.pdf](http://azgovernor.gov/documents/AZBudget/2012/FY2012_ExecBudget_Summary.pdf).

7. See David B. Wexler et al., *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 1–2 (1971); see also *infra* Part I.A.

hospital and send them back to the community—a process known as deinstitutionalization.<sup>8</sup>

In many respects, deinstitutionalization was a failure. While rapidly downsizing the mental hospital, the state failed to establish a proper treatment mechanism in the community to accommodate the newly discharged patients.<sup>9</sup> As a result, many were reinstitutionalized in isolated nursing homes,<sup>10</sup> while others were deposited in jails.<sup>11</sup>

In an attempt to redress the unsavory consequences of deinstitutionalization, advocates sued the State of Arizona for violating the statutory and constitutional rights of the mentally ill. In 1989, the Arizona Supreme Court, in *Arnold v. Arizona Department of Health Services*, ordered the state to create a comprehensive mental health system, regardless of the cost.<sup>12</sup>

The courtroom victory, however, did not translate into sustainable improvements in the mental health arena. Over the course of the *Arnold* litigation, the state lagged behind the compliance schedule and eventually reduced the judicial mandate to an empty promise.<sup>13</sup> Compelled by financial and political realities, the judiciary retreated from an active review of the state's compliance efforts and, in 2010, suspended the *Arnold* lawsuit and stayed the enforcement of court orders.<sup>14</sup>

As protection from state laws wanes, federal laws provide the mentally ill with cold comfort. Technically, a portion of the mentally ill with Medicaid coverage would qualify as a disabled group under the Americans with Disabilities Act (“ADA”). However, the ADA does not specifically address the challenges faced by the mentally ill.<sup>15</sup> Although the U.S. Supreme Court in *Olmstead v. L.C.* recognized that unjustified segregation of the mentally ill in institutions constitutes a form of discrimination,<sup>16</sup> the Court nonetheless advised the judiciary to defer to states' distributive decisions with respect to their own resources, including Medicaid programs for the mentally ill.<sup>17</sup>

Given Arizona's current financial crisis and courts' limited powers to supervise mental health reform, a comprehensive mental health system is far from reality. However, this does not mean that Arizona may neglect its duties to the mentally ill. Rather, precisely because financial distress can trigger and aggravate mental health conditions and generate even more demand for mental health services, the state should seek cost-effective solutions for mental health care rather than abandon the vulnerable to despair and uncertainty.

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8. Wexler et al., *supra* note 7, at 1–2; *see also infra* Part I.A.

9. *See infra* text accompanying notes 28–31.

10. *See infra* text accompanying notes 32–34.

11. *See infra* note 35 and accompanying text.

12. 775 P.2d 521, 538 (Ariz. 1989).

13. *See infra* Part I.C.

14. *See infra* Part I.D.

15. *See infra* Part II.A.

16. 527 U.S. 581, 599–601 (1999).

17. *See infra* Part II.B.

One lesson from *Arnold* is that mental health reform should not rely solely on litigation and judicial oversight. Rather, the future of mental health care in Arizona lies in the maintenance and establishment of coordinated, cost-effective, and patient-centered services.<sup>18</sup> Clinical studies have shown that an integrated care model can reduce the incidence of untreated mental health problems and improve the overall well-being of the mentally ill at a relatively low cost.<sup>19</sup> Quality mental health care—whether it takes place in a hospital or in the community—is not, and will not be, free of cost, but a lack thereof can lead to devastating consequences. Integrating mental health care into the public health system would be a constructive step toward making the much-needed mental health services accessible, affordable, and less stigmatic in Arizona.

Part I of this Note reviews the development and the decline of *Arnold*—the landmark case that helped shape modern mental health care in Arizona. This Part also explains why *Arnold* has become obsolete after two decades of enforcement. Part II discusses the limited protection for the mentally ill under federal laws and focuses on the fundamental-alteration defense as interpreted in *Olmstead*. Further, this Part illustrates the separation-of-powers tension in the mental health reform and the constraints faced by courts attempting to intervene in states' distributive programs. Part III reviews Arizona's carve-out mental health structures and its recent efforts to establish integrated medical homes. This Part also explores different integration models as treatment options for the mentally ill.

## I. *ARNOLD*: UNRAVELING A COURT-ORDERED SAFETY NET FOR THE MENTALLY ILL

### A. *Deinstitutionalization in Arizona*

In 1887, the Insane Asylum of Arizona—the predecessor to the Arizona State Hospital—opened in Phoenix.<sup>20</sup> The state's patient population in the mental hospital nearly doubled from 998 in 1942 to around 1,800 in the early 1950s.<sup>21</sup> It was during this period that state governments across the country began to downsize their mental hospitals and discharge the mentally ill to the community in a process known as deinstitutionalization.

Nationwide, a convergence of social forces contributed to deinstitutionalization. In 1954, the advent of chlorpromazine, the first effective antipsychotic medication, made it possible to care for persons with chronic mental illness outside the hospital.<sup>22</sup> Meanwhile, the expansion of federal welfare programs created strong financial incentives for states to change the locus of care

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18. See *infra* Part III.B.2.

19. See *infra* text accompanying notes 167–77.

20. *Arizona State Hospital – ASH History*, ARIZ. DEP'T OF HEALTH SERVS. [hereinafter *ADHS History*], <http://www.azdhs.gov/azsh/history.htm> (last updated Feb. 10, 2012).

21. *Id.*

22. Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 65–67 (2011).

for the mentally ill away from state hospitals. For instance, to take advantage of federal Medicaid funding, which excluded payments to “institutions for the treatment of mental disease,” states had to send patients to nursing homes and psychiatric wards of general hospitals that received federal subsidies.<sup>23</sup> Other federal programs, such as Supplemental Security Income and food stamps, provided a safety net for the mentally ill to live in the community.<sup>24</sup>

Social events also catalyzed a change in popular attitude toward the mentally ill. During World War II, the prevalence of mental illness among soldiers traumatized by their war experiences generated sympathy toward mental disorders.<sup>25</sup> Following the war, a series of personal accounts, literary works, and documentary films exposing abuses in psychiatric institutions sparked public outcry.<sup>26</sup> In addition, courts’ rulings limited involuntary institutionalization and set minimum standards for care in institutions, thus reinforcing the rights of the mentally ill to live in the community.<sup>27</sup>

In line with the national trend of deinstitutionalization, the Arizona State Legislature passed Senate Bill 1057 in 1970, requiring that a patient be dangerous to themselves or others in order to be confined to the hospital.<sup>28</sup> In 1973, the legislature created the Arizona Department of Health Services (“ADHS”), within which the Division of Behavioral Health Services oversees mental health services, including deinstitutionalization.<sup>29</sup>

As a result of deinstitutionalization, many patients who had been living in the state hospital for years were released and faced a vacuum of care and support upon entering the community.<sup>30</sup> Within a few months of deinstitutionalization, the institutionalized population in Arizona dropped dramatically from almost 2,000 to 300.<sup>31</sup> Although some community-based treatment programs sprouted in an unplanned manner, the fledgling ADHS struggled to assist the mentally ill in transitioning into the community. The Arizona State Hospital refused to work with community agencies and discharged mentally ill patients without any plan for continuing care.<sup>32</sup> As a result, most deinstitutionalized individuals went back to the community without referral, medication, or medical records.<sup>33</sup> Some of the patients were warehoused in nursing homes that shared the characteristics of large

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23. *Id.* at 67.

24. *Id.*

25. *Id.* at 68.

26. *Id.* at 68–70.

27. *See, e.g., O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (holding that “a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely” in the community).

28. *ADHS History*, *supra* note 20.

29. *Id.*

30. *See* MICHAEL S. SHAFER & BILL HART, ARIZ. STATE UNIV., ARIZONA’S PUBLIC BEHAVIORAL HEALTH CARE SYSTEM: CRITICAL ISSUES IN CRITICAL TIMES 2 (2009), available at <http://morrisoninstitute.asu.edu/publications-reports/AzPublicBehavHealthCareSys-CriticalIssuesCriticalTimes>.

31. *ADHS History*, *supra* note 20.

32. *Arnold v. Ariz. Dep’t of Health Servs.*, 775 P.2d 521, 527 (Ariz. 1989).

33. *Id.* at 524–27.

custodial institutions,<sup>34</sup> while many others lived on the fringe of society, roamed the streets in search of a homeless shelter, or landed in jail for petty crimes.<sup>35</sup>

### ***B. The Arnold Promise***

In 1981, Phoenix attorney Charles Arnold brought a class-action suit on behalf of the deinstitutionalized seriously mentally ill (“SMI”) individuals<sup>36</sup> against ADHS, alleging that the state had failed to fulfill its statutory obligations to the mentally ill.<sup>37</sup> In 1985, the trial court ordered the state to provide comprehensive mental health services to *all* class members, regardless of the cost.<sup>38</sup> In 1989, the Arizona Supreme Court affirmed, holding that the state failed to meet its moral and legal obligations to establish a unified, integrated, and coordinated mental health system.<sup>39</sup>

The court concluded that state laws impose upon the state a mandatory, nondiscretionary duty to provide “a full continuum of care” for the entire SMI class.<sup>40</sup> As the court pointed out, mental illness—just like physical illness—can be effectively managed, and a continuum of care would encompass a full spectrum of community support services, including housing, transportation, case management, crisis control, and vocational training.<sup>41</sup> While acknowledging that the mandated relief of systematic reform was “broad and all-encompassing,” the court maintained that it was well within the judicial powers to uphold state laws designed to protect the mentally ill.<sup>42</sup>

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34. *See id.*

35. Sandra Wachholz & Robert Mullaly, *Policing the Deinstitutionalized Mentally Ill: Toward an Understanding of Its Function*, 19 CRIME L. & SOC. CHANGE 281, 285 (1993). The criminal justice system appears to have absorbed part of the population that should be receiving mental health treatment. For a discussion on “transinstitutionalization”—the transfer of the mentally ill from hospitals to prisons—see Shauhin Talesh, *Mental Health Court Judges as Dynamic Risk Managers: A New Conceptualization of the Role of Judges*, 57 DEPAUL L. REV. 93, 97–100 (2007); *Deinstitutionalization: A Psychiatric “Titanic,”* PBS (May 10, 2005), <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html> (excerpting chapters from E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA’S MENTAL ILLNESS CRISIS* (1997)).

36. *Arnold*, 775 P.2d at 521. “Seriously mentally ill” is a diagnosis meaning that the mental disorder is severely and persistently disabling and requires intense behavioral healthcare. ARIZ. REV. STAT. ANN. § 36-550(4) (2012).

37. *Arnold*, 775 P.2d at 521–22; *see also* ARIZ. REV. STAT. ANN. §§ 36-550.01, -550.05, -3403(B)(1) (2012).

38. *Arnold*, 775 P.2d at 528.

39. *Id.* at 530–31. Although the suit was originally brought to address the service gap in Maricopa County, the court interpreted the statutes as applicable to the state. *Id.*

40. *Id.* at 529; *see also* ARIZ. REV. STAT. ANN. §§ 11-251(5), -291(A), 36-550.01, -550.05, -3403(B)(1) (2012). The court construed these provisions to demonstrate a comprehensive legislative scheme requiring state entities to jointly provide “a wide range of [mental healthcare] programs and services . . . as alternatives to institutional care.” *Arnold*, 775 P.2d at 528 (quoting ARIZ. REV. STAT. ANN. § 36-550.01(A) (1989)).

41. *Arnold*, 775 P.2d at 528.

42. *Id.* at 522.

The court then lamented that, far from realizing the “comprehensive state statutory design,” the state’s mental health “system” was fragmented and uncoordinated; as a result, the level of community-based care provided to the SMI was “tragically low,” and individuals who were capable of community living were merely reinstitutionalized in nursing homes.<sup>43</sup> In rejecting the state’s contention that a lack of funding justified the breach of its statutory duty, the court pointed out that the state did not present any direct evidence to show the impossibility of achieving a comprehensive mental health system.<sup>44</sup> Furthermore, the court suggested that the alleged financial hardships would not obliterate the state’s statutory obligation to care for the SMI because the Arizona Legislature must “fund whatever program[] [the statute] has required.”<sup>45</sup>

The court also added a moral dimension to its decision. Speaking for those “from the bottom rung of the ladder,”<sup>46</sup> the court pointed out that the state has a duty to redress the past wrongs done to the SMI, a long-underserved group that had been “imprisoned . . . in the shadows of public apathy.”<sup>47</sup> To remind the state of its responsibility to the mentally ill, the *Arnold* opinion ended with an emotionally charged statement: “[T]he moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadows of life, the sick, the needy and the handicapped.”<sup>48</sup>

In retrospect, *Arnold* prescribed an overly ambitious action plan for the state, and the opinion itself does not stand on unassailable grounds. First, the court did not address what would happen when the state can factually establish financial hardships: Could the state then *justifiably* defy its statutory obligations? In fact, the circumvented funding problem later threatened the validity of the *Arnold* order.<sup>49</sup>

Second, by holding that the state should pay whatever the statutes require, the court overlooked the fact that state laws do not demand the state to commit to the SMI at the expense of depleting the public coffer. *Arnold* read state statutes as a sword for the mentally ill, yet the lawmakers retain the power to repeal the statutes and thus disable this “sword.” In other words, state laws—which are subject to legislative actions—do not guarantee the strong protection on which *Arnold* seems to rely.

Third, *Arnold*’s attempt to institute and supervise systematic reform is limited by the principle of separation of powers among different governmental branches.<sup>50</sup> After all, courts cannot make financial choices or manage the welfare

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43. *Id.* at 523, 527.

44. *Id.* at 533–34.

45. *Id.* at 522.

46. *Id.*

47. *Id.* at 537.

48. *Id.* (quoting Hubert Horatio Humphrey, Address at the Dedication of the Hubert H. Humphrey Building in Washington, D.C. (Nov. 4, 1977), in 123 CONG. REC. 37, 287 (1977)).

49. *See infra* Part I.C–D.

50. For a discussion of several theories explaining why courts are not effective vehicles to advance social reforms, see GERALD N. ROSENBERG, *THE HOLLOW HOPE: CAN*



system on the state's behalf. While the *Arnold* court sought legal and moral justifications for its decision to compel mental health reform, the execution of this aspiration was left in the hands of the state.

### *C. The Reality of Arnold: A Slow, Steady Demise*

Undeniably, the *Arnold* decision led to remarkable progress in the field of mental health care: The lawsuit engaged the state in reform efforts and led to the creation of a Court Monitor to evaluate the state's compliance efforts.<sup>51</sup> While some condemned the *Arnold* decision as imposing heavy financial burdens on the state, many people applauded *Arnold* for giving a real voice to the mentally ill.<sup>52</sup>

But *Arnold* is not a panacea to the structural problems in the state's mental health system. After over two decades of enforcement, *Arnold* remained an ideal rather than a reality in Arizona, an outlier rather than a norm nationwide.<sup>53</sup> What *Arnold* could not cure was a separation-of-powers paradox: The state's lack of financial resources disabled judicial monitoring and augmented state control over the distributive programs.

From the outset, the *Arnold* mandate had been entangled in missed deadlines and unrealized promises. In 1991, the state developed the Implementation Plan ("Blueprint") to answer the court's mandate.<sup>54</sup> Because the state could not fully meet the Blueprint requirements by the court-ordered deadline, the parties then negotiated a narrower set of requirements to end the lawsuit in the Joint Stipulation on Exit Criteria and Disengagement ("Exit Criteria") and created a Court Monitor to assess the state's progress toward completing the *Arnold* requirements.<sup>55</sup> After conducting an audit in 1998, the Court Monitor concluded that the state was "far from" meeting the Exit Criteria.<sup>56</sup>

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COURTS BRING ABOUT SOCIAL CHANGE? 10–21 (1991) (noting three constraints on judicial efficacy: the limited nature of constitutional rights, the lack of judicial independence, and the judiciary's limited enforcement powers).

51. See *infra* text accompanying notes 55–61.

52. See Anjanette Riley, 'Arnold v. Sarn': *Helping or Hurting Arizona's Mentally Ill?*, ARIZ. CAPITOL TIMES, July 17, 2009.

53. See John Petrila & Jeffrey W. Swanson, Mental Illness, Law, and a Public Health Law Research Agenda 12 (Dec. 6, 2010) (unpublished manuscript), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1721189](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1721189) (labeling *Arnold* as a "notable exception").

54. See Joint Stipulation on Exit Criteria and Disengagement at 1–2, *Arnold v. Ariz. Dep't of Health Servs.*, No. C-432355 (Ariz. Super. Ct. Nov. 13, 1995), available at <http://www.azdhs.gov/bhs/scanned/sarnsjointstip.pdf>.

55. The exit stipulation is a method for determining when the state has established a system sufficient to satisfy the statutory requirements and end the lawsuit. See *id.* at 23–27 (stating actions necessary to meet the exit criteria).

56. See DEBRA K. DAVENPORT, ARIZ. AUDITOR GEN., REPORT NO. 99-12, REPORT TO THE ARIZONA LEGISLATURE: A PERFORMANCE AUDIT OF THE DEPARTMENT OF HEALTH SERVICES, DIVISION OF BEHAVIORAL HEALTH SERVICES 31–34 (1999), available at [http://www.azauditor.gov/Reports/State\\_Agencies/Agencies/Health\\_Services\\_Department\\_of/Performance/99-12/99-12.pdf](http://www.azauditor.gov/Reports/State_Agencies/Agencies/Health_Services_Department_of/Performance/99-12/99-12.pdf).

To avoid further litigation, the state negotiated a Supplemental Agreement.<sup>57</sup> In 2004, the Court Monitor scored the state's performance lower than its 1998 audit.<sup>58</sup> In response, the state presented a remedial plan that set a "final" compliance date by 2008.<sup>59</sup> The promise never materialized, and the audits between 2006 and 2009 continued to raise concerns.<sup>60</sup> The 2009 audit found "a pattern of regression and significant declines in a number of areas" and called for an extensive overhaul of the system.<sup>61</sup>

What perpetuated the state's pattern of noncompliance was an alarming shortage of funds. In 1998, the Human Services Research Institute Report estimated the total cost of complying with the *Arnold* lawsuit at \$317 million—a figure that was adjusted to \$800 million in 2008.<sup>62</sup> The growing SMI population and the increasing healthcare expenses led to a mismatch between the supply and demand in mental health services.<sup>63</sup>

The state's financing scheme also jeopardizes its compliance with *Arnold*. In Arizona, public behavioral health<sup>64</sup> funding comes from two major sources: the joint state–federal Medicaid program—Arizona Health Care Cost Containment

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57. See Supplemental Agreement at 5–10, *Arnold v. Ariz. Dep't of Health Servs.*, No. C-432355 (Ariz. Super. Ct. Dec. 10, 1998), available at <http://www.azdhs.gov/bhs/scanned/sarnssuppagree.pdf>.

58. The 2004 audit pointed to "poor clinical outcomes, a lack of peer support services and employment services, ineffective treatment plans and poor case management." *ValueOptions Implementing Corrective Action Plan in Arizona's Maricopa County: State Fines MBHO After Two Client Suicides*, MENTAL HEALTH WKLY., May 9, 2005, at 1.

59. See *Arizona Reaches Historic Agreement to End 25-Year Class-Action Lawsuit*, MENTAL HEALTH WKLY., Dec. 20, 2004, at 1.

60. See, e.g., OFFICE OF THE MONITOR, 2006 INDEPENDENT REVIEW 53–60 (2006), available at [http://www.azdhs.gov/bhs/monitor\\_report06.pdf](http://www.azdhs.gov/bhs/monitor_report06.pdf).

61. The 2009 audit found that 83% of the SMI did not have their mental health needs met according to their treatment plans; three in five did not have an adequate clinical team; four in five did not have a complete assessment of their mental health needs; and less than half were treated with dignity and respect. See Casey Newton, *Audit Calls County's Mental Care Worse: Monitor Faults New Contractor*, ARIZ. REPUBLIC (Jan. 14, 2009, 12:00 AM), <http://www.azcentral.com/arizonarepublic/news/articles/2009/01/14/20090114mentalhealth0114.html>.

62. Order Regarding Joint Stipulation to Stay Litigation During Fiscal Budget Crisis at 3, *Arnold v. Ariz. Dep't of Health Servs.*, No. C-432355 (Ariz. Super. Ct. Mar. 10, 2010) [hereinafter Stay Stipulation], available at <http://www.azdhs.gov/bhs/pdf/Court%20Order%203-9-10.pdf>.

63. When the Arizona Supreme Court decided *Arnold* in 1989, there were around 4,500 indigent SMI patients residing in Maricopa County. *Arnold v. Ariz. Dep't of Health Servs.*, 775 P.2d 521, 524 (Ariz. 1989). Today, Arizona's public behavioral healthcare system annually treats more than 160,600 individuals. As of January 2010, there were 39,051 Arizona adults enrolled in the public system classified as SMI. See DIV. OF BEHAVIORAL HEALTH SERVS., ARIZ. DEP'T OF HEALTH SERVS., BEHAVIORAL HEALTH AT A GLANCE 9 (2010), available at [http://www.azdhs.gov/bhs/pdf/DBHSATAGLANCE\\_2010LKN.pdf](http://www.azdhs.gov/bhs/pdf/DBHSATAGLANCE_2010LKN.pdf).

64. Behavioral health includes both mental health and substance abuse. For the purpose of this Note, "behavioral health" is used only to indicate the mental health component.

System (“AHCCCS”)—for the federally eligible mentally ill, and state general funds for those who do not qualify for Medicaid.<sup>65</sup> Current annual funding for the public behavioral health system totaled about \$1.36 billion, with 83.62% derived from AHCCCS sources and only 8.23% from state general funding.<sup>66</sup> In 2009, funding for the AHCCCS-enrolled *Arnold* class members totaled \$437 million; by contrast, the combined funding for the non-AHCCCS SMI was \$130.5 million.<sup>67</sup> The growth in behavioral funding was attributable almost exclusively to the increase in AHCCCS-based funding.<sup>68</sup> However, funding for the non-AHCCCS SMI population has remained stagnant since 1995.<sup>69</sup> The financing discrepancy ran counter to the *Arnold* goal of providing all SMI members equal access to mental health resources, regardless of their Medicaid status.

The system’s exclusive reliance on Medicaid-based funding has substantially limited the access of the SMI patients who have no Medicaid coverage. Unlike the state’s general funding scheme that delivers care to any uninsured low-income individual regardless of age, gender, or employment status, Medicaid patients must meet stringent enrollment eligibility requirements.<sup>70</sup> In Arizona, close to 40% of the SMI population do not qualify for Medicaid, mostly because they are not “poor” enough to meet the eligibility threshold, even though they may well be teetering on the verge of poverty.<sup>71</sup> Moreover, Medicaid eligibility tends to be short-lived.<sup>72</sup> Individuals with chronic mental problems who experience familial or employment changes may encounter abrupt termination of care when they lose their Medicaid coverage.<sup>73</sup>

Under *Arnold*, healthcare providers should treat the SMI equally, regardless of their ability to pay or their Medicaid eligibility.<sup>74</sup> However, as the state general funding dwindles, service utilization by the non-Medicaid SMI means losing business for providers. In 2008, it was estimated that treatment providers

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65. See ARIZ. SENATE RESEARCH STAFF, ARIZONA BEHAVIORAL HEALTH SERVICES, 48th Leg., 1st Reg. Sess., at 2 (2007), available at <http://www.azleg.gov/briefs/Senate/BEHAVIORAL%20HEALTH%20SERVICES.pdf>.

66. ARIZ. DEP’T OF HEALTH SERVS., *supra* note 63, at 9.

67. See Stay Stipulation, *supra* note 62, at 3.

68. SHAFER & HART, *supra* note 30, at 5.

69. Laura Nelson, Acting Deputy Dir. of ADHS/DBHS, Presentation for the Joint Meeting of the Senate Committee on Healthcare and Medical Liability Reform and the House Committee on Health and Human Services (Feb. 4, 2009) (slides of presentation available at <http://www.azdhs.gov/bhs/pdf/Leg%20Hearing%20BH%202-4-09%20FINAL.pdf>).

70. See ARIZ. HEALTH CARE COST CONTAINMENT SYS., AHCCCS ELIGIBILITY REQUIREMENTS 1–2 (2010), available at <http://www.azahcccs.gov/community/Downloads/resources/EligibilityRequirements.pdf>.

71. See SHAFER & HART, *supra* note 30, at 5. Eligibility for AHCCCS is determined largely by a person’s income level. Therefore, people who are on the verge of the poverty line may still be regarded as “earning too much” to qualify for AHCCCS.

72. See Michael J. Stoil, *When Medicaid Pays the Bills*, BEHAV. HEALTHCARE (Jan. 1, 2006), <http://www.behavioral.net/article/when-medicaid-pays-bills>.

73. *Id.*

74. See *Arnold v. Ariz. Dep’t of Health Servs.*, 775 P.2d 521, 522–27 (Ariz. 1989).

delivered \$17 million in uncompensated care to non-Medicaid SMI.<sup>75</sup> As a result, a number of providers have reportedly warned that they will stop accepting non-Medicaid patients because they cannot afford to care for these patients without a corresponding increase in government subsidy.<sup>76</sup>

#### ***D. Arnold on Hold: A Necessary Evil?***

Mired in a severe budgetary crisis, the Arizona State Legislature was willing and ready to nullify *Arnold* by repealing the lawsuit's legal foundation—the 1979 statute that requires the state to provide services to the mentally ill.<sup>77</sup> Although the statute is still in place, the state's dire financial outlook took a toll on the *Arnold* mandate.<sup>78</sup> On March 9, 2010, the Maricopa County Superior Court issued an order approving the Joint Stipulation to Stay Litigation during Fiscal Budget Crisis (“Stay Stipulation”), thereby putting a two-year hold on *Arnold* and all enforcement activities.<sup>79</sup> Observing that “[t]here is limited State funding available to provide services necessary to comply with the [*Arnold* orders],” the court cautioned that the state's dire financial situation could lead to the worst-case scenario for the mentally ill: elimination of all of their statutory rights.<sup>80</sup> As part of the Stay Stipulation, the Court Monitor was disbanded.<sup>81</sup>

To avoid wholesale changes to the state laws protecting the SMI, *Arnold* supporters had to accept the stay as a necessary evil.<sup>82</sup> To these advocates, *Arnold* was the last hope to hold the state accountable for the care of the mentally ill.<sup>83</sup> With *Arnold* on hold, the mentally ill would face a virtual vacuum of legal safeguards.<sup>84</sup>

The suspension of *Arnold* exposes a moral hazard problem in the separation-of-powers strictures. By “capitalizing” on its severe financial status, the state is capable of escaping judicial sanctions and shifting the risk of inadequate care to the mentally ill. After the Stay Stipulation, the state further slashed \$60 million in state general funding for the SMI and eliminated numerous services.<sup>85</sup> Although part of the agreement stipulates that the lawmakers will not change the state law for the SMI at the moment, the state still retains the power to alter the law at a future time and can use such bargaining power to initiate further cuts.<sup>86</sup>

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75. *More System Changes Offered in Arizona, but Budget Woes Cast Pall over State*, MENTAL HEALTH WKLY., Nov. 2, 2009, at 1.

76. *See Ariz. Treatment Providers Protest Against Uncompensated Care*, ALCOHOLISM & DRUG ABUSE WKLY., Apr. 20, 2009, at 3, 3–4.

77. *See* David Miller, *Lawsuit in Arizona: A ‘Necessary Evil,’* ARIZ. CAPITOL TIMES, June 1, 2010.

78. *Id.*

79. *See* Stay Stipulation, *supra* note 62, at 4.

80. *Id.* at 3–4.

81. *Id.* at 5.

82. Miller, *supra* note 77.

83. *See* Petrila & Swanson, *supra* note 53, at 12.

84. *See infra* Part III.A.

85. Casey Newton, *State Cuts Set to Hit Vulnerable Patients*, ARIZ. REPUBLIC, June 28, 2010, at A1.

86. *See* Miller, *supra* note 77.

Foreseeably, the state's diminishing support will only spawn a further storm in the turbulent lives of the mentally ill. When the economy is in trouble, the state may opt to save money by terminating services for the least politically powerful—the mentally ill. The adverse financial impact can aggravate patients' conditions and increase the demand for the more expensive services, such as acute and emergency care. The rising costs due to crisis control thus create a self-fulfilling prophecy that providing comprehensive mental health care is formidably expensive and the state can legitimately refuse to pay for it.

The budget cut and the corresponding service reduction hit hardest the 14,000 SMI without Medicaid coverage.<sup>87</sup> Even the state's traditionally more robust Medicaid budget is at risk. As a result of the rollback of Proposition 204, a voter-approved initiative that expanded Medicaid income eligibility from 75% of the federal poverty level to 100%, 5,200 SMI are in jeopardy of losing Medicaid coverage.<sup>88</sup> The non-Medicaid patients have already faced a sudden withdrawal of mental health services—including brand-name medication, case management, therapy, housing, transportation, and hospitalization.<sup>89</sup> After the suspension of *Arnold*, the under-financed mental health system is collapsing against those who are the least capable of absorbing the shock of systemic failure.

## II. OLMSTEAD: LEAVING THE DOOR AJAR FOR STATES' DISTRIBUTIVE DECISIONS

### A. *The Integration Mandate and Olmstead*

The Americans with Disabilities Act prohibits discrimination on the basis of disability in many spheres, including employment, public services, and accommodations.<sup>90</sup> Although the ADA provides a sweeping antidiscrimination framework, it does not specifically address the needs and challenges faced by the mentally ill.

The Department of Justice ("DOJ") has clarified the potential application of the ADA to the mentally ill. In what is known as the "integration mandate," the DOJ implementation regulations provide that "[a] public entity shall administer

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87. See Stay Stipulation, *supra* note 62, at 2; Mary K. Reinhart, *Arizona Budget: Mentally Ill May Lose Health Benefits*, ARIZ. REPUBLIC (Jan. 15, 2011, 12:00 AM), <http://www.azcentral.com/news/election/azelections/articles/2011/01/15/20110115arizona-budget-mentally-ill-health-benefits.html>.

88. See Mary K. Reinhart, *Arizona Supreme Court Urged to Reject Cutbacks in Medicaid*, ARIZ. REPUBLIC (May 24, 2011, 12:00 AM), <http://www.azcentral.com/arizonarepublic/news/articles/2011/05/24/20110524arizona-supreme-court-medicaid-cuts.html>. For a discussion of Proposition 204 and Arizona's Medicaid funding, see Peter Suderman, *Smoked Out: Arizona's Unfortunate Reliance on Tobacco Industry Revenues to Fund Health Insurance*, REASON (July 6, 2011), <http://reason.com/archives/2011/07/06/smoked-out>.

89. See Mary K. Reinhart, *State, Critics Disagreeing on Impact of Mental-Health Cuts*, ARIZ. REPUBLIC (Sept. 21, 2011, 12:00 AM), <http://www.azcentral.com/news/articles/2011/09/21/20110921mental-health-cuts-toll-debated.html>.

90. See Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended at 42 U.S.C. §§ 12101–12213 (2012)).

services, programs, and activities in the *most integrated setting* appropriate to the needs of qualified individuals with disabilities.<sup>91</sup> Under the integration mandate, a public entity is only required to “make reasonable modifications” to accommodate the disabled, but not those modifications that “would fundamentally alter” the nature of the program.<sup>92</sup>

The U.S. Supreme Court addressed the fundamental-alteration defense in *Olmstead v. L.C.* and held that unjustified segregation of the mentally ill constitutes “discrimination based on disability” under the ADA.<sup>93</sup> In that case, two plaintiffs with mental illness brought a class-action suit against the State of Georgia, alleging that their continued confinement in state mental hospitals—despite psychiatrists’ recommendation that they be placed in community-based programs—violated the integration mandate.<sup>94</sup>

In the opinion, the Court recognized that institutionalization is stigmatizing and debilitating and pointed out that Georgia’s failure to provide community placements amounted to a form of discrimination.<sup>95</sup> Meanwhile, the Court also cautioned that states’ responsibility to provide community placement is not boundless.<sup>96</sup> Since states need to serve “a large and diverse population,” the Court stressed that states should have the flexibility to distribute their limited resources without excessive judicial interference.<sup>97</sup> Given the necessity for states to balance various social interests, the complexity of operating a range of welfare programs, and the zero-sum nature of social funding, *Olmstead* suggested that states are permitted to commit only minimally to the mentally ill.<sup>98</sup>

### ***B. The Fundamental-Alteration Defense***

*Olmstead* noted that states can raise a fundamental-alteration defense by showing the existence of: (1) overall cost concerns; (2) even-handed distribution; or (3) a comprehensive working scheme for the mentally ill.<sup>99</sup> Based on the clear roadmap supplied by the Court in *Olmstead*, states now enjoy substantial leeway to legitimize their reluctance to provide for the mentally ill.

#### *I. Cost Analysis*

*Olmstead* made it clear that a simple cost comparison would not sufficiently negate the fundamental-alteration defense.<sup>100</sup> Although the lower courts determined that it would be less expensive for the two original *Olmstead* plaintiffs to live in the community than to stay in the hospital, the Court rejected this approach and instead construed the cost analysis to reflect the requested

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91. 28 C.F.R. § 35.130(d) (2012) (emphasis added).

92. *Id.* § 35.130(b)(7).

93. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999).

94. *Id.* at 593.

95. *Id.* at 600.

96. *Id.* at 603.

97. *See id.* at 605–06; *see also id.* at 612–13 (Kennedy, J., concurring).

98. *See id.* at 605 (majority opinion).

99. *Id.* at 604.

100. *Id.*

programs' overall financial impact on states.<sup>101</sup> According to the Court, even though the number of residents in an institution decreases, states still incur fixed overhead expenses to run mental hospitals.<sup>102</sup>

By allowing states to factor in all financial obligations in the context of mental health provisions, the Court substantially lowered the threshold to prove a fundamental-alteration defense.<sup>103</sup> Recent studies suggest that community placements are not inherently less expensive than institutions.<sup>104</sup> In the past, community providers incurred lower labor costs than mental hospitals, partly because the population served in the community had less severe conditions.<sup>105</sup> Now, as more individuals with complex mental health needs are residing in the community, the cost advantage previously enjoyed by the community programs may have dissipated.<sup>106</sup> Against the backdrop of rising healthcare costs, a growing SMI population, and a deteriorating economy, states will find it easier to argue that the aggregate costs of accommodating the mentally ill impose an unbearable financial burden.

### 2. Equitable Distribution

Alternatively, states can show that a range of social services for the mentally ill are already in place and that requiring a different distribution scheme would prejudice social groups not covered by the litigation.<sup>107</sup> The Court suggested that states have to consider the big picture of societal welfare and balance competing social needs.<sup>108</sup> Under this reasoning, the SMI, a fraction of the disabled population, should not benefit more from the ADA than other disabled individuals. In other words, the Court viewed the appearance of impartiality and evenhandedness as essential to the integrity of the ADA.<sup>109</sup>

This equitable-distribution requirement effectively pits the mentally ill against other disabled individuals.<sup>110</sup> By suggesting that the ADA beneficiaries necessarily have to compete for the limited government resources, the *Olmstead* Court presupposed that states as welfare providers need not first explore the feasibility of expanding their income base and creating a bigger pie to be divided among different interest groups. Instead, the Court seemed to tell the vulnerable not to ask for too much from states—a position that appears neither equitable nor

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101. *Id.*

102. *Id.*

103. See Joanne Karger, Note, "Don't Tread on the ADA": *Olmstead v. L.C. ex rel. Zimring and the Future of Community Integration for Individuals with Mental Disabilities*, 40 B.C. L. REV. 1221, 1258 (1999).

104. Kevin K. Walsh et al., *Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research*, 41 MENTAL RETARDATION 103, 117 (2003).

105. *Id.* at 105.

106. *Id.*

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

108. See *id.* at 591–92.

109. See Petrila & Swanson, *supra* note 53, at 26.

110. See Karger, *supra* note 103, at 1262.

consistent with the ADA's mandate of integrating the mentally ill in a setting of their choice.

The Court expressed concerns that the mentally ill—by filing a lawsuit—can disrupt an orderly distributive process and claim a disproportionately larger share in a zero-sum game.<sup>111</sup> But the Court did not consider the other side of the same coin: If a state fails to sufficiently provide for the mentally ill, it deprives them of a fair share under the equitable distribution principle. Furthermore, it is unclear under what standards states may be deemed to administer the programs with an even hand. To maintain distributive justice and accommodate competing claims from different social groups, states' standard political strategy often involves increasing the size of the pie and enabling win-win situations. However, when a state's economic pie is shrinking, even-handed social distribution may no longer be a viable option.

### 3. *Comprehensive Scheme*

The third way for states to argue a fundamental-alteration defense is to show a comprehensive working plan to transition the mentally ill into the community along with a waiting list that would move at a "reasonable pace."<sup>112</sup> Based on this instruction, an effectively working plan and a reasonably paced waiting list have become an immediate jumping-off point in states' defense against the ADA challenge.<sup>113</sup>

In contrast to the roadmap for states to raise a defense, *Olmstead* offered the mentally ill no equivalent guidance. Justice Kennedy pointed out in his concurrence that the quality of the community-based services remained a blind spot in the plurality opinion.<sup>114</sup> He warned that "if the principle of liability . . . is not applied with caution and circumspection, States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition."<sup>115</sup> As a general antidiscrimination policy, the ADA is prohibitory—rather than remedial—in nature and does not guarantee the quality or timeliness of states' performance. Therefore, states may cut corners and tighten the budgetary thumbscrews on the mentally ill without violating the ADA.

*Olmstead* has frequently been called the *Brown v. Board of Education* of disability law.<sup>116</sup> Like in *Brown*, the end point of *Olmstead*—desegregation—was stated, but the Court gave little guidance on how to reach that result.<sup>117</sup> Moreover,

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

112. *Id.* at 605–06.

113. SARA ROSENBAUM & JOEL TEITELBAUM, KAISER COMM'N ON MEDICAID & THE UNINSURED, *OLMSTEAD AT FIVE: ASSESSING THE IMPACT* 6 (2004), available at <http://www.kff.org/medicaid/upload/olmstead-at-five-assessing-the-impact.pdf>.

114. *See Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring).

115. *Id.*

116. Charles R. Bliss & C. Talley Wells, *Applying Lessons from the Evolution of Brown v. Board of Education to Olmstead: Moving from Gradualism to Immediate, Effective, and Comprehensive Integration*, 26 GA. ST. U. L. REV. 705, 705 (2010).

117. *Id.* at 706.



in a watered-down parallel to the famously vague “all deliberate speed” requirement in *Brown*, the *Olmstead* Court permitted states to create working plans and draw down the waiting list “at a reasonable pace.”<sup>118</sup> Because judicial decisions are not self-enforcing, the Court’s use of vague instructions in *Brown* and *Olmstead* allows breathing room for states to implement social change. By deferring to states’ policymaking and budgetary expertise, the Court in turn enables more willing compliance and preserves the legitimacy of judicial power.

### *C. Reading Olmstead in the Ninth Circuit*

Post-*Olmstead*, the Ninth Circuit Court of Appeals encountered the fundamental-alteration defense on three occasions. In *Townsend v. Quasim*, the court found that the State of Washington engaged in facial discrimination by providing community-based nursing home services only to the mentally disabled who fell below a certain income level (the “categorically needy”), thus excluding those with a higher income level (the “medically needy”).<sup>119</sup> In rejecting the state’s generalized claims of budgetary woes, the court held that the possibility that community placement might require an additional outlay of funds does not by itself constitute a fundamental alteration.<sup>120</sup>

In the absence of facial discrimination presented in *Townsend*, the Ninth Circuit is more inclined to defer to states’ distributive decisions. In *Sanchez v. Johnson*, the Ninth Circuit held that the State of California successfully presented a comprehensive working plan.<sup>121</sup> In that case, a class of developmentally disabled persons alleged that the state paid a lower rate to community workers than to employees of state institutions and thus led to unnecessary segregation of the developmentally disabled in institutions.<sup>122</sup> The Ninth Circuit rejected the plaintiffs’ contention and pointed out that the state sufficiently demonstrated commitment to the mentally ill.<sup>123</sup> Based on the evidence that the state increased the size of the Medicaid waiver program in the past decade, the court concluded that a comprehensive, effectively working plan existed.<sup>124</sup>

Similarly, in *Arc of Washington State Inc. v. Braddock*, the Ninth Circuit looked to the State of Washington’s past deinstitutionalization progress.<sup>125</sup> There, the plaintiff claimed that Washington’s Medicaid waiver program was too small to accommodate the growing mentally ill population.<sup>126</sup> Nevertheless, the court concluded that the state need not expand its service capacity.<sup>127</sup> In granting the state’s fundamental-alteration defense, the court emphasized that Washington

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118. *Id.* at 718–19.  
119. 328 F.3d 511, 514, 518 n.2, 520 (9th Cir. 2003).  
120. *Id.* at 519–20.  
121. 416 F.3d 1051, 1068 (9th Cir. 2005).  
122. *Id.* at 1054–55.  
123. *Id.* at 1067.  
124. *Id.* at 1068.  
125. 427 F.3d 615, 621 (9th Cir. 2005).  
126. *Id.* at 619.  
127. *Id.* at 621.

achieved substantial deinstitutionalization over the past two decades.<sup>128</sup> Further, the court suggested that the state's waiting list was moving at a reasonable speed, because the waiver program was open to all eligible individuals as soon as a slot became available.<sup>129</sup>

Together, these three cases indicate that as long as states do not facially discriminate against an entire segment of disabled people, the Ninth Circuit will probably allow states to maintain the status quo and manage their social programs at whatever pace they deem fit. In fact, the Ninth Circuit has set a fairly low threshold for states to prove a fundamental-alteration defense. As illustrated in *Sanchez* and *Braddock*, the Ninth Circuit seemed to adopt a backward-looking approach and relied on states' past records of "progress" to find an existing working plan.<sup>130</sup> In both cases, the court did not ask whether states' pace of community placement was truly reasonable in light of the present demands and resources for mental health services; nor did it consider how the requested expansion of the waiver program would fundamentally alter the states' provisional scheme.

### III. FROM DUALISM TO INTEGRATION: BUILDING A FUTURE FOR THE MENTALLY ILL

#### *A. Mental Health Reform Through Litigation*

For many of the mentally ill in Arizona, neither state nor federal laws provide adequate protection. On the state level, the safety net created by *Arnold* has significantly eroded due to a number of factors, including Arizona's declining economy, the underlying statutes' vulnerability to a legislative repeal, and courts' lack of capacity to supervise systematic reform.<sup>131</sup> Since the Court Monitor—the only mechanism to evaluate the state's compliance—was dismantled, *Arnold* has become a hollow legal victory.<sup>132</sup>

If the mentally ill who are enrolled in AHCCCS—Arizona's Medicaid program—contemplate the possibility of federal protection, they might be disappointed to find that *Olmstead* does not afford strong protection. The ADA does not specifically address the needs of the mentally ill; rather, it conceives a broad antidiscrimination policy for all individuals with a qualified disability.<sup>133</sup> Therefore, *Olmstead* advised courts to refrain from interfering with states' distributive programs or creating the appearance of favoritism to the mentally ill.<sup>134</sup> Foreseeably, by following the three-pronged *Olmstead* roadmap, Arizona's mental health authorities can easily raise a fundamental-alteration defense. First, the state can argue that the aggregate costs of funding a comprehensive mental health care system are unbearable. Second, the state can point out that Arizona has

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128. *Id.*

129. *Id.* at 622.

130. *See supra* text accompanying notes 121–129.

131. *See supra* Part I.B–C.

132. *See supra* Part I.B–C.

133. *See supra* Part II.A.

134. *See supra* Part II.B.

already established a range of services for the mentally ill. Finally, given its dire financial straits, the state would necessarily have to shift funds from other social programs to serve the mentally ill, resulting in inequitable distribution. Based on a reading of the current case law, the Ninth Circuit would likely find an “effectively working plan,” even though past progress achieved under *Arnold*, arguably, is not indicative of the state’s present commitment to the mentally ill.

Some advocates are exploring the possibility of using the Medicaid Act as a vehicle for litigation. In *Rodgers v. Ball*, the Ninth Circuit found that the “free choice provision”<sup>135</sup> of the Medicaid Act confers on Medicaid recipients an enforceable right of action.<sup>136</sup> Despite its potential for mental-health-related actions, the Medicaid Act lacks the teeth to initiate broader mental health reform for three reasons. First, Medicaid has stringent eligibility requirements and excludes from coverage a significant number of people with mental illness.<sup>137</sup> Second, Medicaid’s defined scope of reimbursement—which does not cover vital mental health services such as inpatient psychiatric services—may disadvantage patients in need of comprehensive treatment.<sup>138</sup> Third, because the Medicaid Act becomes binding only when states accept federal funding, states can withdraw from Medicaid to avoid liabilities. In fact, Arizona opted out of Medicaid for the program’s first 20 years.<sup>139</sup> When the federal government rejects Arizona’s request to further slash Medicaid funding,<sup>140</sup> it is not unthinkable that the state may cut off its nose to spite its face: terminating its Medicaid participation altogether to render the federal requirements obsolete.

### ***B. Mental Health Reform Through Integration***

Providing mental health care is a serious matter of social responsibility and human dignity. As *Arnold* pointed out, the state’s “duty [to provide comprehensive mental services] may well be more expensive in the breach than in the fulfillment.”<sup>141</sup> When the state drops the SMI from the tracking system and

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135. 42 U.S.C. § 1396n(c)(2)(C), (d)(2)(C) (2012).

136. 492 F.3d 1094, 1107 (9th Cir. 2007).

137. See Stoil, *supra* note 72.

138. HONBERG ET AL., *supra* note 5, at 3.

139. Prior to 1982, Arizona was the only state that declined to participate in Medicaid. *Chapter 1: Overview of AHCCCS*, CNTY. SUPERVISORS ASS’N OF ARIZ. 1, <http://www.countysupervisors.org/uploads/AHCCCS%20Overview.pdf> (last visited Mar. 28, 2012).

140. Although the federal Medicaid agency approved Arizona’s Proposition 204 rollback that would drop from Medicaid childless adults who earn above 75% of the federal poverty level, the agency rejected the state’s proposal to further reduce the enrollment level for childless adults and eliminate coverage for parents with family income above 75% of the federal poverty level; specifically, it reasoned that cost pressures on the state are not a sufficient justification to depart from federal Medicaid law. See Max Levy, *Feds Approve Portion of Medicaid Cuts Requested by the State*, CRONKITE NEWS (Oct. 7, 2011), <http://cronkitenewsonline.com/2011/10/feds-approve-portion-of-medicaid-cuts-requested-by-the-state>; Mary K. Reinhart, *Arizona Medicaid Cuts Can Proceed, Feds Say*, ARIZ. REPUBLIC (July 2, 2011, 12:00 AM), <http://www.azcentral.com/arizonarepublic/news/articles/2011/07/02/20110702arizona-medicaid-cuts-approved.html>.

141. *Arnold v. Ariz. Dep’t of Health Servs.*, 775 P.2d 521, 537 (Ariz. 1989).

cuts back on essential services such as case management, some of the affected individuals might go down the same dangerous road as Jared Loughner did—compromising public safety and perpetuating the madman stereotype of the mentally ill.

Most people with mental disorders are victims, not perpetrators. The hard-earned progress of *Arnold* has been virtually wiped out by budget cuts. Two decades after the *Arnold* decision, the SMI still have to fight for the dwindling mental health resources.<sup>142</sup>

As the state's mental health system is failing, informal arrangements fill in the service gap in unexpected ways. In Arizona, prisons are providing the bulk of inpatient mental health treatment.<sup>143</sup> As one study shows, the odds of the SMI being held in an Arizona detention facility, compared to a psychiatric hospital, are 9.3 to 1.<sup>144</sup> In other words, the alternatives to a comprehensive mental health system have become the criminal justice system, the emergency room, and the homeless shelter.<sup>145</sup>

Contrary to what *Olmstead* suggested, courts should not fear that protecting the mentally ill would amount to selective favoritism, when the “favored” group is in fact distinctively disadvantaged and underserved. The lack of public support will likely worsen the mentally ill's conditions, trigger complications, and generate even more demands for mental health services, thus creating vicious medical and financial cycles for the state. Within a year since Arizona's 2010 budget cuts, the number of calls to mental health crisis hotlines across the state spiked by 26.3%, and the number of SMI inmates in the Maricopa County jail system increased by about 20%.<sup>146</sup> In the long run, the cuts could negatively impact taxpayers and healthcare providers by putting more pressure on jails and emergency rooms.<sup>147</sup>

Certainly, Arizona is not the only state cutting mental health funding to mitigate the fiscal crisis that plagues the nation,<sup>148</sup> and compared to other states, Arizona offered a more generous Medicaid-benefit package to the mentally ill.<sup>149</sup> However, even though financing the mental health system is challenging, the state should do more—not less—for the mentally ill in this time of heightened economic uncertainty and shrinking treatment resources, rather than balance the budget deficit on the backs of the most vulnerable. One way to provide affordable,

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142. See Paul Rubin & Amy Silverman, *Jan Brewer's Response to Jared Loughner? Slash Services from an Already Beleaguered Mental-Health System*, PHX. NEW TIMES (Jan. 20, 2011), <http://www.phoenixnewtimes.com/2011-01-13/news/jan-brewer-s-response-to-jared-lee-loughner-slash-more-than-35-million-in-services-from-an-already-beleaguered-mental-health-system>.

143. *Id.*

144. *Id.*

145. See Reinhart, *supra* note 89.

146. *Id.*

147. Innes, *supra* note 5.

148. See Marc Lacey et al., *States' Budget Crises Cut Deeply into Financing for Mental Health Programs*, N.Y. TIMES, Jan. 21, 2011, at A18.

149. Innes, *supra* note 5.

accessible, and less stigmatic mental health care is to reform the state's current carve-out provision structures and integrate mental health care into the primary care system.

### *I. Carve-Out Structures*

In Arizona, mental health funding and service delivery structures remain separate—or “carved out”—from the primary healthcare system.<sup>150</sup> Within the mental health carve-out, multiple tiers of authorities are at work. AHCCCS contracts with the ADHS, which then subcontracts with five private providers, or the Regional Behavioral Health Authorities (“RBHAs”).<sup>151</sup> Some RBHAs further contract with a network of specialty behavioral health providers.<sup>152</sup> For instance, Magellan, the current RBHA in Maricopa County, contracts with four provider networks, each of which owns a group of clinics and offers different approaches to treating patients.<sup>153</sup>

Initially designed to contain costs by reducing reliance on inpatient services and outsourcing responsibilities to private providers, the mental health carve-out does not necessarily achieve cost-effective results because its architects have overlooked a critical fact: Mental and physical health problems are interwoven.<sup>154</sup> In Arizona, the SMI die 32 years earlier than state residents on average, and the vast majority of those premature deaths stem from preventable physical conditions such as diabetes, asthma, and heart disease.<sup>155</sup> Their untreated chronic physical conditions may result in frequent emergency room visits, at dramatically higher costs than promptly treating the underlying conditions.<sup>156</sup>

The structural isolation of mental health care from primary care deters patients from seeking comprehensive treatment. A patient with multiple diagnoses—for instance, a mental disorder, a substance abuse problem, and a physical ailment—would face a bewildering array of specialty providers and financing mechanisms within different organizations—each with its own logic, culture, and procedure.<sup>157</sup> The disconnect between mental health care and primary

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150. See *The Humpty Dumpty Syndrome: Integration and Behavioral Health*, ARIZ. HEALTH FUTURES (St. Luke's Health Initiatives, Phoenix, Ariz.), Winter 2003, at 1, 8 [hereinafter *Humpty Dumpty Syndrome*], available at [http://www.slii.org/pdfs/issue\\_briefs/ib-03winter.pdf](http://www.slii.org/pdfs/issue_briefs/ib-03winter.pdf).

151. *Id.* at 9.

152. *Id.*

153. Casey Newton, *County's Mental-Health System Failing*, ARIZ. REPUBLIC (Aug. 30, 2009, 12:00 AM), <http://www.azcentral.com/arizonarepublic/news/articles/2009/08/30/20090830mentalhealth0830.html>.

154. *Humpty Dumpty Syndrome*, *supra* note 150, at 8.

155. *Maricopa Integrated Health Home (IHH) Project: Fact Sheet*, MAGELLAN OF ARIZ. 2, <http://www.magellanofaz.com/media/373512/ihh%20fact%20sheet%208%201%202011%20final.pdf> (last visited Mar. 8, 2012).

156. Richard Clarke et al., *Project Aims to Help Those with Mental Illness*, ARIZ. REPUBLIC (Aug. 21, 2011, 3:39 PM), <http://www.azcentral.com/arizonarepublic/opinions/articles/2011/08/21/20110821improving-health-mental-illness.html>.

157. *Humpty Dumpty Syndrome*, *supra* note 150, at 9.

care also reinforces misperceptions against the mentally ill.<sup>158</sup> As a result, many patients with mental conditions avoid visiting a doctor out of fear and stigma.

Poor communications between physicians and behavioral health specialists further compound the systematic fragmentation. Although RBHAs operate a phone consultation program to connect primary care providers to a psychiatrist, only one call was placed in the program's first 18 months.<sup>159</sup> Given that many providers have an insufficient understanding of what the "other side" can do, referrals from one system to another often result in confusion and delay.<sup>160</sup>

The constant turnover in leadership and management, coupled with service disruption within the mental health carve-out, also makes it difficult to establish continuity between providers and patients, as well as among providers themselves.<sup>161</sup> As the *Arnold* Court Monitor pointed out in the 2008 audit, the private contractors' procurement system created "'inherent instability' in the behavioral health system, with new contractors taking over and changing the system completely."<sup>162</sup> As a result, "every few years, the community start[ed] over."<sup>163</sup> With each change in providers, the services patients received were "frequently changed or even eliminated without their knowledge."<sup>164</sup> The primary care providers, on the other hand, had no clue whom to contact for a patient in the event of a turnover.<sup>165</sup>

The ancient dualism philosophy—which proclaimed the strict separation of mind and body—does not survive modern science, which considers mental disorders a manifestation of a behavioral, psychological, or biological dysfunction in the individual.<sup>166</sup> Ironically, the antiquated dualism theory is alive and well in our mental health system, segregating mental health treatment from primary health, diminishing the quality of life for patients with mental health problems, and increasing the healthcare bill for the state.

## 2. *The Integration Model*

An integrated healthcare system—which features data sharing and on-site coordination between behavioral and primary care professionals—bears the potential to reduce medical costs, identify untreated conditions, improve patients' overall well-being, and bridge the policy and cultural gaps that have traditionally

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158. *Id.* at 14, 16.

159. *Id.* at 12.

160. *Id.* at 13.

161. Newton, *supra* note 153. For the timeline of RBHAs in Maricopa County, see Nelson, *supra* note 69, at 6–18.

162. Alison Knopf, *Magellan, Maricopa Pass Contract Midpoint*, BEHAV. HEALTHCARE (Feb. 1, 2010), <http://www.behavioral.net/article/magellan-maricopa-pass-contract-midpoint>.

163. *Id.*

164. Newton, *supra* note 153.

165. *Humpty Dumpty Syndrome*, *supra* note 150, at 12–13.

166. See Gregg R. Henriques, *The Harmful Dysfunction Analysis and the Differentiation Between Mental Disorder and Disease*, 1 SCI. REV. MENTAL HEALTH PRAC. (2002).

divided primary and behavioral care.<sup>167</sup> Nationwide, three integration models have achieved acclaim and recognition:

- (1) The IMPACT Model—initially developed by the University of Washington to treat depression in 18 primary care clinics across five states—has been adapted to treat diverse patient populations in the United States and abroad.<sup>168</sup> In this program, a primary care team works with a behavioral health provider to implement a treatment plan.<sup>169</sup> If the initial plan does not improve the patient's condition, the team consults with a psychiatrist to provide stepped care.<sup>170</sup> IMPACT was found to double the effectiveness of treatment and lower healthcare costs compared to the conventional method.<sup>171</sup>
- (2) The Cherokee Model is offered in Tennessee and proves to be especially effective in rural areas where providers are scarce. In this model, the behavioral health provider is an embedded, full-time member in a primary care team.<sup>172</sup> The team keeps integrated medical records, holds weekly team meetings to facilitate cross-consultation, and allows patients to meet jointly with a physician and a psychiatrist.<sup>173</sup> Data show that patients enrolled in the Cherokee Model have “lower utilization of specialty mental health services and subsequent primary care visits.”<sup>174</sup>
- (3) The Partnership Model provides an alternative to integration programs with a unified structure such as IMPACT. Under the Partnership Model, primary health and behavioral health providers maintain separate organizations but partner to ensure that the SMI patients are receiving optimal physical health care.<sup>175</sup> The key components of this model include regularly screening patients for physical changes during psychotropic medications, placing primary care providers in behavioral health facilities, and creating wellness programs to help patients manage their health conditions.<sup>176</sup> These components are based on clinical studies

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167. See Christina Reardon, *Integrating Behavioral Health and Primary Care—The Person-Centered Healthcare Home*, SOC. WORK TODAY, Jan.–Feb. 2010, at 14, 15.

168. *Overview of the IMPACT Trial*, IMPACT, <http://impact-uw.org/about> (last visited Mar. 27, 2012).

169. See Barbara J. Mauer, *A New “Home” for People with Serious Mental Illnesses*, NAT'L COUNCIL MAG., Winter 2009, at 6, 6–7.

170. *Id.* at 7.

171. *Id.*

172. *Id.*

173. MARY BUTLER ET AL., MINN. EVIDENCE-BASED PRACTICE CTR., AHRQ PUB. NO. 09-E003, INTEGRATION OF MENTAL HEALTH / SUBSTANCE ABUSE AND PRIMARY CARE 143 (2008), available at <http://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>.

174. *Id.* at 144.

175. See Reardon, *supra* note 167.

176. *Id.*

and program experiences from various states, including Georgia and Massachusetts.<sup>177</sup>

Currently, Arizona is taking steps toward integration. In 2011, the state accepted a \$500,000 federal grant to place doctors in mental health clinics. The resulting pilot program—the Maricopa Integrated Health Home Project (“IHH”)—aims to provide a “medical home” environment where the SMI can feel safe and comfortable when receiving one-stop-shop solutions to their medical needs.<sup>178</sup> IHH envisions a range of intervention services for the SMI, including wellness-and-prevention programs, self-management training, and peer-support specialist consultation.<sup>179</sup>

The medical homes project breathes some hope into Arizona’s mental health system, which has suffered severe budget cuts for years. Still in its early planning stage, IHH promises a more streamlined treatment method for the mentally ill, yet it remains to be seen whether the program will lead to structural overhaul and systematic integration.

Several factors, for example, may limit the long-term effectiveness of IHH. First, participation in the pilot program is limited to the SMI enrolled in AHCCCS.<sup>180</sup> As a result, those who are not covered by Arizona’s Medicaid program and those who have general mental health problems that are not seriously debilitating to be classified as SMI would not enjoy the benefits of integrated care.<sup>181</sup> Even patients who currently receive Medicaid benefits are not immune from the state’s budget cut and may lose their coverage.<sup>182</sup> In other words, the scope of IHH may be too narrow to institute system-wide reform.

Second, the success of IHH depends heavily on federal support. In addition to the initial federal grant as start-up seed money, IHH will receive federal funds in the first eight years at a 900% match rate, reaping \$9 for every \$1 the state spends.<sup>183</sup> However, the relationship between the state and the federal government casts uncertainty over the continuity of funding streams. As one of the states challenging the constitutionality of the Affordable Care Act (“ACA”), Arizona nonetheless accepts a \$1 million planning grant under the ACA, half of which goes

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177. See BARBARA J. MAUER, NAT’L COUNCIL FOR CMTY. BEHAVIORAL HEALTHCARE, BEHAVIORAL HEALTH / PRIMARY CARE INTEGRATION AND THE PERSON-CENTERED HEALTHCARE HOME 19–22 (2009), available at <http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf>.

178. Clarke et al., *supra* note 156; Mary K. Reinhart, *Funds to Aid Arizona’s Mentally Ill*, ARIZ. REPUBLIC (Aug. 2, 2011, 12:00 AM), <http://www.azcentral.com/arizonarepublic/local/articles/2011/08/02/20110802funds-aid-arizona-mentally-ill.html#ixzz1akCffpEE>.

179. Clarke et al., *supra* note 156.

180. Press Release, Magellan Health Servs., Local Healthcare Leaders Partner to Improve Health, Wellness and Longevity of Those Challenged with Mental Illness 1 (Aug. 2, 2011), available at <http://www.magellanofaz.com/media/373496/ihh%20press%20release%208%201%202011%20final.pdf>.

181. See *supra* text accompanying notes 70–73.

182. See Reinhart, *supra* note 89.

183. See Reinhart, *supra* note 178.



into launching IHH.<sup>184</sup> Therefore, the state's stance on the federal healthcare law may threaten the sustainability of IHH.

Third, IHH has been characterized as another RBHA dwelling within the mental health carve-out, rather than an intermediary agency engaging *both* the mental and primary care systems.<sup>185</sup> If IHH simply incorporates individual doctors but does not involve primary care providers in meaningful ways, the program's significance would be reduced to a mere subcontractor. In this scenario, IHH would leave intact the structural flaws existing in the carve-out: differing clinical cultures, a fragmented delivery system, and varying reimbursement mechanisms.

The medical homes model in Arizona should be the starting point to pursue a variety of integrated treatment options for the mentally ill. The Cherokee Model, for instance, offers important insight into consolidating healthcare resources to serve large geographic areas. Under this model, the mental health outreach starts in a primary care setting for the simple reason that primary care is where patients are located; when the local community is aware that people are treated equally for all types of illnesses, the mentally ill are able to overcome their fear of stigma and actively seek treatment at Cherokee.<sup>186</sup> With the help from a behavioral health co-worker, physicians no longer need to "sell" a referral to specialty mental health care to patients or worry about treating patients with a combination of mental and physical needs.<sup>187</sup> Based on the Cherokee experience, Arizona can learn to bring together professionals trained in different areas of mental and primary care and integrate the systems both structurally and financially.<sup>188</sup> In addition, Arizona's policymakers should consider funding and expanding the psychiatry residency program in the primary care facilities.<sup>189</sup>

Community health centers, on the other hand, can simulate the Partnership Model or a parallel to the IMPACT Model. These community-based behavioral health providers can partner with full-scope primary care organizations to maximize communications and information exchange. Alternatively, the community providers can designate a primary care consultant on the team to help tailor treatment plans and formulate stepped care for patients' special needs. Regardless of the form of integration, the state should encourage partnership on each and every level. In this way, integrated care would not be confined to those eligible for IHH, but become generally available to people with mental health issues.

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184. See Sarah Bufkin, *Brewer Swallows Opposition to Affordable Care Act, Accepts Grant to Pursue Mental-Illness Model*, THINKPROGRESS (Aug. 2, 2011, 4:17 PM), <http://thinkprogress.org/health/2011/08/02/285937/brewer-swallows-opposition-to-affordable-care-act-grant-to-pursue-mental-illness-model>.

185. See *Integrated Behavioral Health and Primary Care: RBHA with Health Homes*, ARIZ. DEP'T OF HEALTH SERVS., <http://azdhs.gov/diro/integrated/rbha/index.htm> (last visited Apr. 6, 2012).

186. BUTLER ET AL., *supra* note 173, at 142.

187. *Id.* at 143.

188. See Mauer, *supra* note 177, at 18.

189. See Steven Herron, *UA Psychiatry Residency*, DEP'T PSYCHIATRY, <http://psychiatry.arizona.edu/academic-programs/ua-psychiatry-residency> (last visited Apr. 6, 2012).

Building medical homes for the SMI represents a positive first move toward integrated, holistic, and patient-centered mental health services. But IHH should never end our inquiry for other effective integration possibilities, simply because there is no one-size-fits-all mental health treatment arrangement. The mentally ill should have a choice to decide how and where to approach their conditions.

### CONCLUSION

As *Arnold* has taught us, a comprehensive mental health system cannot rely solely upon judicial enforcement. When the state plays multiple roles as the lawmaker, provider, and financer of mental health services, courts have limited power to compel the financially distressed state to live up to the statutory requirements. Although the *Arnold* Stay Stipulation is expected to expire on June 30, 2012, the process for the *Arnold* parties to reach a mutual agreement and create a new court order that redefines the state's obligation to the mentally ill is bound to be long and tortuous.<sup>190</sup>

The *Olmstead* decision also manifests an understanding that judicial intervention can be futile, thereby reinforcing the state's control over distributive social programs. Based on the Ninth Circuit's construction of *Olmstead*, the state can easily raise a fundamental-alteration defense by referring to its past deinstitutionalization progress, even though the reality of a fragmented and overstretched system offers no signs of an "effectively working plan."

Although courts are not in a position to force the state to provide for the mentally ill, federal matching funds have offered the state an incentive to experiment with integrated medical homes. Standing alone, one program would not lead to structural integration or fix the problems inherent in Arizona's carve-out structures. To truly achieve integration, Arizona should implement integrated care in both primary care and behavioral care settings. While cutting the budget and eliminating services for the least politically powerful seem to be the easiest way for the state to save money, the human and social costs of abandoning the mentally ill cannot be measured in monetary terms.

As Stephen Levine wrote, "If there is a single definition of healing it is to enter with mercy and awareness those pains, mental and physical, from which we have withdrawn in judgment and dismay."<sup>191</sup> When patient advocates, healthcare professionals, state and federal officials, and the public at large join in the efforts to better understand the needs of the mentally ill and seek solutions to the mental health challenges, this is where healing—for a long-disfranchised and stigmatized group—truly begins.

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190. See JANICE K. BREWER, OFFICE OF THE ARIZ. STATE GOVERNOR, THE EXECUTIVE BUDGET: FISCAL YEAR 2013, at 23 (2012), available at <http://www.azospb.gov/documents/2012/FY2013-ExecutiveBudget-Summary.pdf>.

191. STEPHEN LEVINE, A YEAR TO LIVE: HOW TO LIVE THIS YEAR AS IF IT WERE YOUR LAST 48 (2009).