TASC Training & Advocacy Support Center

TASC is sponsored by the Administration on Disabilities (AoD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Rehabilitation Services Administration (RSA), and the Social Security Administration (SSA). TASC is a division of the National Disability Rights Network (NDRN).

FACT SHEET

LEGAL STRATEGIES TO REDUCE THE INSTITUTIONALIZATION OF PERSONS WITH DISABILITIES DURING THE COVID-19 VIRUS

April 2020

Prepared by Mark Murphy
Center for Public Representation

I. Introduction

The COVID-19 pandemic has caused widespread disruption in the lives of nearly everyone living in the United States. But for people with disabilities living in large congregate settings, such as psychiatric hospitals, intermediate care facilities for persons with intellectual and other developmental disabilities, board and care homes, and nursing facilities, the risk to health and safety is particularly acute.[1]

[1] *See, e.g.*, WCVB-TV, *Nearly half of developmentally disabled at state home infected with coronavirus,* available at https://www.wcvb.com/article/nearly-half-of-developmentally-disabled-at-state-home-in-massachusetts-infected-with-coronavirus/32178605 (April 17, 2020); WGBH, *Mental Health Advocacy Groups Launch Investigation of Lemuel Shattuck Hospital After 'Rapid Spread' of COVID-19* Cases, available at https://www.wgbh.org/news/local-news/2020/04/16/mental-health-advocacy-groups-launch-investigation-of-lemuel-shattuck-hospital-after-rapid-spread-of-covid-19-cases (April 16, 2020); The New York Times, *"It's Hit Our Front Door': Homes for the Disabled See a Surge of Covid-19,* available at https://www.nytimes.com/2020/04/08/nyregion/coronavirus-disabilities-group-homes.html?searchResultPosition=43 (April 9, 2020); The Dallas Morning News, *Some workers at Denton state home – with one of the largest COVID-19 outbreaks in Texas – fear for safety, jobs, ava*ilable at https://www.dallasnews.com/news/politics/2020/04/02/some-workers-at-denton-state-home-site-of-largest-covid-19-outbreak-in-texas-fear-for-safety-jobs/ (April 2, 2020).

It is much more difficult (and, in some cases, impossible) for people with disabilities living in institutional settings to implement many of the recommended actions designed to lessen exposure to the coronavirus, including frequent hand washing, cleaning of surfaces, and generally limiting contact with others via social distancing and other means.[2] For example, many residents need assistance with activities of daily living or other help provided by health care professionals and other staff members who are required to move about the facility as well as to travel outside of it, thus increasing the possibility of exposure to the virus. And many institutionalized persons with disabilities have ongoing health conditions that could, should they become infected, lead to a greater degree of illness and increased likelihood of death. In short, having fewer people living in institutionalized settings would reduce the risk of infection, serious illness, and even death for residents and staff, as well as contribute to the health of the general public.

II. Strategies to Reduce Institutionalization

As a result, disability advocates, including some P&As, have started discussing ways to persuade state officials and facility administrators to limit admissions to, and promote the prompt and safe discharge from, congregate settings.[3] As of this writing, it appears that litigation seeking

---

[2] The Centers for Disease Control and Prevention (CDC) has issued numerous guidance documents related to COVID-19, including one specifically related to disability. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-disabilities.html (last visited April 19, 2020). The CDC has also issued guidance specific to long-term care facilities and other health care settings. *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhea (last visited April 19, 2020); https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019ncov%2Finfection-control%2Finfection-prevention-control-faq.html (last visited April 19, 2020). The Centers for Medicare and Medicaid Services (CMS) also has issued guidance documents relevant to people with disabilities in congregate facilities. *See Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs)*, available at https://www.cms.gov/files/document/qso-20-23-icf-iid-prtf.pdf (March 30, 2020) (last visited April 19, 2020).

[3] *See, e.g.*, Bazelon Center for Mental Health Law, *During the Pandemic, States and Localities Must Decrease the Number of Individuals in Psychiatric Hospitals by*

such discharges for reasons related to COVID-19 has been filed in only one case. On April 16, 2020, the plaintiffs in *Costa v. Bazron*[4] filed a First Amended Class Action Complaint and Writ of Habeas Corpus on behalf of the residents of St. Elizabeths Hospital, a large psychiatric facility in Washington, D.C., asserting claims under both the U.S. Constitution and the Americans with Disabilities Act to compel prompt discharge of patients from the facility.[5] Many similar efforts to reduce facility populations in light of the COVID-19 crisis have been undertaken, to varying degrees of success to date, with respect to persons institutionalized in correctional facilities (both prisons and jails),[6] juvenile detention facilities,[7] and Immigration and Custom Enforcement (ICE) detention facilities.[8]

Reducing Admissions and Accelerating Discharges ("*During the Pandemic"*), available at http://www.bazelon.org/wp-content/uploads/2020/04/4-15-20-BC-psych-hospitals-statement-FINAL.pdf (April 15, 2020); Letter dated April 18, 2020 from Connecticut Legal Rights Project to Governor Ned Lamont and Attorney General William Tong, available at https://www.clrp.org/homeDetail.php?CLRP-Encourages-Gov.-Lamont-to-issue-Executive-Order-to-Release-Patients-at-State-Operated-Psychiatric-Facilities-Due-to-Dangers-of-COVID-19-119.

[4] No. 1:19-CV-3185 (RDM) (D.D.C. April 16, 2020). The Amended Complaint contains useful information about the COVID-19 virus, how it can spread, and the particular problems it poses to persons in large congregate facilities.

[5] The *Costa* litigation was originally filed in 2019 in response to a different health crisis that arose at St. Elizabeths Hospital. In September 2019, the residents of the hospital were left without safe, running water for approximately one month after the discovery that the water supply was toxic.

[6] *See, e.g*., *Valentine v. Collier,* No. 20-20207 (5th Cir. April 22, 2020) (staying injunction granted by District Court on 8th Amendment claim involving COVID-related prison conditions); *See, e.g*., Maryland Court of Appeals, *Administrative Order Guiding the Response of the Trial Courts of Maryland to the COVID-19 Emergency as It Relates to Those Persons Who Are Incarcerated or Imprisoned* (April 14, 2020), available at https://mdcourts.gov/sites/default/files/admin-orders/20200414guidingresponseoftrialcourts.pdf. Information, including pleadings and other legal papers, related to litigation seeking the release of incarcerated persons from prisons and jails is available from the Civil Rights Litigation Clearinghouse, available at https://clearinghouse.net/results.php?searchSpecialCollection=62, and the UCLA Covid-19 Behind Bars Data Project, available at https://law.ucla.edu/centers/criminal-justice/criminal-justice-program/related-programs/covid-19-behind-bars-data-project/.

[7] Maryland Court of Appeals, *Administrative Order Guiding the Response of the Circuit Courts Sitting as Juvenile Courts as It Relates to Those Juveniles Who Are Detained, Committed Pending Placement or in Commitments,*(April 13, 2020), available at https://mdcourts.gov/sites/default/files/admin-orders/20200413guidingresponseofcircuitcourtssittingasjuvenilecourts.pdf.

[8] *See, e.g.,Thakker v. Doll*, 2020 WL 1671563 (M.D. Pa., March 31, 2020).

While several arguments made in the corrections and ICE contexts also apply to the dangerous conditions present in disability-related facilities, especially regarding the health risks inherent in having large numbers of people congregated together, there also are significant legal and practical differences. Most prominently, for nearly all incarcerated persons and ICE detainees, a positive outcome is achieved simply by leaving the facility, without more. That is not so clearly the case for institutionalized persons with disabilities, for whom services and supports often are needed to ensure their safety in the community. Thus, there are a number of disability-specific factual and legal issues that need to be carefully considered when using advocacy or legal strategies seeking the discharge of people from institutional settings in a safe, but expeditious, manner.[9]

Separate from and prior to litigation, there are several administrative, legislative, and public policy strategies that a P&A can engage in to prevent the admission and promote the discharge of institutionalized persons or otherwise increase the safety of such persons. These actions can occur prior to or simultaneously with the development of the legal claims discussed below and can help inform how those claims are framed. Some actions may be ongoing and necessary to assure that any progress made is not reversed once the COVID-19 crisis has passed.[10]

- Advocate ending facility admissions for as long as possible, but at the very least until officials can assure that no one with the virus enters the facility. Some states and facilities have already stopped admitting new residents, either through formal action or using less formal means, such as discouraging referral sources from recommending people for admission. However it is accomplished, it is critical that additional people with disabilities avoid unnecessary institutional placements, which, in addition to any civil rights violations, would

[9] For reasons of clarity and length, the discussion below primarily focuses on strategies most applicable in cases designed to obtain the discharge of persons with mental illness from psychiatric hospitals and ICFs/IDD. Much of the information contained in the discussion below, however, is relevant to efforts seeking the discharge of persons with disabilities from other types of congregate facilities. CPR is available to assist P&As in discussing and developing strategies related to seeking discharges from those other facilities as well.

[10] This is not an exhaustive list, and individual circumstances in a particular state may dictate different actions.

place them at increased risk of COVID-19 infection and of receiving inadequate medical care. An exception to this general rule could occur when a person would be in a more restrictive and less appropriate institution absent the admission to the facility, e.g., someone in a densely crowded jail not receiving necessary treatment or services who could and should be transferred to a less densely crowded and more appropriate hospital setting. Finally, successful prevention of admitting infected persons, including staff, to the facility may not be feasible absent more widespread testing, so additional efforts could be required to ensure that people with disabilities and direct care staff have the same access to testing as everyone else.

- Advocate for legislative and policy changes at the federal and state levels designed to protect the health and safety of people with disabilities, including those in or at risk of being admitted to congregate facilities. For example, the Center for Public Representation and other disability rights organizations are working to ensure that the next COVID-related legislative package from Congress contains the disability community's priorities,[11] including additional funding for home and community-based services to allow more people with disabilities to remain in their homes. Another important advocacy priority is the designation of direct support professionals, personal care attendants, and other direct care workers as essential personnel in order to ensure access to personal protective equipment (PPE) and testing.[12]

- Communicate and collaborate with other legal organizations working on behalf of institutionalized persons, especially public defender offices or other entities that represent people with disabilities in commitment proceedings and/or who maintain contact with clients in facilities. Such organizations are a useful source of information, especially if regular P&A monitoring in facilities is curtailed.[13] In the

[11] *See Disability Community Asks for COVID-19 Legislation*, available at https://medicaid.publicrep.org/wp-content/uploads/2017/06/Disability-Community-Package-4-COVID-19-Asks.pdf.

[12] For up-to-date information and materials relating to advocacy and legislative efforts at the national level on COVID-19 issues affecting persons with disabilities, visit the COVID-19 section of CPR's website at https://www.centerforpublicrep.org/covid-19/.

[13] Several P&As have made a decision to limit or suspend facility monitoring and onsite advocacy. Other P&As have implemented various forms of remote monitoring and

event that legal action is planned, public defenders can assist in identifying potential plaintiffs and issues that need to be addressed or otherwise provide additional resources, including in some circumstances becoming co-counsel should litigation be filed.

III. Litigation Strategies

In addition to these advocacy strategies, seeking to ensure the health and safety of institutionalized persons during the COVID-19 crisis may also involve litigation, including asserting legal claims using accelerated procedures, such as motions for a temporary restraining order or a preliminary injunction. What follows is a brief discussion of some of the important issues that need to be carefully considered before any such litigation involving institutionalized residents is commenced.

A. Legal Claims

Persons institutionalized in psychiatric hospitals or ICFs/IDD at risk of serious illness or death caused by COVID-19 have potential claims under the Fourteenth Amendment to the U.S. Constitution and under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.[14]

There is no dispute that the Due Process Clause of the Fourteenth Amendment protects the right of a person committed to a psychiatric hospital or an ICF/IDD to be held in safe conditions.[15] "If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily committed — who may

---

assistance to institutionalized persons. *See* Disability Rights Ohio, "Remote Monitoring Protocol," available from Disability Rights Ohio or NDRN. And Disability Rights Texas has been designated as essential staff in the state's public and private facilities, so it can continue its institutional monitoring and advocacy during the pandemic.

[14] Since ADA and Section 504 claims are generally analyzed *in para materia*, the remainder of this discussion will reference only the ADA.

[15] *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982). *See also Ingraham v. Wright*, 430 U.S. 651, 673 (1977) (safety is a "historic liberty interest" that survives lawful confinement). It is less clear whether and to what extent this constitutional guarantee extends to other persons institutionalized in state psychiatric or IDD facilities who have not been judicially committed but who are *de facto* involuntarily detained, either because they lack capacity to seek their release or because there is no realistic, available alternative that would ensure their safety in the community. *See, e.g., Torisky v. Schweiker*, 446 F.3d 438, 444-48 (3d Cir. 2006).

not be punished at all — in unsafe conditions."[16] But the remedy for a due process protection from harm claim in the COVID-19 context – accelerated discharge from the hospital and the receipt of community services – is normally not the remedy obtained in the usual case asserting this claim. Instead, the institutional improvements usually are limited to additional actions that must be taken to prevent harm and revised training practices and other policies of the facility necessary to provide "minimally adequate or reasonable training to ensure safety."[17]

Such "minimally adequate" changes, however, are very unlikely to be sufficient in the context of an outbreak of a potentially deadly virus, and thus, if P&As bring a due process claim, they must be prepared to prove, if necessary via expert testimony, that general improvements to the usual hospital practices and procedures will not be enough to ensure safe conditions and protect residents from harm. The absence of the recommended procedures for minimizing the likelihood of an outbreak or the spread of the virus, such as ensuing effective social distancing, isolation of symptomatic persons, properly trained and protected staff, and appropriate staff and resident testing protocols, would constitute the "substantial departure from accepted professional judgment"[18] necessary to show a constitutional violation.[19] In addition, part of the remedy sought could include changes to the process by which people are admitted or evaluated for discharge and then released, such as prohibiting admissions except under specific conditions, accelerating discharge evaluations and procedures, adopting a default position that, given the potential risk of serious illness and death, people should be immediately transitioned to the community whenever possible, and requiring the hospital to test a resident for the virus prior to release.[20]

---

[16] *Youngberg*, 457 U.S. at 316.
[17] *Id*. at 319.
[18] *Youngberg*, 457 U.S. at 323.
[19] A plaintiff can also prove a violation of substantive due process by showing that the actions taken – or not taken – are so egregious that they "shock the conscience." *See County of Sacramento v. Lewis*, 523 U.S. 839 (1998). While such a claim is normally difficult to prove, the unusual (and often unfortunate) circumstances presented by the COVID-19 virus and its impact on institutionalized persons might give rise to such a claim. This claim is asserted in *Costa v. Bazron*. *See* Amended Complaint at ¶ 220.
[20] *See also*, Bazelon Center for Mental Health Law, *During the Pandemic*, supra note 3, at 2-3.

Title II of the ADA also provides potential legal claims, both to prevent the unnecessary admission to a segregated (and dangerous) institution, as well as to promote the prompt release from that setting. First, P&As can assert that, due to their disability, persons in psychiatric hospitals or ICFs/IDD are being discriminated against by being held in unduly dangerous conditions, and thus face disproportionate risk of serious illness and even death despite the existence of safer effective alternatives, i.e., services that can be provided outside of the hospital or ICF. Among other possible claims, the challenged actions and inactions regarding COVID-19 constitute methods of administration that subject residents to discrimination and deny them equal access to the benefits of the mental health services that the public entity is supposed to provide.[21]

Second, P&As can assert that the hospital or ICF has failed to modify its policies and practices related to admissions, evaluations, and discharge and has otherwise not provided the reasonable accommodations necessary to assure the health and safety of residents. A claim of this type would seek a remedy similar to the Fourteenth Amendment claim discussed above, such as modifications to the usual admission, evaluation, and discharge processes, e.g., accelerated decision-making and release to community services that will meet a person's immediate needs, even if all needed services are not yet in place but are in process, given the risk of staying in the hospital or ICF.

Third, a litigation strategy usually should include an *Olmstead* claim as well.[22] Such a claim could complement the reasonable modification arguments discussed above, and include both the process changes as well as a limitation on admission and acceleration of discharge to community services as necessary remedies. The current circumstances also could make it more difficult for public entities to successfully assert a fundamental alteration defense. P&As can counter the usual defense claims by arguing that it can never be a fundamental alteration to move people from segregated to more integrated settings when the former is demonstrably more dangerous, not just less preferable. Unlike the usual *Olmstead* case, P&As can show in the COVID-19 context that the harm of being unnecessarily institutionalized goes well beyond "severely diminish[ing] the everyday life activities of individuals, including family relations, social

[21] *See* 28 C.F.R. § 35.130(b)(3); *Costa v. Bazron*, Amended Complaint at ¶ 229.
[22] *See Costa v. Bazron*, supra note 4, Amended Complaint at ¶ 228.

contacts, work options, [and] economic independence,"[23] and instead, places a person at heightened risk of a very serious illness and death.

B. Potential Representative Plaintiffs

Although the potential dangers associated with COVID-19 make it important to reduce a hospital's population as quickly and safely as possible, practical considerations – especially the need to assure that community services are available to those who need them – likely will require that a P&A carefully chose the categories of residents for whom discharge is sought rather than seek discharge of all persons regardless of circumstances. In making this determination, a key factor to consider is the level of medical care provided in the hospital or ICF. An uninformed observer – or a federal judge – may assume that since psychiatric facilities are commonly called hospitals, they offer medical as well as mental health services. This is rarely the case, and even less so with respect to lifesaving care, like the use of ventilators. At most, they may provide routine medical services, although many state psychiatric facilities do not even offer this level of care, such as regular respiratory evaluation and treatment. ICFs/ IDD are more likely to provide a broader range of regular medical care, but even these facilities usually do not offer specialized treatment. Any claim seeking discharge is likely to be stronger if no or few medical services are regularly provided to residents in the facility, and thus residents only can access these services (whether COVID-related or otherwise) in the community. To put it another way, can defendants plausibly argue that a resident will be better off remaining in the psychiatric hospital or ICF because any medical needs that arise can be handled appropriately there?

Unlike some other congregate facilities, such as ICFs/IDD or nursing homes, a portion of the population of many psychiatric hospitals is quite fluid, often due to frequent admissions and discharges. Within this fluid population, there often are subgroups of short-term (length of stay under 14 days) and intermediate-term (length of stay of 14-90 days) admission categories. Thus, it likely will be possible to identify categories of residents who may be easier to move to community services more quickly than others. Persons in those categories should be the focus of any legal action brought to reduce the hospital population. Such residents are more likely to have recent connections to community services and resources, such as

[23] *Olmstead v. L.C.*, 527 U.S. 581, 600-01 (1999).

housing (whether their own home, a family home, or supported housing), family and peer supports, or an assertive community treatment (ACT) team, and thus may be good candidates to be discharged quickly and safely. Depending on the hospital, discharging the short-term and intermediate-term stay groups could meaningfully reduce – although obviously not eliminate – the risks associated with a COVID-19 outbreak.

Similar analyses could occur with other categories of patients, including those for whom the discharge planning process had begun and discharge was likely to happen soon, as well as forensic patients, depending on factors such as the reason for forensic commitment and degree of ongoing need for community services. Within any category, however, it will be important to identify those most likely, with necessary supports and services, to remain safe and healthy once discharged from the hospital, especially while the COVID-19 virus remains active.[24] How this analysis plays out will differ from hospital to hospital, of course, but identifying a group of patients for whom discharge can occur relatively quickly, with limited risk to health and safety, is likely a necessary prerequisite to any successful legal action.[25]

Finally, a claim for prompt discharge of residents of psychiatric hospitals or ICFs/IDD who have been institutionalized for longer periods ranging from many months to many years will be more challenging and will almost invariably require some proof of available community supports. In some states, there may be some limited availability in existing community support programs, through vacancies in current programs, unused capacity, or the ability to quickly and easily reallocate resources. In all states, Appendix K amendments to Home and Community-Based Waivers[26] and special 1135 waivers[27] of other Medicaid requirements during emergencies afford states

---

[24] *See* Bazelon Center for Mental Health Law, *During the Pandemic*, supra note 3, at 3.
[25] A P&A considering bringing an action using associational standing will still need to do the type of analysis discussed here in order to include exemplars and other details likely to be needed in any legal complaint.
[26] *See* National Health Law Program, *COVID-19 Changes to HCBS Using Appendix K: Approval Trends*, available at https://healthlaw.org/resource/covid-19-changes-to-hcbs-using-appendix-k-approval-trends/ (March 30, 2020).
[27] *See* National Health Law Program, *Overview of the Medicaid-Related Provisions of the Coronavirus Response Packages,* available at https://healthlaw.org/resource/overview-of-the-medicaid-related-provisions-of-the-coronavirus-response-packages/ (April 2, 2020).

significant flexibility to address urgent needs and protect institutionalized persons from ongoing harm.

C. Additional Practical Considerations

In addition to the legal and factual issues already discussed, there are other practical considerations P&As should consider as part of the litigation evaluation and development process.

First, expert testimony is almost certainly going to be necessary in order to bring a successful claim seeking population reduction in psychiatric hospitals or ICFs/IDD. Areas of expert testimony are likely to include the nature of COVID-19; how it spreads; the particular dangers of the virus to people in congregate settings;[28] what mitigation actions are not being taken by the facility; and how residents to be discharged can be connected to needed community services quickly and safely.

Second, P&As should consider including a media/public relations component as part of any litigation strategy. It remains an unfortunate fact that many in the general public perceive people with psychiatric, IDD, and other disabilities, especially those who may receive treatment in institutions, as more of a danger to public safety than they actually are. Having a mechanism by which accurate information is provided to the public via the media and other sources, as well as a process to respond quickly to negative stories or reactions, could increase the likelihood of success.

Third, it is worth noting that even if a litigation strategy is unsuccessful, in whole or in part, a P&A's advocacy and legal actions could lead to better COVID-related conditions in facilities. For example, even if a court is not inclined to order the discharge of residents (or as many residents as

[28] *See, e.g., Costa v. Bazron*, supra note 4, Amended Complaint at ¶¶ 37-55. Most of the Complaints filed on behalf of incarcerated persons seeking release from prisons and jail for COVID-related reasons contain detailed information about these issues, albeit in the prison context. Other legal papers in these cases, such as motions for temporary restraining orders and preliminary injunctions, contain similar information as well as expert affidavits and declarations that may be helpful in understanding the issues that will need to be included in any action related to psychiatric hospitals or other facilities for people with disabilities. The Complaints and other legal papers are available at the online sites identified in note 6, supra.

requested), part of any relief sought could include improvements in how the facility in question addresses COVID-19 issues, including requiring a facility to report regularly on the number of tests performed, the number of positive tests, mitigation and remediation efforts undertaken, staff training, and the status of PPE availability and use, among other issues.

As the above discussion demonstrates, litigation seeking the discharge of persons residing in psychiatric hospitals, ICFs/IDD, or other congregate facilities due to the COVID-19 pandemic presents numerous factual and legal challenges. Such litigation also will likely involve procedural and resource challenges, including identifying and retaining appropriate experts and conducting litigation on an accelerated schedule. Despite these challenges, the dangers being faced by institutionalized persons during the COVID-19 pandemic compels careful consideration of what actions P&As can take to insure that such persons are as safe as possible. CPR is available to consult with and assist P&As in this process.