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**THE LEAST RESTRICTIVE ENVIRONMENT FOR
PROVIDING EDUCATION, TREATMENT, AND
COMMUNITY SERVICES FOR PERSONS WITH DISABILITIES:
RETHINKING THE CONCEPT**

*Donald H. Stone**

I. INTRODUCTION

Persons with disabilities seek acceptance and connection in society. From individuals with mental illness, children with intellectual disabilities, and wheelchair users, all desire integration rather than isolation, mainstreaming rather than segregation. In fact, the American with Disabilities Act of 1990 (hereinafter “ADA”),¹ the landmark civil rights act protecting persons with a physical or mental impairment, has a stated purpose that recognizes the right to fully participate in all aspects of society.² Discrimination against individuals with disabilities is all too frequently found in housing, education, institutionalization and access to public services.³ At the cornerstone of disability protection is the concept of providing services in the least restrictive environment (hereinafter “LRE”), or the most integrated setting appropriate, known as the mainstreaming concept.⁴

In the involuntary confinement of the allegedly dangerously mentally ill, the education of the child with disabilities, and the location of community group homes for the intellectually disabled,

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¹ Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified as amended at 42 U.S.C. §§ 12101-12213).

² 42 U.S.C. § 12101(a)(1) (2018).

³ *Id.* § 12101(a)(3).

⁴ *See infra* notes 47-63 and accompanying text.

disability advocates have sought integration and mainstreaming as a common theme. Why is the mainstreaming approach to persons with disabilities such a prevalent concept? Are persons with disabilities always appropriately served utilizing a strict mainstream approach? Are educational institutions using the least restrictive environment to underfund educational programs? Are psychiatric hospitals abiding by the requirement that in-patient hospitalization be provided only if a less restrictive alternative is not appropriate?

This Article will discuss and analyze the LRE concept prevalent in the ADA and the Individuals with Disabilities Education Act (hereinafter “IDEA”),⁵ as well as state laws as they relate to the involuntary civil commitment of the mentally ill and community based treatment for persons with disabilities. A historical perspective of the least restrictive environment will be examined. An exploration of the various uses of the least restrictive environment in civil commitment laws, special education, group homes and community based treatment, guardianships, and architectural accessibility will occur. A new approach to the least restrictive environment will be offered with recommendations for service providers, educational institutions, and government entities.

II. HISTORICAL PERSPECTIVES OF THE LEAST RESTRICTIVE ENVIRONMENT

The bedrock principle of disability law, the least restrictive environment, has appeared in court decisions and legislation for more than fifty years.⁶ The concept finds its roots in the civil rights movement and court decisions of the 1950s and 60s, which set the stage for the desire for equality for all persons regardless of race, gender, or disability.⁷ The LRE has been expressed in a variety of ways, however its origins can ultimately be traced back to due process

⁵ Pub. L. No. 101-476, 104 Stat. 1103 (2004) (codified as amended at 20 U.S.C. §§ 1400-1487).

⁶ See *infra* notes 7-27 and accompanying text.

⁷ See, e.g., *Brown v. Bd. of Ed. of Topeka*, 347 U.S. 483 (1954). Although dealing with racial equality, *Brown* influenced disability rights as well as “led the way to a growing understanding that all people, regardless of race, gender or disability, have a right to a public education.” Kelli J. Esteves & Shaila Rao, *The Evolution of Special Education*, PRINCIPAL (Nov./Dec. 2008), <https://www.naesp.org/sites/default/files/resources/1/Principal/2008/N-O-web2.pdf>.

concerns addressed by the U.S. Supreme Court in *Shelton v. Tucker* in 1960.⁸ The *Shelton* Court explained,

[E]ven though the governmental purpose be legitimate and substantial, the purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of the *less drastic means* for achieving the same basic purpose.⁹

The foundation of the LRE doctrine (noted by the Court as the “less drastic means”) was illustrated in this case involving an Arkansas statute which compelled school teachers, as a condition of employment in a state-supported school or college, to file an affidavit listing every organization they belonged or contributed to in the past five years.¹⁰ The *Shelton* Court declared this statute invalid as a violation of the Due Process Clause of the Fourteenth Amendment.¹¹ While not directly relating to disability law, this language laid the foundation for the LRE principle.

The LRE concept in the education arena can be traced back to the Education for All Handicapped Children Act of 1975,¹² renamed the Individuals with Disabilities Education Act (“IDEA”) in 2004.¹³ In the IDEA, the least restrictive environment is a guiding principle and is described as,

[T]o the maximum extent appropriate, children with disabilities . . . are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that

⁸ 364 U.S. 479 (1960). Eric D. Paulsrud, *The Least Restrictive Alternative: A Theory of Justice for the Mentally Retarded*, 10 U. ARK. LITTLE ROCK L. REV. 465, 488 (1987).

⁹ *Id.* at 488 (emphasis added) (footnote omitted).

¹⁰ *Id.* at 480.

¹¹ *Id.* at 490.

¹² Pub. L. No. 94-142, 29 Stat. 773 (1975) (codified as amended at 20 U.S.C. §§ 1400-1411).

¹³ Pub. L. No. 101-476, 104 Stat. 1103 (2004) (codified as amended at 20 U.S.C. §§ 1400-1487); Brian L. Porto, *Application of 20 U.S.C.A. § 1412(a)(5), Least Restrictive Environment Provision of Individuals with Disabilities Education Act (IDEA)*, 20 U.S.C.A. §§ 1400 *et seq.*, 189 A.L.R. Fed. 297 (2003).

education in regular classroom with the use of supplementary aids and services cannot be achieved satisfactorily.¹⁴

The IDEA findings assert that education of children with disabilities can be made more effective by ensuring access to the general educational curriculum in the regular classroom to the maximum extent possible.¹⁵ Such a strong edict to focus the dialogue on educational placement in the regular classroom will be challenged in this Article, exploring a new alternative to the discussion between school officials and the parents of disabled children.

The ADA also speaks volumes on the right to fully participate in all aspects of society,¹⁶ with the goal of equality of opportunity,¹⁷ full participation,¹⁸ and the mandate that a public accommodation “shall afford goods, services, facilities, privileges, advantages, and accommodations to an individual with a disability in the most integrated setting appropriate to the needs of the individual.”¹⁹ In addition, the ADA prevents a qualified individual with a disability from being excluded from participating in services, programs, or activities of a public entity.²⁰ Furthermore, different or separate services may not be provided “unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others.”²¹ This notion of an integrated setting forms the basis of the LRE, the domain of first choice.

In the context of the involuntary civil commitment of a person with a mental illness who is allegedly dangerous to himself or others, state statutes have also utilized the LRE criteria as one of the necessary elements to secure in-patient psychiatric hospitalization.²² In Maryland, for example, a key element for involuntary admission is that there is “no available less restrictive form of intervention that is

¹⁴ 20 U.S.C. § 1412(a)(5)(A) (2018).

¹⁵ *Id.* § 1400(c)(5)(A).

¹⁶ 42 U.S.C. § 12101(a)(1) (2018).

¹⁷ *Id.* § 12101(a)(7).

¹⁸ *Id.*

¹⁹ 28 C.F.R. § 36.203(a) (2018); *id.* § 36.104 (defining a public accommodation as a “facility operated by a private entity whose operations affect commerce”).

²⁰ 28 C.F.R. § 36.104 (defining public entity as a state or local government).

²¹ *Id.* § 35.130(b)(1)(iv).

²² *See infra* Appendix A.

consistent with the welfare and safety of the individual.”²³ This Article will examine this concept and make recommendations that mandate greater responsibility directed to state mental health officials.

In the context of community based treatment preference, rather than institutionalization, the U.S. Supreme Court, in its landmark case of *Olmstead v. L.C.*, prohibited unjustified segregation of persons with disabilities, describing it as a “form of discrimination.”²⁴ The Court noted that the ADA requires public entities to avoid institutional settings and “to secure opportunities for people with developmental disabilities to enjoy the benefits of community living,”²⁵ as institutional confinement “severely diminishes the everyday life activities of individuals.”²⁶ The affirmation for placing individuals with mental disabilities in less restrictive settings affirms the ADA mandate of full participation in all aspects of society.²⁷ This has led to significantly more community based mental health services and housing opportunities.

In the context of guardianship law, a legal guardian owes a duty to make every reasonable effort to ensure that the placement of his or her ward is the least restrictive alternative.²⁸ The varied ways in which the least restrictive setting is included in disability law, from access to services, education, community based treatment, and guardianship duties, demonstrates the powerful doctrine so prevalent in society today. Whether the term is “least restrictive environment,” “least restrictive alternative,” or “least restrictive setting,” one thing is clear; the mandate of inclusion of the disabled into all aspects of society is a fundamental guiding principle of disability law.

²³ MD. CODE ANN., HEALTH-GEN. § 10-632(e)(2)(v) (West 2018).

²⁴ 527 U.S. 581, 599-600 (1999).

²⁵ *Id.* at 599.

²⁶ *Id.* at 601.

²⁷ *Id.* at 587.

²⁸ See, e.g., NEB. REV. STAT. ANN. § 30-2628(a)(1) (2018) (“When establishing the ward’s place of abode, a guardian shall make every reasonable effort to ensure that the placement is the least restrictive alternative.”); WYO. STAT. ANN. § 3-1-206(a)(i)-(ii) (2018) (ensuring that the ward under guardianship “shall have the right to: (i) The least restrictive and most appropriate guardianship or conservatorship suitable to the ward’s circumstances” applying to “residential, educational and employment environments”); ALASKA STAT. § 13.26.316 (2018) (“[T]he guardian . . . shall assure that the ward has a place of abode in the least restrictive setting consistent with the essential requirements for the ward’s physical health and safety.”).

III. THE DEFINITION OF THE LEAST RESTRICTIVE ALTERNATIVE CONCEPT

When Congress announced its motivation for enacting the ADA, it recognized that physical and mental disabilities in no way diminish a person's right to fully participate in all aspects of society.²⁹ In the ADA regulations addressing public entities, state or local governments must not provide different or separate services to individuals with disabilities "unless such action is necessary."³⁰ Similarly, in the ADA regulations addressing public accommodations, an individual with a disability cannot be provided with services that are different or separate unless such action is necessary.³¹ In addition, such services shall be afforded "in the most integrated setting appropriate to the needs of the individual."³²

In the context of special education services for children with a disability, Congress seeks full participation³³ and maintains that education can be made more effective by "ensuring their access to the general education curriculum in the regular classroom[] to the maximum extent possible."³⁴ Furthermore, the regulations acknowledge that education can be made more effective by "providing appropriate special education and related services, and aids and supports in the regular classroom, to such children, whenever appropriate."³⁵ This mainstream focus, *i.e.*, educating children with a disability in the regular classroom, is the centerpiece of the IDEA.³⁶ This focus will be challenged as part of this Article.

For the involuntary civil commitment of persons with mental illness, almost all relevant state statutes contain a consideration of the LRE principle in one form or another.³⁷ For instance, the New Jersey statute delineates a requirement that "[i]n determining the commitment placement, the court shall consider the least restrictive environment for the patient to receive . . . treatment that would ameliorate the danger

²⁹ 42 U.S.C. § 12101(a)(2) (2018).

³⁰ 28 C.F.R. § 35.130(b)(1)(iv) (2018).

³¹ *Id.* § 36.104 (public accommodations include a "facility operated by a private entity whose operations affect commerce" and fall within twelve distinct categories); *id.* § 36.202.

³² *Id.* § 36.203(a).

³³ 20 U.S.C. § 1400(c)(1) (2018).

³⁴ *Id.* § 1400(c)(5)(A).

³⁵ *Id.* § 1400(c)(5)(D).

³⁶ *See id.* § 1400.

³⁷ *See infra* Appendix A.

posed by the patient and provide the patient with appropriate treatment.”³⁸ The New Jersey civil commitment statute further defines the term “least restrictive environment” as, “the available setting and form of treatment that appropriately addresses a person’s need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person’s interests in freedom of movement and self-direction.”³⁹

The Pennsylvania Administrative Code provides a similarly comprehensive description of the least restrictive alternative, focusing on the placement or status being “available and appropriate.”⁴⁰ These limiting concepts whereby the least restrictive alternative must be available will be another key focus of this Article, and requiring the creation of less restrictive settings as a mandate will be explored.

The LRE concept is also articulated in state guardianship laws. In Maryland, for instance, a guardian of a person is appointed by the court for a disabled person for decisions involving “health care, food, clothing, or shelter” when “no less restrictive form of intervention is available which is consistent with the person’s welfare and safety.”⁴¹

IV. COURT APPLICATION AND INTERPRETATION OF THE LRE

In *Olmstead v. L.C.*, the U.S. Supreme Court announced, in no uncertain terms, the preference for the less restrictive setting, and highlighted the benefits of community living over institutions for persons with mental disabilities.⁴² The ADA, according to the Court, identifies “unjustified ‘segregation’ of persons with disabilities as a ‘for[m] of discrimination,’” criticizing unjustified segregation as perpetuating unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.⁴³ Furthermore, the Court recognized that institutional confinement

³⁸ N.J. STAT. ANN. § 30:4-27.15a(a) (West 2018).

³⁹ *Id.* § 30:4-27.2(gg).

⁴⁰ 55 PA. CODE § 5100.2 (2018) (“The least restrictive placement or status available and appropriate to meet the needs of the patient and includes both restrictions on personal liberty and the proximity of the treatment facility to the person’s natural environment.”).

⁴¹ MD. CODE ANN., EST. & TRUSTS § 13-705(b) (West 2018).

⁴² 527 U.S. 581, 582 (1999).

⁴³ *Id.* at 600 (alteration in original) (citing 42 U.S.C. § 12101(a)(2)).

“severely diminishes everyday life activities of individuals.”⁴⁴ The *Olmstead* decision is foundational in various areas of disability law.

A. Special Education

The courts have on several occasions highlighted the least restrictive setting in the special education arena. In the leading case of *Sacramento City Unified School District, Bd. of Educ. v. Rachel H.*, the U.S. Court of Appeals for the Ninth Circuit heard the demands for placement in the regular classroom by parents of a child with intellectual disabilities.⁴⁵ The Court recognized the IDEA’s preference for educating children with disabilities in regular classrooms with their peers.⁴⁶ The Court held the appropriate test in determining compliance with the IDEA’s mainstream requirement was a four factor balancing test, “(1) the educational benefits of placement full-time in a regular class; (2) the non-academic benefits of such placement; (3) the effect [the child with the disability] had on the teacher and children in the regular class; and (4) the cost of mainstreaming [the child].”⁴⁷ These four factors were identified as considerations the school division must take into account when determining if the disabled child’s least restrictive environment is appropriate.⁴⁸

The debate between educational placement in the regular or special education setting was also confronted previously in 1989 by the U.S. Court of Appeals for the Fifth Circuit in *Daniel R.R. v. State Board of Education*, whereby the court recognized that the conversation must shift to requiring schools to offer a “continuum of alternative placements.”⁴⁹ In determining compliance with the mainstreaming requirement, the *Daniel R.R.* court held that the Education of the Handicapped Act (hereinafter “EHA”), the precursor to the IDEA, did not contemplate an all-or-nothing educational setting

⁴⁴ *Id.* at 601. “[E]veryday life activities” include “family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” *Id.*

⁴⁵ 14 F.3d 1398 (9th Cir. 1994) (discussing how the child’s proposed placement, as affected by the school division, wrongly necessitated the child to move between the regular classroom and the special education section six times each day).

⁴⁶ *Id.* at 1403.

⁴⁷ *Id.* at 1404. See *Murray v. Montrose Cty. Sch. Dist.*, 51 F.3d 921, 929 (1995) (holding that the IDEA’s LRE requirement contains a preference for placement in neighborhood school, but not a mandate).

⁴⁸ *Sacramento City Unified Sch. Dist.*, 14 F.3d at 1404.

⁴⁹ 874 F.2d 1036, 1043 (5th Cir. 1989).

of the regular or special education program, but rather a continuum of services.⁵⁰

Building upon previous court interpretations of the mainstreaming principle, the U.S. Court of Appeals for the Third Circuit in *Oberti v. Board of Education of the Borough of Clementon School District* provided another set of factors in evaluating the appropriate educational placement.⁵¹ This includes evaluating the steps that the school has taken to include the child in a regular classroom, as the continuum must include supplementary services such as a “resource room or itinerant instruction” to expand options beyond the regular classroom.⁵² A second factor is evaluating the educational benefits the child will receive in the regular classroom as compared to the special education classroom.⁵³ The third factor is an evaluation of the “possible negative effect the child’s inclusion may have on the education of the other children in the regular classroom.”⁵⁴

After considering these factors, if the court determines that the school district was justified in removing the child from the regular classroom and providing education in a segregated special education class, the court must then consider whether the school has included the child in school programs with nondisabled children to the maximum extent appropriate.⁵⁵ This is where the IDEA would mandate schools

⁵⁰ *Id.* at 1050 (noting that the appropriate mix of placement options will vary from child to child). See 34 C.F.R. § 300.551 (2018) (requiring a continuum of alternative placements).

⁵¹ 995 F.2d 1204, 1217-18 (3d Cir. 1993) (involving an eight year-old with Down’s Syndrome who was removed from the regular classroom by school officials and placed in a segregated special education classroom).

⁵² *Id.* at 1215 (footnote omitted) (quoting *Greer ex rel. Greer v. Rome City Sch. Dist.*, 950 F.2d 688, 696 (11th Cir. 1991)). The determination should be made as to “whether the school district has made reasonable efforts to accommodate the children in the regular classroom.” *Id.* at 1217.

⁵³ *Id.* (referring to the special education classroom as “segregated,” implying a less than desirable placement option). “[I]n making this comparison the court must pay special attention to those unique benefits the child may obtain from integration in a regular classroom which cannot be achieved in a segregated environment, i.e., the development of social and communication skills from interaction with nondisabled peers.” *Id.* at 1216.

⁵⁴ *Id.* at 1217 (emphasizing “that in considering the possible negative effect of the child’s presence on the other students, the court must keep in mind the school’s obligation under the [IDEA] to provide supplementary aids and services to accommodate the child’s disabilities”).

⁵⁵ *Id.* at 1218. See *S.H. v. State-Operated Sch. Dist. of the City of Newark*, 336 F.3d 260, 272 (3d Cir. 2003) (adopting a two-prong test to determine whether the school district has satisfied the mainstreaming requirement: 1) can the school educate the child in the “regular classroom with use of supplementary aids and services,” and 2) if not, has “the school mainstream[ed] the child to the maximum extent possible.” (citing *Oberti*, 995 F.2d at 1215)).

provide a continuum of alternative placements to meet the needs of the disabled child.⁵⁶

On the other hand, there have also been courts that have questioned the strong preference for education in the regular classroom. In *M.A. ex rel. G.A. v. Voorhees Township Board of Education*, the placement of a child with autism in an out-of-district placement was viewed as the least restrictive setting, running contrary to the strong emphasis on education in the regular classroom.⁵⁷ The school division successfully argued that the child's out-of-district placement was the least restrictive environment in which to receive a free and appropriate education.⁵⁸ The child's current education involved mainstreaming in homeroom, art, gym, and lunch; however, the court recognized that the disabled child had minimal to no real interaction with other peers, something one would expect in the regular classroom setting.⁵⁹ Accordingly, the court acknowledged that the child was not receiving a meaningful educational benefit and that education at an out-of-district school for children with special needs comports with the IDEA, and that the child would receive a free and appropriate education in the LRE through the out-of-district placement.⁶⁰ The court cared greatly about the provision of a "free and appropriate education" (hereinafter "FAPE"), although such an education may not always be provided in the LRE.⁶¹

In *Hartmann ex rel. Hartmann v. Loudoun County Board of Education*, an eleven year old autistic child's parents were seeking education in the regular classroom and disputed evidence of no academic progress shown in the regular classroom.⁶² The Fourth Circuit recognized the IDEA's mainstreaming presumption not as an inflexible federal mandate, and pointed out that disabled children are

⁵⁶ *Oberti*, 995 F.2d at 1218 (holding that the appropriate mix between regular and special education setting "will vary from child to child and . . . from school year to school year as the child develops" (quoting *Daniel R.R. v. State Bd. of Educ.*, 874 F.2d 1036, 1050 (5th Cir. 1989))).

⁵⁷ 202 F. Supp. 2d 345, 369-70 (D.N.J. 2002).

⁵⁸ *Id.* at 370.

⁵⁹ *Id.* at 366 (discussing that experts for the parents acknowledged that the child was receiving "parallel skill development").

⁶⁰ *Id.* at 368-69. See *Roncker ex rel. Roncker v. Walter*, 700 F.2d 1058, 1063 (6th Cir. 1983) (discussing a preference in favor of mainstreaming).

⁶¹ *M.A. ex rel. G.A.*, 202 F. Supp. 2d at 361-62.

⁶² 118 F.3d 996, 1000 (4th Cir. 1997) (explaining that the school recommended placement in a class of five autistic students, a teacher, and an aid in a regular elementary school which would allow for mainstreaming in art, music, gym, literacy, and recess).

to be educated with non-disabled children only to the maximum extent appropriate.⁶³ This flexibility, inherent in the IDEA placement provision, is often sorely misinterpreted to pigeonhole disabled children inappropriately into the regular classroom.

Public schools responsible for educating disabled children should fully explore an array of placement alternatives before simply settling on educating the disabled child in the regular classroom. There is a more complex examination necessary before blindly following the IDEA encouragement for mainstreaming disabled students. Recently in 2017, the U.S. Supreme Court recognized this question in an attempt to search for clarity as to the meaning of an appropriate education.⁶⁴ In *Endrew F. ex rel. Joseph F. v. Douglas County School District RE-1*, the parents of an autistic student sought funding for a private school that specialized in educating children with autism.⁶⁵ The Court evaluated the adequacy of the child's education, explaining in no uncertain terms that to meet its substantive obligation under the IDEA, a school "must offer an [individualized education program] reasonably calculated to enable a child to make progress appropriate in light of the child's circumstances."⁶⁶ Thus, the IDEA demands more than "*de minimis*" progress from year to year.⁶⁷ This promising and optimistic approach will hopefully cause school systems to consider more than the cheapest and easiest way to educate disabled children, which is not always in the regular classroom to be lost and forgotten.

B. Mental Health and Involuntary Civil Commitment

In *O'Connor v. Donaldson*, the U.S. Supreme Court expressed that the purpose of involuntary hospitalization is the treatment of mental illness and not simply custodial care or punishment if the mentally ill person is not a danger to himself or others.⁶⁸ The minimal due process protections require that a state "cannot constitutionally

⁶³ *Id.* at 1001. See 20 U.S.C. § 1412(5)(B) (2018).

⁶⁴ *Endrew F. ex rel. Joseph F. v. Douglas Cty. Sch. Dist. RE-1*, 137 S. Ct. 988 (2017). See *Bd. of Educ. of the Hendrick Hudson Cent. Sch. Dist. v. Rowley*, 458 U.S. 176 (1982) (interpreting the IDEA holding that a deaf student was not entitled to a sign language interpreter because the child was advancing from grade to grade, and this was evidence that she was receiving the most appropriate form of education).

⁶⁵ *Endrew F.*, 137 S. Ct. at 991.

⁶⁶ *Id.* at 999.

⁶⁷ *Id.* at 1001.

⁶⁸ 422 U.S. 563, 570 (1975).

confine without more a nondangerous person who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”⁶⁹ The Court emphasized that the confinement of a nondangerous person based upon a diagnosis of a mental disorder alone lacks constitutional sufficiency.⁷⁰ The need for an expansion of out-patient community based mental health treatment and services is imperative.⁷¹ Coupled with the directive in state civil commitment law is the additional mandate that “[t]here is no available less restrictive form of intervention consistent with the welfare and safety of the individual.”⁷²

In the landmark decision of *Addington v. Texas*, the U.S. Supreme Court acknowledged that involuntary civil commitment “constitutes a significant deprivation of liberty,” resulting in adverse social consequences to the mentally ill individual.⁷³ Recognizing the significant due process implications of involuntary civil confinement, the state must establish proof at the civil commitment hearing by a clear and convincing evidence standard of proof.⁷⁴

An additional significant bedrock principle of due process protection for individuals confronted by involuntary civil commitment is to limit the length of confinement in a psychiatric facility. In *Jackson v. Indiana*, the U.S. Supreme Court specifically prohibited indefinite confinement, asserting that the result violates the Fourteenth Amendment’s guarantee of due process.⁷⁵ In the Court’s analysis, it imposed a rule of reasonableness, mandating that without a showing

⁶⁹ *Id.* at 576.

⁷⁰ *Id.* at 575. See Donald H. Stone, *Dangerous Minds: Myths and Reality Behind the Violent Behavior of the Mentally Ill, Public Perceptions, and the Judicial Response Through Involuntary Civil Commitment*, 42 L. & PSYCHOL. REV. 59, 63 (2018) (citing *O’Connor*, 422 U.S. at 575).

⁷¹ *Id.* at 63-64 (offering recommendations on the danger criterion in civil commitment hearings).

⁷² MD. CODE ANN., HEALTH-GEN. § 10-632(e)(2)(v) (West 2018).

⁷³ 441 U.S. 418, 425-26 (1979) (citing *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *In re Gault*, 387 U.S. 1 (1967); *Specht v. Patterson*, 386 U.S. 605 (1967)).

⁷⁴ *Addington*, 441 U.S. at 433. See Donald H. Stone, *There Are Cracks in the Civil Commitment Process: A Practitioner’s Recommendations to Patch the System*, 43 FORDHAM URB. L.J. 789, 818 (2016) (containing recommendations on requiring the burden of proof to be the more stringent beyond a reasonable doubt standard).

⁷⁵ *Jackson*, 406 U.S. at 738.

of dangerousness, a person involuntarily committed could only be held for a reasonable period of time.⁷⁶

Several early court decisions have also acknowledged the least restrictive alternative principle. In *Lake v. Cameron*,⁷⁷ the U.S. Court of Appeals for the D.C. Circuit examined the duty to explore alternatives to in-patient hospitalization and noted that “an earnest effort should be made to review and exhaust available resources in the community in order to provide care reasonably suited to her needs.”⁷⁸ In a second case involving the involuntary confinement at Saint Elizabeth’s Hospital in Washington D.C., the court in *Covington v. Harris* noted that the principle of the least restrictive alternative “inheres in the very nature of civil commitment.”⁷⁹

The need for in-patient hospitalization is often seen as a last resort, as the court in *Welsch v. Likins* recognized the “right of least restrictive alternatives under the due process clause.”⁸⁰ The courts have recognized the widespread acceptance of a constitutional duty by state officials to explore and provide the least stringent practicable alternative to confinement of noncriminals.⁸¹ The court placed the burden on the State to make good faith attempts to place persons with mental illness in suitable and appropriate settings to address their mental and physical condition while least restrictive on their liberties.⁸² These early court decisions lay the framework for the concept of the

⁷⁶ *Id.* at 733. See also *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974) (addressing due process safeguards against unjustified deprivation of liberty involving such issues as the timely nature of the petition, nature of jury trial rights, length of detention prior to a hearing, right to counsel, hearsay evidence, and privilege against self-incrimination).

⁷⁷ 364 F.2d 657 (D.C. Cir. 1966). See *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974) (holding that state officials are to consider settings that are least restrictive of patients’ liberties).

⁷⁸ *Lake*, 364 F.2d at 660. See *In re S.L.*, 462 A.2d 1252, 1258 (N.J. 1983) (holding that the state shall confine in a setting least restrictive of one’s liberty).

⁷⁹ 419 F.2d 617, 623 (1969). The *Covington* court also recognized that “[t]he principle of the least restrictive alternative is equally applicable to alternative dispositions within a mental hospital.” *Id.*

⁸⁰ *Welsch*, 373 F. Supp. at 501. See also *Hickox v. Christie*, 205 F. Supp. 3d 579 (D.N.J. 2016).

⁸¹ *Welsch*, 373 F. Supp. at 502.

⁸² *Id.* See *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 93 (1984) (noting that the “large size of [the institution] prevented it from providing the necessary habitation in the least restrictive environment”); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 438 (1985) (discussing the ignorance and prejudice that persons with intellectual disabilities were subjected to through a history of unfair and grotesque mistreatment and the attempt to locate group homes in community settings).

LRE that is now commonplace in civil commitment statutes. The U.S. Supreme Court continued to demonstrate this view by recognizing the constitutionally protected interests of non-restrictive confinement in *Youngberg v Romeo*.⁸³

State civil commitment statutes often highlight the LRE concept. Some describe the principle as the least restrictive alternative, as is seen in Alaska in which the term is defined as follows:

“[L]east restrictive alternative” means mental health treatment facilities and conditions of treatment that
 (A) are no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and
 (B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury.⁸⁴

In North Dakota, the least restrictive appropriate setting requires a “setting that allows an individual with a developmental disability to develop and realize the individual’s fullest potential and enhances the individual’s ability to cope with the individual’s environment.”⁸⁵ A Pennsylvania regulation emphasizes the importance of the “proximity of the treatment facility to the person’s natural environment.”⁸⁶ Wisconsin factors in the limitation on the “patient’s freedom of choice and mobility” in the provision of treatment and services.⁸⁷

What is commonplace in the LRE criteria in civil commitment statutes is the requirement that the placement is appropriate and/or

⁸³ 457 U.S. 307, 322 (1982) (finding that mentally ill persons are “entitled to minimally adequate training” in light of the liberty interest “in safety and freedom from unreasonable restraints”). See *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975) (one of the first deinstitutionalization cases, placing the duty of locating an alternative facility on both the hospital and local government).

⁸⁴ ALASKA STAT. § 47.30.915(11) (2018). See *infra* Appendix A for comprehensive list of state civil commitment statutes highlighting the LRE concept.

⁸⁵ N.D. CENT. CODE § 25-01.2-01(6) (2018).

⁸⁶ 55 PA. CODE § 5100.2 (2018).

⁸⁷ WIS. ADMIN. CODE DHS § 94.02(27) (2018).

available.⁸⁸ The presence of the LRE being “available” often becomes a burdensome road block to successful release from an inpatient psychiatric hospital. As will be fully articulated in this Article’s recommendation section, the burden is too often wrongfully placed on the patient rather than the State or in-patient psychiatric facility in practice.

The LRE concept is also standard in various state assisted outpatient treatment statutes.⁸⁹ For instance, New York stipulates that the physician must state that the treatment plan is the least restrictive alternative.⁹⁰ California’s assisted outpatient treatment requires that “[p]articipation . . . be in the least restrictive placement necessary to ensure the person’s recovery and stability.”⁹¹ Oklahoma’s alternatives to hospitalization similarly require a statement by the petitioner that the treatment is the least restrictive alternative.⁹² As is often seen in the involuntary civil commitment statutes for inpatient psychiatric hospitalization, the assisted outpatient treatment statutes also contain the limitation that the least restrictive alternative is presently available and appropriate.⁹³ As with the involuntary commitment statutes, the inclusion of the term “available” causes great challenges and dismay unless the statute clearly places the burden of persuasion on the State.

C. Guardianship

In situations where a legal guardian is sought to provide decision making authority surrounding a disabled person’s management of his property, medical decisions, and personal matters, state guardianship statutes often express the desire to respect the least restrictive form of intervention.⁹⁴ In Wisconsin, for example, the

⁸⁸ *E.g.*, ARIZ. REV. STAT. ANN. § 36-540(b) (2018); 55 PA. CODE § 5100.2; 405 ILL. COMP. STAT. 5/3-811(a) (2018); LA. STAT. ANN. § 28:55(e)(1) (2018); MICH. COMP. LAWS § 330.1708 (2018).

⁸⁹ *See infra* notes 90-93.

⁹⁰ N.Y. MENTAL HYG. LAW § 9.60(i)(3) (McKinney 2018). *See also* N.J. STAT. ANN. § 30:4-27.15a(a) (West 2018) (“[T]he court shall consider the least restrictive environment for the patient to receive clinically appropriate treatment.”).

⁹¹ CAL. WELF. & INST. CODE § 5346(a)(7) (West 2018). *See also* N.M. STAT. ANN. § 43-1B-3(e) (West 2018) (“[T]he person . . . is in need of assisted outpatient treatment as the least restrictive appropriate alternative to prevent a relapse or deterioration likely to result in serious harm to self or likely to result in serious harm to others.”).

⁹² OKLA. STAT. tit. 43A § 5-416(I) (2018).

⁹³ *See, e.g.*, KY. REV. STAT. ANN. § 202A.0815(4) (West 2018).

⁹⁴ *See infra* notes 95-97.

powers of guardianship of the estate must be guided by a consideration of the “least restrictive form of intervention of the ward.”⁹⁵ Furthermore, in a 2010 dispute in Tennessee between a daughter and her elderly father, the state Court of Appeals utilized the state statute mandating an imposition of the least restrictive environment in the analysis of the father’s need for a guardian.⁹⁶ Similarly, the Missouri Court of Appeals showed great deference in a close case to the dignity and personhood of a disabled person in applying the LRE principle in refusing to appoint a legal guardian.⁹⁷ In short, the LRE finds a prominent place when a disabled person faces the loss of autonomy and decision making authority.

D. Community Based Group Homes

Long before the *Olmstead* mandate of community based treatment, mental health advocates had long fought for the less restrictive environment principle for mental health treatment. The ADA and the Fair Housing Act⁹⁸ added legal might to the LRE, shining the spotlight on the importance of requiring persons with disabilities to receive public services and accommodations in the most integrated setting appropriate to meet their needs, and ensuring the right to fully participate in all aspects of society.⁹⁹

Several studies have examined the delivery of services to people with disabilities.¹⁰⁰ A National Council on Disability report in 2015 examined the research on the impact of the size and types of

⁹⁵ WIS. STAT. § 54.20(1) (2018). *See also* ALASKA STAT. § 13.26.301 (2018) (stating that a guardian is appointed “only the authority that is least restrictive upon the liberty of the [ward]”).

⁹⁶ *Todd v. Justice*, No. E2009-02346-COA-R3-CV, 2010 WL 2350568, at *8 (Tenn. Ct. App. June 14, 2010) (“The court has an affirmative duty to ascertain and impose the least restrictive alternatives upon the disabled person.” (quoting TENN. CODE ANN. § 34-1-127)).

⁹⁷ *Nelson v. Nelson*, 891 S.W.2d 181 (Mo. Ct. App. 1995) (refusing to take a strict paternalistic approach). *See also* D.C. CODE § 21-2045.01(c)(4) (2018) (requiring the appointment of a guardian that is the least restrictive guardianship order appropriate for the ward).

⁹⁸ Pub. L. No. 90-284, 82 Stat. 81 (1968) (codified at 42 U.S.C. §§ 3601-3619).

⁹⁹ 42 U.S.C. § 12101(a)(2) (2018); ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008).

¹⁰⁰ *Home and Community-Based Services: Creating Systems for Success at Home, at Work and in the Community*, NAT’L COUNCIL ON DISABILITY, https://www.ncd.gov/rawmedia_repository/HCBS%20Report_FINAL.pdf (last visited Nov. 29, 2018) (reviewing the impact of the *Olmstead* decision by the U.S. Supreme Court in 1999).

community settings on outcomes for people with disabilities.¹⁰¹ The results supported the proposition that “smaller, more dispersed and individualized community settings further integration and positive outcomes for individuals with disabilities.”¹⁰² This report also provided important recommendations to states regarding community settings, including:

- (1) limiting residence setting size;¹⁰³
- (2) quality management;¹⁰⁴
- (3) financial alignment across current funding, resource and rate setting, setting of system goals, and the current HCBS regulations;¹⁰⁵
- (4) assuring stakeholder engagement throughout the planning and implementation of plans, processes, and programs;¹⁰⁶
- (5) oversight that enhances provider expectations about qualifications, training, and giving necessary services and supports;¹⁰⁷ and
- (6) expansion of opportunities that promote self-determination and consumer control in living alternatives across the broad array of people with disabilities receiving federal benefits.¹⁰⁸

The report highlighted the LRE principle through the use of the Medicaid waiver program in 1981, which laid the foundation for “people with even the most intensive service needs [to] effectively be supported in small, non-restrictive integrated community settings.”¹⁰⁹ The report also focused on the benefits of integrating persons with

¹⁰¹ *Id.* at 22-30.

¹⁰² *Id.* at 7.

¹⁰³ *Id.* at 9. The report also notes that a majority of U.S. studies reported that programs utilizing smaller residence sizes showed better outcomes. *Id.* at 28.

¹⁰⁴ *Id.* at 9. The report recommends data collection to track systems performance. *Id.* at 60.

¹⁰⁵ *Id.* at 9. The report encourages provider reimbursement practices that “support service delivery in the most integrated setting.” *Id.* at 60.

¹⁰⁶ *Id.* at 9. The report suggests establishing relationships with families and disability advocates to advise on policy issues. *Id.* at 61.

¹⁰⁷ *Id.* at 9. Staff should receive “adequate training to provide effective services.” *Id.* at 61.

¹⁰⁸ *Id.* at 9. The report encourages “self-directed, consumer controlled living alternatives.” *Id.* at 61.

¹⁰⁹ *Id.* at 12. The Omnibus Budget & Reconciliation Act of 1981 is the primary mechanism for community based services. *Id.* at 14.

disabilities into society and the resulting better quality of life outcomes across such areas as community participation and housing stability.¹¹⁰

There are studies that demonstrate that although community residential homes for persons with disabilities have “no negative impact on the surrounding neighborhood[,] . . . the accommodation of these group homes in residential districts remains a controversial issue.”¹¹¹ An important recommendation to local governments to ensure that local zoning ordinances do not raise barriers for inclusion of group homes for the disabled and aging populations is to classify such homes for residential uses, as opposed to commercial properties.¹¹² In addition, the Department of Health and Human Services Office for Civil Rights (hereinafter “OCR”), the office responsible for investigating complaints alleging a violation of the ADA’s integration regulation, must continue its efforts to move persons with disabilities from institutional facilities to the community.¹¹³ Such an investigation process will ensure compliance with the *Olmstead* decree, as well as with the ADA mandate promoting the LRE.¹¹⁴

A common trend in this arena is the unfortunate concept known as “not in my backyard” (hereinafter “NIMBY”), whereby local residents strongly oppose the location of alcohol and drug treatment facilities in their community.¹¹⁵ This outcry is often extended to community resistance to locating mental health services and housing

¹¹⁰ *Id.* at 17-18. See Florence D. DiGennaro Reed et al., *Barriers to Independent Living for Individuals with Disabilities and Seniors*, 7 ASS’N FOR BEHAV. ANALYSIS INT’L 70, 70 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4711747/pdf/40617_2014_Article_11.pdf (“[A]dults usually enjoy greater choice when they live in their own homes relative to individuals living in congregate care or group home settings.”). Barriers to independent living include personal safety, household skills, and medication assistance. *Id.* at 74.

¹¹¹ Michele B. McGlyn & Donald L. Elliott, *Group Home Regulations under State and Federal Law*, 35 COLO. LAW. 37, 38 (2006).

¹¹² *Id.* at 38.

¹¹³ *Delivering on the Promise: OCR’s Compliance Activities Promote Community Integration*, U.S. DEP’T HEALTH & HUMAN SERVICES (Sept. 2006), <https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/compliance-activities-promote-integration/index.html>.

¹¹⁴ *Id.* See *Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289 (E.D.N.Y. 2009) (involving an organization alleging violations of the ADA integration mandate on behalf of mentally ill persons living in state-licensed adult homes).

¹¹⁵ Amanda Habermann, *Not In My Backyard: Communities Resist Mental Health, and Alcohol and Drug Treatment Facilities*, SOVEREIGN HEALTH, <https://www.sovhealth.com/edit-ori-als/not-in-my-backyard/not-backyard-communities-resist-mental-health-alcohol-drug-treatment-facilities/> (last visited Nov. 29, 2018).

in the local residents' community.¹¹⁶ Based largely on unfounded fears and negative stereotypes, NIMBY promotes discrimination and stigmatization of people with physical or mental illnesses.¹¹⁷

There are important sociological reasons for integrating group homes for persons with physical or mental disabilities within residential settings in the community. Such benefits include community integration, educating the community about stigmatized populations, and even the deterrence of crime near group homes because residents are specifically required to maintain positive behavior and are vigilant of this fact.¹¹⁸

An interesting and compelling 2016 study explored this issue of whether drug treatment centers actually bring more crime to a neighborhood, and revealed that the public anxiety about such facilities is not borne out by the data.¹¹⁹ The study showed that violent crime is more likely to be present near a liquor store or corner store than a drug treatment center.¹²⁰ By comparing crimes that arose at fifty-three methadone treatment programs with crimes near liquor stores and convenience stores, the study proved that “[t]here [were] significantly more rapes, homicides, assaults, and robberies near the stores” as compared to the methadone clinics.¹²¹

¹¹⁶ *Id.*

¹¹⁷ *Id.* (“While many residents fear that alcohol and drug treatment facilities will increase crime rates due to the established link between substance abuse and crime, there is no evidence that suggests that people with [substance use disorders] who receive adequate treatment are any more likely to commit crimes than other people in the general population.”).

¹¹⁸ Leonard A. Jason et al., *Counteracting ‘Not in My Backyard’: The Positive Effects of Greater Occupancy within Mutual-help Recovery Homes*, 36 J. COMMUNITY PSYCHOL. 947 (2008).

¹¹⁹ Dale Keiger, *Do Drug Treatment Centers Bring More Crime to a Neighborhood?*, JOHN HOPKINS MAG., Spring 2016, <https://hub.jhu.edu/magazine/2016/spring/nimby-drug-treatment-centers/> (citing C. Debra M. Furr-Holden et al., *Not in My Back Yard: A Comparative Analysis of Crime Around Publicly Funded Drug Treatment Centers, Liquor Stores, Convenience Stores, and Corner Stores in One Mid-Atlantic City*, 77 J. STUD. ON ALCOHOL & DRUGS 17 (2016) (recognizing that “[d]rug treatment centers are a public health need” and as “necessary as urgent care centers and emergency department” (alteration in original))).

¹²⁰ *Id.* See also Jeff Deeney, “A Methadone Clinic? Not in My Neighborhood!”, SUBSTANCE.COM (Jan. 16, 2015), <https://www.substance.com/a-methadone-clinic-not-in-my-neighborhood/>.

¹²¹ *Methadone Treatment Programs—NIMBY or Not?*, MEDMARK TREATMENT CENTERS (Feb. 5, 2016), <https://medmark.com/methadone-treatment-programs-nimby-or-not/> (citing Furr-Holden et al., *supra* note 119). See also Brandon Duncan, “Not in My Backyard” Views Hinder Efforts to Curb Addiction Epidemic, STEPWORKS RECOVERY CTR. (Nov. 30, 2016), <http://www.stepworks.com/2016/11/30/nimby-opposition-to-addiction-treatment-facilities-ups-risks/> (discussing local county ordinances that place strict limits on locating addiction

Disability Rights California issued another important report addressing NIMBY in 2014.¹²² The recommendations include encouraging state and local government to “support efforts to reduce stigma against people with mental health disabilities” and to “promote funding for affordable housing and supportive services.”¹²³ In addition, the report recommends encouraging the state to promote supportive housing to individuals with mental health disabilities at risk of institutionalization and to encourage local authorities to utilize zoning ordinances to discourage “NIMBYism.”¹²⁴

The importance of enabling individuals with disabilities to interact with non-disabled persons to the fullest extent possible is a foundational principle of the LRE concept. Such integrated settings offer individuals with disabilities opportunities to reside, work and obtain supportive services in the community as individuals without disabilities do.¹²⁵ Scattered-site housing with supportive services, as opposed to congregate settings populated exclusively or primarily with persons with disabilities, provides a more integrated setting.¹²⁶

The U.S. Department of Justice (hereinafter “DOJ”) Civil Rights Division is tasked with enforcement of the integration mandate of the ADA and compliance with the *Olmstead* mandate.¹²⁷ In addition, the U.S. Department of Housing and Urban Development (hereinafter “HUD”) plays an important role in increasing efforts to move individuals out of institutions and into integrated community settings.¹²⁸ HUD directives require states to take the lead in offering a range of housing options in a community setting with “substantial opportunities for individuals with disabilities to live and interact with

treatment facilities, negatively resulting in their location away from residential areas to shopping centers).

¹²² DISABILITY RIGHTS CAL., EVERYONE’S NEIGHBORHOOD: ADDRESSING “NOT IN MY BACKYARD” OPPOSITION TO SUPPORTIVE HOUSING FOR PEOPLE WITH MENTAL HEALTH DISABILITIES (2014), <https://www.disabilityrightsca.org/system/files/file-attachments/CM5301.pdf>.

¹²³ *Id.* at 7.

¹²⁴ *Id.*

¹²⁵ U.S. DEP’T JUST.: C.R. DIVISION, STATEMENT OF THE DEPARTMENT OF JUSTICE ON ENFORCEMENT OF INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND *OLMSTEAD V. L.C.* (2011), https://www.ada.gov/olmstead/q&a_olmstead.htm [hereinafter DOJ and *Olmstead*].

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ U.S. DEP’T OF HOUSING & URBAN DEVELOPMENT, STATEMENT OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT ON THE ROLE OF HOUSING IN ACCOMPLISHING THE GOALS OF *OLMSTEAD I* (2013), <https://www.hud.gov/sites/documents/olmsteadguidnc060413.pdf>.

individuals without disabilities.”¹²⁹ Also within HUD’s wheelhouse, the Fair Housing Act (hereinafter “FHA”) is clearly intended to promote such integration in the housing arena in order to accomplish the goals of *Olmstead*.¹³⁰ It is clear that integrated settings are best found in “mainstream society,” which includes access to community activities and opportunities, affords the individual a choice in daily activities, and offers opportunities for interaction between disabled and non-disabled individuals “to the fullest extent possible.”¹³¹ These principles highlight the nature and substance of the LRE concept.

Overwhelming evidence has demonstrated that permitting individuals with disabilities to reside in a family-like setting in the community is not only less expensive than institutionalization, but is also substantially more effective and teaches important life skills.¹³²

E. Architectural Accessibility

The LRE is also prevalent in the architectural design and construction of public places.¹³³ The ADA prohibits discrimination on the “basis of disability in the full and equal enjoyment of goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.”¹³⁴ The ADA mandate of inclusion prohibits a public accommodation from offering disabled persons “opportunit[ies] to participate in or benefit from” the goods and services that are not “equal to [those] afforded to other individuals.”¹³⁵ The inclusion obligation prohibits a “different or separate” benefit to persons with disabilities “unless such action is necessary.”¹³⁶ The ADA promotes public accommodations affording goods and services

¹²⁹ *Id.* at 4.

¹³⁰ *Id.* at 9.

¹³¹ DOJ and *Olmstead*, *supra* note 125.

¹³² *APA Policy Guide on Community Residences*, AM. PLAN. ASS’N (Sept. 22, 1997), <https://www.planning.org/policy/guides/adopted/commres.htm> (highlighting the importance of locating community residences in the “same residential zoning districts as dwellings occupied by biological families”).

¹³³ *See infra* notes 134-41.

¹³⁴ 28 C.F.R. § 36.201(a) (2018). A place of public accommodation means “a facility operated by a private entity whose operations affect commerce and fall within” one of twelve categories including places of lodging, restaurants, movie theaters, museums, and places of recreation. *Id.* § 36.104.

¹³⁵ *Id.* § 36.202(b).

¹³⁶ *Id.* § 36.202(c).

to individuals with disabilities “in the most integrated setting appropriate to the needs of the individual.”¹³⁷

There have been challenges in the context of public accommodations, specifically to relegating disabled persons to the back of the theater, as was seen in *Fiedler v. American Multi-Cinema, Inc.*¹³⁸ The allegation in *Fiedler* was that the movie theater deprived the disabled wheelchair user of the full and equal enjoyment of the facility, and the plaintiff sought seating dispersed throughout the theater.¹³⁹ The court denied summary judgment on the basis that determining whether dispersed wheelchair seating would pose a danger to other patrons in the case of an emergency demanded a fact-specific assessment.¹⁴⁰ Nonetheless, the court’s analysis recognized the importance of architectural accessibility for disabled individuals in public accommodations.¹⁴¹

One possible solution to these recurring issues is the increase in use of universal design. In contrast to “accessible design,” whereby the needs of disabled individuals are specifically considered, and “usable design,” whereby specialized products are created for efficient use, universal design incorporates “products and environments to be usable by all people . . . without the need for adaption or specialized design.”¹⁴² Utilizing universal design is the purest form of inclusion because it serves to benefit all people, and not just those who are “average” or “typical.”¹⁴³ The use of universal design in addressing persons with “mobility, agility, and perceptual acuity” is an important

¹³⁷ *Id.* § 36.203(a).

¹³⁸ 871 F. Supp. 35, 36 (D.D.C. 1994) (discussing plaintiff’s claim that the placement of wheelchair seating in the rear of the theater “relegat[ed] him to inferior seating”).

¹³⁹ *Id.* The court ultimately denied the defendant’s motion for summary judgment, holding that, although seats should be dispersed under the ADA, an “individualized assessment” of the facts was necessary to ensure safety of all patrons in the case of an emergency. *Id.* at 39. *See* United States v. Hoyts Cinemas Corp., 380 F.3d 558 (1st Cir. 2004) (challenging “lines of sight” in stadium theater seating for wheelchair-bound individuals).

¹⁴⁰ *Fiedler*, 871 F. Supp. at 40.

¹⁴¹ *Id.* at 37–40.

¹⁴² *What is the Difference Between Accessible, Usable and Universal Design?*, DISABILITIES, OPPORTUNITIES, INTERNETWORKING, & TECH., <https://www.washington.edu/doi/t/what-difference-between-accessible-usable-and-universal-design> (last updated Sept. 15, 2017). Examples of universal design include automatically opening doors at grocery stores or sidewalks with “curb cuts.” *Id.*

¹⁴³ *Id.*

design principle for architects, and should be more frequently considered.¹⁴⁴

Planning and designing for persons with disabilities is crucial to making inclusion a reality. The promise of inclusion within places of public accommodations will by necessity require creative and thoughtful architects and planners to address the needs presented by persons with disabilities seeking acceptance and full participation in all society has to offer.

F. Termination of Parental Rights

The least restrictive alternative principle is also commonly seen in family law in termination of parental rights (hereinafter “TPR”) proceedings.¹⁴⁵ In situations when a parent neglects, abuses, or abandons a child and the State’s protective services apparatus intervenes, courts are guided by the LRE principle to ensure that TPR is a last resort.¹⁴⁶ For instance, in *C.V.T. v. Department of Children and Family Services*, the court reversed the termination of the mother’s parental rights due to the failure of the Department of Children and Family Services to establish that termination was the least restrictive means of preventing harm to the child in question.¹⁴⁷ Similarly, in a second case involving TPR, a Florida court in *In re Z.C.* highlighted the least restrictive means test.¹⁴⁸ The court recognized the importance of the least restrictive mandate in finding that the Department of Children and Family Services must prove that termination is the least restrictive way to protect the child.¹⁴⁹ It is evident that the determination of what is in the best interest of the child is guided by the least restrictive alternative decision in far reaching areas of the law and public policy initiatives.

¹⁴⁴ Allen C. Abend, *Planning and Designing for Students with Disabilities*, NAT’L CLEARINGHOUSE FOR EDUC. FACILITIES 2 (2001), <http://www.ncef.org/pubs/disabilities.pdf>.

¹⁴⁵ See *infra* notes 147-49 and accompanying text.

¹⁴⁶ See *infra* notes 147-49 and accompanying text.

¹⁴⁷ 843 So. 2d 366, 368 (Fla. Dist. Ct. App. 2003) (“If the Mother were able to continue making progress towards recovery, termination would not be the least restrictive means of preventing harm to the child.”). See *In re R.J.M.*, 266 S.E.2d 114, 114 (W. Va. 1980) (discussing the least restrictive alternative regarding TPR and how “courts are not required to exhaust every speculative possibility of parental improvement”).

¹⁴⁸ 88 So. 3d 977, 987 (Fla. Dist. Ct. App. 2012) (noting that the trial court misapplied the least restrictive means test by basing its decision to be terminated solely on the availability of the alternative placement).

¹⁴⁹ *Id.* at 988.

V. WHERE WE GO FROM HERE?: A NEW FOCUS OF SPECIAL EDUCATION

During nearly forty years since the passage of the Education for All Handicapped Children Act of 1975, children with disabilities have been integrated or mainstreamed in large numbers and in various ways.¹⁵⁰ However, this shift has also brought various challenges and unanswered questions. Should the presumption of providing appropriate special education for children with disabilities in the regular classroom continue to be the first option of choice? Why not start with the middle option within the range of alternatives, the suitable choice of placement in the mainstream, regular classroom part of the day and placement in a special education class the other part of the day? Placement decisions should begin here first, and movement to a less restrictive setting or a more restrictive setting would be contingent on the individualized education program (hereinafter “IEP”) meeting resulting in the appropriate placement setting.

The IDEA sets forth a requirement that school divisions ensure a continuum of alternative placement options to meet the unique needs of children with disabilities.¹⁵¹ This cascade model of special education services ranges “from the least restrictive placement in the regular education classroom to the most restrictive placement in a hospital or institutional setting.”¹⁵² The cascade model “facilitates tailoring of treatment” of the degree of placement specialization and the maximum number of children in the various placement options.¹⁵³ The model envisions placement in the regular educational classroom as the “primary and optimal setting,” and a child would be moved to a more restrictive setting only for “compelling educational reasons and . . . moved back as quickly as possible.”¹⁵⁴ First established by Evelyn Deno in 1970, this system provides seven levels, ranging from

¹⁵⁰ See *supra* Section IV.A.

¹⁵¹ 34 C.F.R. § 300.115(a) (2018). For example, in Maryland, the continuum of alternative placements must be available to the extent necessary to implement the IEP. Md. Code Regs. 13A.05.01.10(B) (2018).

¹⁵² ENCYCLOPEDIA OF SPECIAL EDUCATION: A REFERENCE FOR THE EDUCATION OF CHILDREN, ADOLESCENTS, AND ADULTS WITH DISABILITIES AND OTHER EXCEPTIONAL INDIVIDUALS 362-63 (Cecil R. Reynolds & Elaine Fletcher-Janzen eds., 3d ed. 2007).

¹⁵³ *Id.* at 362 (quoting Evelyn Deno, *Special Education as Developmental Capital*, 37 EXCEPTIONAL CHILDREN 229, 235 (1970)).

¹⁵⁴ *Id.*

education in the regular classroom to hospital or in-patient residential settings as follows:

Level 1: Children in regular classes . . . with or without medical or counseling supportive therapies.

Level 2: Regular class attendance plus supplementary instructional services

Level 3: Part-time special class

Level 4: Full-time special class

Level 5: Special stations

Level 6: Homebound

Level 7: Instruction in hospital or domiciled setting [in-patient programs]¹⁵⁵

The IDEA starting point is level one, in that it requires that “appropriate special education and related services, and aids and supports,” whenever appropriate, are provided for in the regular classroom.¹⁵⁶ Rather than starting placement discussions at level one and moving to other options when necessary to provide appropriate education, the discussion between parents and school officials should instead begin at level 3, the setting whereby a disabled student spends the primary part of the day in the regular classroom and is taught for three hours or less per day in the special education class.¹⁵⁷

The special education class would be dramatically reduced in class size with teachers specifically trained in special education.¹⁵⁸ This bold proposal, starting at level 3 rather than the current default of level 1, would result in more varied educational settings offered for all students with disabilities. While it is true that education in the regular classroom may offer social benefits to the disabled child,¹⁵⁹ and surely it is less costly to the school district than level 3 or 4,¹⁶⁰ tossing disabled

¹⁵⁵ Deno, *supra* note 153 (“The most specialized facilities are likely to be needed by the fewest children on a long term basis.”).

¹⁵⁶ 20 U.S.C. § 1400(c)(5)(D) (2018).

¹⁵⁷ Deno, *supra* note 153.

¹⁵⁸ REBECCA A. HINES, INCLUSION IN MIDDLE SCHOOLS 4-5 (2001), <https://files.eric.ed.gov/fulltext/ED459000.pdf>.

¹⁵⁹ CAROL A. KOCHHAR ET AL., SUCCESSFUL INCLUSION: PRACTICAL STRATEGIES FOR A SHARED RESPONSIBILITY (2d ed. 1999).

¹⁶⁰ Lori Garrett-Hatfield, *The Cost of Mainstreaming Vs. Special Education Classes*, CAREER TREND, <https://careertrend.com/the-cost-of-mainstreaming-vs-special-education-classes-12067245.html> (last updated July 21, 2017). Educating a student with disabilities costs on average almost twice as much as educating a typical non-disabled student. Jay G.

children into a regular classroom environment as a default without consideration for their individualized circumstances may in fact be doing them a disservice.

In order to ensure that the inclusion mandate is respected, flexibility should be paramount in the placement discussion. This discussion may very well lead to the ultimate placement result at level 1; however, starting at the middle of the scale, rather than the extreme end, will lead to a more detailed and fuller discussion of creative options. Placing children with disabilities routinely in the regular classroom as the presumptive choice, without significant thought and discussion of alternatives, may prove to be an unwise and short-sighted model.

There are voices of discontent rising up in various communities against the notion of default inclusion. For instance, members of the special education teaching community have voiced opposition.¹⁶¹ As is seen in “Special Education: The Myth of the Least Restrictive Environment,” Dr. Steven Simpson opines that classrooms filled with thirty kids, four or five who are special education students, is frustrating for the teacher.¹⁶² Trying to serve special education students in the regular classroom in an overcrowded setting with teachers who may be untrained in special education is a recipe for failure.¹⁶³ For school divisions to be laser-focused on placement in the regular classroom for disabled students as the first choice option may result in roadblocks for other more appropriate and unique initiatives to be seriously considered.

The deaf/hard-of-hearing (hereinafter “DHH”) community is particularly vocal in their opposition to mainstreaming as the default setting.¹⁶⁴ Their needs are unique in that the typical school curriculum

Chambers et al., *What Are We Spending on Special Education Services in the United States, 1999-2000?*, AM. INSTITUTES FOR RES. (June 2004), <https://www.air.org/sites/default/files/SE-EP1-What-Are-We-Spending-On.pdf>.

¹⁶¹ See *infra* notes 162-63.

¹⁶² Steven W. Simpson, *Special Education: The Myth of the Least Restrictive Environment* (Nov. 1, 2005), BRIDGES4KIDS, <https://www.bridges4kids.org/articles/2005/11-05/Simpson11-1-05.html> (discussing how reducing the class size to 15 rather than 30 is a monetary problem).

¹⁶³ *Id.* See Kristie Lauren Trifolis, *LRE Under the IDEA: Has Mainstreaming Gone Too Far?*, SETON HALL L. SCH. STUDENT SCHOLARSHIP (May 1, 2014), http://scholarship.shu.edu/cgi/viewcontent.cgi?article=1594&context=student_scholarship (noting that not all disabled students can benefit from mainstreaming, class sizes are too large, teachers are poorly prepared, and non-disabled students may be neglected).

¹⁶⁴ Kevin T. Williams, *Least Restrictive Environment (LRE) and Deaf Students*, NAT'L TECHNICAL INST. FOR THE DEAF (Apr. 1, 2016), <http://www.raisingandeducatingdeafchildren>.

is grounded and designed in spoken language skills.¹⁶⁵ For this reason, the regular classroom is “arguably restrictive in that it is not designed for DHH children.”¹⁶⁶ In response to a 1988 report that recommended various changes to how the federal education system supports deaf students, the Department of Education issued policy guidelines in 1992 that highlighted the difficulties faced by deaf students in obtaining a FAPE.¹⁶⁷ In these guidelines, the Department stressed that additional factors may need to be considered in developing an IEP for these students.¹⁶⁸ The deaf community is also unique among many other disabled individuals in that deafness is often not viewed as a disability at all, but instead as a cultural experience with a common language (e.g., ASL), community, and values.¹⁶⁹ Placing DHH children who identify this way in the regular classroom is akin to placing a non-English speaker in an English speaking class and expecting him to achieve at the same level as native speakers.¹⁷⁰

Some critics of the LRE in the special education setting also point to concerns of race and class inequalities. It is clear that lower resource schools invest less in special education staffing and certain special education services as compared to higher resource schools.¹⁷¹ When only limited services are available, “an availability inquiry may find that the student needs a more restrictive placement simply because the lower-achieving school has not made needed services available.”¹⁷²

org/2016/04/01/least-restrictive-environment-lre-and-deaf-students/. See Lamar Alexander, *Deaf Students Education Services*, U.S. DEP’T EDUC.: OFF. FOR C.R., Oct. 26, 1992, <https://www2.ed.gov/about/offices/list/ocr/docs/hq9806.html> (expressing concern that deaf students have significant obstacles to overcome in order to have access to FAPE, particularly with regard to communication needs).

¹⁶⁵ Williams, *supra* note 164.

¹⁶⁶ *Id.*

¹⁶⁷ Alexander, *supra* note 164. Leeanne Seaver, *Deaf is Different: Educational Impacts and Cultural Perspectives*, HANDS & VOICES, <http://www.handsandvoices.org/articles/education/law/different.html> (last visited Nov. 29, 2018).

¹⁶⁸ Alexander, *supra* note 164 (factors include “1. Communication needs and the child’s and family’s preferred mode of communication; 2. Linguistic needs; 3. Severity of hearing loss and potential for using residual hearing; 4. Academic level; and 5. Social, emotional, and cultural needs including opportunities for peer interactions and communication”).

¹⁶⁹ Seaver, *supra* note 167.

¹⁷⁰ *Id.*

¹⁷¹ Cari Carson, *Rethinking Special Education’s “Least Restrictive Environment” Requirement*, 113 MICH. L. REV. 1397, 1408-09 (2015) (citing JAY G. CHAMBERS ET AL., CTR. FOR SPECIAL EDUC. FIN., DISTRICT REVENUES AND STUDENT POVERTY: IMPLICATIONS FOR SPECIAL EDUCATION RESOURCES AND SERVICES 3-4 (1995), <http://csef.air.org/publications/csef/briefs/brief5.pdf>).

¹⁷² *Id.* at 1409.

This may then lead to low-income students being pigeonholed into inappropriate placements and lost within the system for the duration of their education.¹⁷³ To make matters worse, children in these low-income school districts are also disproportionately students of color.¹⁷⁴

Parents of disabled children are also not entirely in support of the mainstream concept. Frequently, “parents run in the opposite direction” of the LRE, “seeking education in specialized programs.”¹⁷⁵ “Integration for integration’s sake,” once seen as a valid concern to combat rampant discrimination, is “no longer perceived as a pressing one.”¹⁷⁶

Furthermore, integration is often illusory, with “only token interaction at a distance” between general students and disabled students.¹⁷⁷ Education advocates are recognizing that the LRE mandate must be considered in the context of the *Endrew F.* directive that “school[s] must offer [education that is] reasonably calculated to enable a child to make progress appropriate in light of the child’s circumstances.”¹⁷⁸ The more demanding standard of educational progress is greater than the “merely more than *de minimis*” test of the past.¹⁷⁹ There are no longer the grave concerns of disabled students being excluded completely from educational programs, as was seen in the early days of the passage of the IDEA.¹⁸⁰ Today, students with disabilities are demanding and expecting an educational program that will give them every opportunity to fulfill their potential.

Despite these objections, the benefits of mainstreaming should not be ignored when it is indeed appropriate and productive for the disabled student to be placed in the regular classroom. Many educational specialists highlight the benefits of mainstreaming for the disabled student, the students without disabilities, and the teacher.¹⁸¹ For example, the National Longitudinal Transition Study reviewed the

¹⁷³ *Id.*

¹⁷⁴ *Id.* at 1408 (citing CHILDREN’S DEF. FUND, THE STATE OF AMERICA’S CHILDREN 34-35 (2014), <http://www.childrensdefense.org/library/state-of-americas-children/2014-soac.pdf>).

¹⁷⁵ Bonnie Spiro Schinagle & Marilyn J. Bartlett, *The Strained Dynamic of the Least Restrictive Environment Concept in the IDEA*, 35 CHILD. LEGAL RTS. J. 229, 230 (2015).

¹⁷⁶ *Id.* at 249.

¹⁷⁷ *Id.* at 247; Ruth Colker, *The Disability Integration Presumption: Thirty Years Later*, 154 U. PA. L. REV. 789, 799-800 (2006).

¹⁷⁸ *Endrew F. ex rel. Joseph F. v. Douglas Cty. Sch. Dist. RE-1*, 137 S. Ct. 988, 999 (2017).

¹⁷⁹ *Id.* at 1000.

¹⁸⁰ *Id.* at 999.

¹⁸¹ *See infra* note 182.

educational outcomes of 11,000 students with disabilities and found that “more time spent in a general education classroom was positively correlated with: a) fewer absences from school, b) fewer referrals for disruptive behavior, and c) better outcomes after high school in the areas of employment and independent living.”¹⁸² Moreover, students without disabilities made greater gains in math and reading when taught in inclusive settings.¹⁸³

Research has indicated that students with disabilities benefit from inclusion, resulting in more appropriate social behavior, higher levels of achievement, and improved ability of students and teachers to adapt to different teaching and learning styles.¹⁸⁴ However, researchers have also found that removing the barriers to inclusion requires smaller class sizes and additional, properly trained teachers.¹⁸⁵ One challenge is that many teachers are not sufficiently prepared to work in an inclusive setting.¹⁸⁶ The necessary collaboration among teachers requires “a shift in control and sharing of a learning environment rather than having individual space, both concepts foreign to the traditionally trained teacher.”¹⁸⁷ Nonetheless, there has been criticism of the inclusion model, ranging from “low self-esteem of students with disabilities” to “poor academic grades.”¹⁸⁸

The importance of significantly smaller class sizes and enhanced teacher training is pivotal in order for the inclusion model to be beneficial to students with disabilities. The fear of the disabled student being lost in the shuffle and not receiving appropriate educational benefits continues to be a concern for parents and educators.¹⁸⁹ The need for greater funding expenditures for educational programs is also a necessity. Significant research

¹⁸² Xuan Bui et al., *Inclusive Education Research & Practice*, MD. COALITION FOR INCLUSIVE EDUC. 2 (2010), <http://docplayer.net/15573125-Inclusive-education-research-practice.html> (citing MARY WAGNER ET AL., *THE ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE OF YOUTH WITH DISABILITIES: A REPORT FROM THE NATIONAL LONGITUDINAL TRANSITION STUDY-2 (NLTS2)*, NAT'L CTR. FOR SPECIAL EDUC. RES. ix-xii (2006), <https://ies.ed.gov/ncser/pdf/20063000.pdf>).

¹⁸³ *Id.* at 3.

¹⁸⁴ KOCHHAR ET AL., *supra* note 159.

¹⁸⁵ HINES, *supra* note 158.

¹⁸⁶ *Id.* at 5.

¹⁸⁷ *Id.* (“[A]ccepting new ideas about teaching, learning, and learning styles is called for and not always embraced by teachers.”).

¹⁸⁸ *Id.* Another criticism is the lack of training for teachers in the general education setting. *Id.*

¹⁸⁹ Schinagle & Bartlett, *supra* note 175, at 230.

demonstrates that disabled students require the opportunity to “[d]evelop positive social-emotional skills,” “[a]cquire and use knowledge and skills,” and “[u]se appropriate behaviors to meet their own needs.”¹⁹⁰ Inclusion settings offer greater opportunities for social and emotional development.¹⁹¹ Although research shows that included children demonstrate academic gains, one would still wonder whether a mix of educational settings with part of the day spent in a specialized class with significantly fewer students (less than 26) and teachers with specialized training (hereinafter “mixed classroom setting”) could offer even better academic outcomes for disabled students.¹⁹²

The mixed classroom setting might offer even greater academic success without sacrificing the social and emotional benefits an inclusive setting can provide. This educational alternative should be more frequently considered before disabled students are placed all day, every day, in a mainstream setting that may not be best for them. Recognizing this alternative may be an unpopular proposition, but the discussion of educational placement options should *start* with the mixed classroom setting, and then move along the continuum as appropriate. The placement alternative along the cascade system should permit easy movement to a less restrictive or more restrictive setting, depending on the unique needs of the disabled child.

One must not lose sight of the fundamental principle of the IDEA, which creates a presumption in favor of integrating children with disabilities, to the maximum extent appropriate, into the regular classroom.¹⁹³ Although the mainstreaming goal is laudable, it cannot be achieved uniformly, and may in certain circumstances actually violate the IDEA itself.¹⁹⁴ The emphasis must be on the necessity that the educational program *appropriately* meets the child’s needs.

¹⁹⁰ WILLIAM R. HENNINGER, IV & SARIKA S. GUPTA, *FIRST STEPS TO PRESCHOOL INCLUSION: HOW TO JUMPSTART YOUR PROGRAMWIDE PLAN* 37 (2014), <http://archive.brookespublishing.com/documents/gupta-how-children-benefit-from-inclusion.pdf>.

¹⁹¹ *Id.* at 40.

¹⁹² *Id.* at 40-41.

¹⁹³ *A.G. ex rel. S.G. v. Wissahickon Sch. Dist.*, 374 F. App’x 330, 333 (3d Cir. 2010).

¹⁹⁴ *See Capistrano Unified Sch. Dist. v. Wartenberg ex rel. Wartenberg*, 59 F.3d 884, 897 (9th Cir. 1995) (holding that “where separate teaching would produce superior results” to mainstreaming, mainstreaming is neither appropriate nor satisfactory).

VI. THE LRE PRINCIPLE IN INVOLUNTARY CIVIL COMMITMENT

When a person with a mental illness is allegedly a danger to themselves or others, an in-patient psychiatric facility is often the placement of choice unless there is a less restrictive setting that is appropriate.¹⁹⁵ An additional burden facing a person with a mental illness is that judges often find that the less restrictive setting must be readily available.¹⁹⁶ The question of who has the burden to prove that the LRE is not available and how much proof is actually necessary to meet this burden is less than clear in practice.

What is sufficient evidence to show that the LRE setting outside an in-patient psychiatric hospital is unavailable? Does the hospital, state, or local jurisdiction have the burden to present clear and convincing evidence that no LRE is available? What if the primary reason for no LRE being available is due to lack of funding? What if it is less expensive to offer a community based treatment plan? Should that be satisfactory to the judge in determining placement options? Is it a lost cause to advocate for an LRE if such an option is not currently available because the state's mental health apparatus has chosen not to create such a community based model? Are we approaching the question in an individual case-by-case way when what is necessary is a systemic overhaul of funding for mental health treatment?

All too often, mental health policymakers and decisionmakers determine the placement of individuals with mental illness on the basis of what is currently available in the local community rather than on the basis of what would appropriately meet their needs.¹⁹⁷ The pressing demand for community based alternatives, including treatment and housing, must be appropriately funded to make the appropriate LRE available more frequently in a community setting rather than a hospital setting. State governments must take the lead in funding these much needed community based options and local housing alternatives. Only then will the LRE become more than an empty promise for persons with mental illness.

¹⁹⁵ See *infra* Appendix A.

¹⁹⁶ See *supra* note 93 and accompanying text.

¹⁹⁷ See *infra* Appendix A. See, e.g., KY. REV. STAT. ANN. § 202B.040(3) (West 2018).

A. Treatment of Substance Abuse

The continuum of alternative settings is also a guiding principle in the treatment of substance abuse and addiction.¹⁹⁸ The stated “goal is to place patients in the least restrictive environment that is still safe and effective and then move them along a continuum of care as they demonstrate capacity and motivation to cooperate with treatment.”¹⁹⁹ The continuum of treatment settings range from the most intensive to least, including “inpatient hospitalization, residential treatment, intensive outpatient treatment, and outpatient treatment.”²⁰⁰ The least restrictive care ensures patients’ civil rights and their right to choice of care.²⁰¹ The treatment setting should provide for the freedom to participate in society, and should permit disagreement with clinician recommendations for care. A one size fits all approach should never be the treatment option of choice, as an individual inquiry should be the preferred method.

B. Funding Challenges

In an ideal world, funding particular programs for persons with disabilities would not be a factor in determining the appropriate setting. A person with a mental illness would receive community mental health services and suitable housing regardless of the cost. One, of course, quickly recognizes that funding particular programs is a complicated maze of public and private endeavors. Federal, state, and local funding for social service programs is often intertwined, and generally such public entities are focused on all residents of the community, including the disabled and the non-disabled, the indigent, the homeless, and other underserved populations in the community.²⁰² When funding for such programs is in short supply, as it often is, local and state agencies are forced to make tough choices regarding cuts and allocation of limited resources.²⁰³

¹⁹⁸ ELEANOR SULLIVAN & MICHAEL FLEMING, A GUIDE TO SUBSTANCE ABUSE SERVICES FOR PRIMARY CARE CLINICIANS 78 (1997), https://www.ncbi.nlm.nih.gov/books/NBK64827/pdf/Bookshelf_NBK64827.pdf.

¹⁹⁹ *Id.* at 60.

²⁰⁰ *Id.* at 78.

²⁰¹ *Id.* at 51.

²⁰² *See* Concerned Parents to Save Dreher Park Ctr. v. City of W. Palm Beach, 846 F. Supp. 986, 993 (S.D. Fla. 1994).

²⁰³ *See infra* notes 204-09 and accompanying text.

For instance, in West Palm Beach, Florida in 1986, the city made “a variety of recreational and social programs available to individuals with disabilities and their families.”²⁰⁴ In 1993, as a result of budget cuts, the City made a choice to effectively eliminate these programs.²⁰⁵ In the resulting litigation, the court held that the budget cuts resulted in the complete elimination of the programs designed for persons with disabilities.²⁰⁶ Rather than reduce the cost of all recreational programming across the board, the City opted to eliminate solely those programs for the disabled.²⁰⁷ The court in *Dreher Park* noted that “[a]lthough the ADA contemplates that public entities will provide ‘integrated settings’ for services and programs, the requirement is for ‘the most integrated setting *appropriate* to the needs of the individuals with disabilities.’”²⁰⁸ Although the recreation programs that continued to receive funding were open to non-disabled and the disabled, the specific nature of the recreation program previously offered was specially designed to meet the unique needs of persons with disabilities.²⁰⁹

The ADA permits different or separate programs to be “provided if they are ‘necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others.’”²¹⁰ The court held that the Dreher Park Center programs for disabled persons were “needed to give equal benefits of recreation to persons with disabilities,” and when such programs were eliminated, disabled persons were denied the benefit of the City’s leisure services in violation of Title II of the ADA.²¹¹ The resounding message from the court was that when the City chose to provide leisure services to non-disabled persons, “the ADA requires that the City provide equal opportunit[ies] for persons with disabilities to receive comparable benefits.”²¹² Thus, the ADA clearly prohibits the

²⁰⁴ *Dreher Park*, 846 F. Supp. at 988.

²⁰⁵ *Id.* at 989.

²⁰⁶ *Id.* Recreational programs cut included summer day camps for disabled children, adventure clubs for children with varying disabilities, social programs for visually-impaired and blind adults and teenagers, programs for siblings of those with disabilities, a lip reading instruction program, and more. *Id.* at 988.

²⁰⁷ *Id.* at 989.

²⁰⁸ *Id.* at 991 (quoting 28 C.F.R. § 35.130(d)).

²⁰⁹ *Id.*

²¹⁰ *Id.* (citing 28 C.F.R. § 35.130(b)(1)(iv)).

²¹¹ *Id.* at 992.

²¹² *Id.*

exclusion of persons with disabilities from meaningful participation in programs and services when local and state governments are facing budget deficits.²¹³

The ADA strongly mandates inclusion rather than exclusion, but separate programs may prove to be necessary to meet the mission of providing persons with disabilities certain recreational programs.²¹⁴ However, without funding to provide for these separate programs, the promise of inclusion rings hollow.

This “necessity exception” has sometimes been used to justify discrimination. Fortunately, courts have largely rejected this argument.²¹⁵ In *Burns-Vidlak ex rel. Burns v. Chandler*, a challenge was brought on behalf of blind and disabled individuals who claimed they were being excluded from participation in Hawaii’s pilot program for integrating preexisting health care plans.²¹⁶ The court focused on the ADA’s narrow exception that so-called discrimination is permitted only when “necessary.”²¹⁷ A public entity is prohibited from imposing “eligibility criteria that screen out . . . [individuals with disabilities], unless such criteria can be shown to be *necessary* for the *provision of the service, program or activity offered*.”²¹⁸ The court rejected as a matter of law the State’s claim that the proposed healthcare program does not violate the ADA “because it is ‘necessary’ to exclude disabled individuals to ensure the financial viability of the program.”²¹⁹ This categorical exclusion from participation was appropriately rejected by the court.

In *Lovell v. Chandler*, a later challenge to the same Hawaii healthcare program, disabled persons again argued that they were wrongfully excluded from participating in the program.²²⁰ The court focused its discussion on providing different or separate benefits “if ‘such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are *as effective as those provided to others*.’”²²¹ The court held that the “‘different and

²¹³ See *supra* notes 204-212 and accompanying text.

²¹⁴ 28 C.F.R. § 35.130(b)(1)(iv) (2018).

²¹⁵ See *infra* notes 216-24 and accompanying text.

²¹⁶ 939 F. Supp. 765, 767-68 (D. Haw. 1996).

²¹⁷ *Id.* at 769-70 (quoting 28 C.F.R. § 35.130(b)(8)).

²¹⁸ *Id.* (quoting 28 C.F.R. § 35.130(b)(8)).

²¹⁹ *Id.* at 772.

²²⁰ 303 F.3d 1039, 1045-46 (9th Cir. 2002) (noting that the ADA prohibits overt denials of equal treatment of individuals with disabilities).

²²¹ *Id.* at 1055 (quoting 28 C.F.R. § 35.130(b)(1)(iv)).

separate' benefit the State provided was no benefit at all."²²² Thus, "the State cannot avoid liability under the 'necessity' exception."²²³ The ADA mandates that entities providing benefits for persons with disabilities in an inclusive setting, or, when necessary, in a separate setting, must be as effective as those services provided to others.²²⁴ Different or separate clearly does not mean the absence of benefits, but rather services that are as effective as those provided to all citizens.

VII. RECOMMENDATIONS

In order to respect the important liberty interests at stake for persons with disabilities, it is imperative that the least restrictive alternative is a central and guiding principle in a variety of settings including community based mental health treatment, housing options, appropriate educational settings and in all places of public accommodations and government entities. For individuals with mental or physical disabilities who seek the "right to fully participate in all aspects of society,"²²⁵ from "employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to services," the ADA compels equality of opportunity, full participation, independent living, and economic self-sufficiency.²²⁶ The following are recommendations to guide state legislatures and private entities, school officials, policymakers, and everyday individuals in developing, implementing, and participating fully in an enlightened, humane, and fair society, including those with mental or physical disabilities in our nation:

1. In special education placement decisions, begin the conversation on the appropriate setting with placement primarily in the regular classroom setting for the majority of the day, and placement in a specialized education classroom setting for part of the day. Movement to a more or less restrictive setting along the cascade of alternatives will depend on the decisions made at the IEP conference.

²²² *Id.*

²²³ *Id.* See *Messier v. Southbury Training Sch.*, 562 F. Supp. 2d 294 (D. Conn. 2008) (pertaining to residents of a state-run institution for the mentally disabled who claimed a violation of the ADA for the failure to place them in community based residential settings).

²²⁴ 28 C.F.R. § 35.130(b)(1)(iv) (2018).

²²⁵ 42 U.S.C. § 12101(a)(1) (2018).

²²⁶ *Id.* § 12101(a)(3).

2. When making an educational placement decision for a student who is deaf or hard of hearing, the primary factor shall be providing significant opportunities for receiving an education with other students with similar disabilities, and such placement shall take priority over education in the regular classroom with non-disabled students.

3. In the civil commitment context, amend the state law criteria for in-patient hospitalization to require a showing that there is no less restrictive form of intervention that is appropriate and consistent with the welfare and safety of the individual, removing from most state statutes the additional “availability” clause.²²⁷

4. Explicitly place the burden in the civil commitment proceedings on the moving party seeking involuntary hospitalization to show that there is no appropriate less restrictive form of intervention that is consistent with the welfare and safety of the individual.²²⁸

5. Coordinate mental health funding at the federal, state, and local levels with a goal of offering community based outpatient mental health treatment services to all those in need. Increase total funding for such services by 50% over the next decade.

6. Require a coordinated effort between psychiatric hospitals and community mental health service providers to create and fund community based mental health treatment services to identify those services currently available in the community.

7. Raise the burden of proof to beyond a reasonable doubt in involuntary civil commitment hearings, or, at a minimum, on the criterion that there is no less restrictive form of intervention that is consistent with the welfare and safety of the individual, rather than the clear and convincing standard currently in place in a vast majority of state civil commitment statutes.

8. Continue to include the least restrictive alternative doctrine in guardianship laws, termination of parental rights laws, and assisted outpatient treatment statutes.

9. Support the principle that, as a society, we should provide greater protections to the mentally ill, ensuring that involuntary

²²⁷ See *supra* Section IV.B; see also *infra* Appendix A.

²²⁸ See, e.g., NEB. REV. STAT. § 71-925(1) (“The state has the burden to prove by clear and convincing evidence that . . . neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject’s liberty than inpatient or outpatient treatment ordered by the mental health board are available or would suffice to prevent the harm.”).

inpatient confinement is truly a last resort when all less restrictive forms of intervention are inappropriate.

10. Mandate each state mental health agency to create and fund additional community based treatment and housing alternatives for all persons facing involuntary civil commitment. Requiring the state to provide a written discharge plan including outpatient mental health care and housing to the administrative law judge hearing the civil commitment of a person facing involuntary admission into a psychiatric facility within 10 days of said person being initially admitted to a facility on an observational status.

VIII. CONCLUSION

The least restrictive environment, the guiding principle for education and treatment and acceptance of persons with disabilities, is here to stay. Revisiting and reevaluating the concept will lead to even greater acceptance of persons with disabilities into the mainstream of society. Forcing government officials to expand funding, think and act creatively, and consider a variety of alternatives in the mental health and special education arenas will benefit all of society.

There is clearly a recognition of the importance of inclusion and mainstreaming of disabled individuals into all aspects of society. Isolation and exclusion have hopefully given way to a more enlightened society, and with more acceptance of individuals who are viewed as different. The provision of services ranging from education, treatment, housing, and participating in programs and activities offered in the least restrictive environment continues to guide the disability advocacy movement.

One must continue to examine the significance that the LRE has on the design of an appropriate education, treatment, housing, and services or programs offered to individuals with disabilities. We as a society must not default to the LRE simply out of convenience when it is often the least expensive alternative to fund. The prominent cascade of alternatives in education, treatment, housing, and services must be the approach. We must continue to respect individual choice and independent decision-making authority. One size fits all should never be the approach in serving disabled children, adults with mental illness, or deaf or physically disabled individuals.

Whether the concept is called “the less restrictive form of intervention,” “less drastic means,” “least restrictive environment,”

“least restrictive alternative,” “least restrictive appropriate setting,” “least restrictive treatment alternative,” or “least restrictive alternative mode of treatment,” what is clear is the desire of all of us to be unwavering in our desire to experience equality of opportunity, full participation, independent living, and to be left free of government intrusion and constraint. Let us all make the LRE more than an empty mandate by removing frustrations and opening up the dialogue to the endless possibilities a society that steeps in the LRE concept can bring about.

APPENDIX A
THE LRE IN CIVIL COMMITMENT STATUTES: A STATE BY STATE GUIDE

State	Statute	Statutory Language	Statutory Definition Provided?
Alabama	ALA. CODE § 22-52-10.1 (2019)	The least restrictive alternative necessary and available for the treatment of the respondent's mental illness shall be ordered.	None
Alaska	ALASKA STAT. § 47.30.755(b) (2019)	If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days.	ALASKA STAT. § 47.30.915(11) (2019): "[L]east restrictive alternative" means mental health treatment facilities and conditions of treatment that (A) are no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and (B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury[.]

Arizona	ARIZ. REV. STAT. ANN. § 36-540(B) (2019)	The court shall consider all available and appropriate alternatives for the treatment and care of the patient. The court shall order the least restrictive treatment alternative available .	ARIZ. REV. STAT. ANN. § 36-501(21) (2019): “Least restrictive treatment alternative” means the treatment plan and setting that infringe in the least possible degree with the patient’s right to liberty and that are consistent with providing needed treatment in a safe and humane manner.
Arkansas	ARK. CODE ANN. § 20-47-214(c) (2019)	This section shall be construed to allow the person sought to be involuntarily admitted to request treatment under an alternative least restrictive appropriate setting .	ARK. CODE ANN. § 20-47-202(11) (2019): “Least restrictive appropriate setting” for treatment means the available treatment setting which provides the person with the highest likelihood of improvement or cure and which is not more restrictive of the person’s physical or social liberties than is necessary for the most effective treatment of the person and for adequate protection against any dangers which the person poses to himself or herself or others[.]

California	CAL. WELF. & INST. CODE § 6509(a) (West 2019)	If the court finds that the person has a developmental disability, and is a danger to himself, herself, or to others, the court may make an order that the person be committed to the State Department of Developmental Services for suitable treatment and habilitation services. Suitable treatment and habilitation services is defined as the least restrictive residential placement necessary to achieve the purposes of treatment.	None
Colorado	COLO. REV. STAT. § 27-65-116(1)(a) (2019)	Any person receiving evaluation or treatment under any of the provisions of this article is entitled to medical and psychiatric care and treatment, with regard to services listed in section 27-66-101 and services listed in rules authorized by section 27-66-102, suited to meet his or her individual needs, delivered in such a way as to keep him or her in the least restrictive environment , and delivered in such a way as to include the opportunity for participation of family members in his or her program of care and treatment when appropriate, all subject to available appropriations	None
Connecticut	CONN. GEN. STAT. § 17a-498(c)(3) (2019)	If the court finds by clear and convincing evidence that the respondent has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, the court shall make an order for his or her commitment, considering whether or not a less restrictive placement is available , to a hospital for psychiatric disabilities to be named in such order, there to be confined for the period of the duration of such psychiatric disabilities or until he or she is discharged or converted to voluntary status pursuant to section 17a-506 in due course of law.	None

Delaware	DEL. CODE ANN. tit.16, § 5005(a) (2019)	At the completion of the emergency detention period, the person shall not be admitted to a hospital except pursuant to the written certification of a psychiatrist that based upon the psychiatrist's examination of such person: (1) Appears to be a person with a mental condition; (2) The person has been offered voluntary inpatient treatment and has declined such care and treatment or lacks the capacity to knowingly and voluntarily consent to such care and treatment; (3) As a result of the person's apparent mental condition, the person poses a present threat, based upon manifest indications, of being dangerous to self or dangerous to others; and (4) Less restrictive alternatives have been considered and determined to be clinically inappropriate at the present time.	None
District of Columbia	D.C. CODE § 21-545(b)(2) (2019)	If the Court or jury finds that the person is mentally ill and, because of that mental illness, is likely to injure himself or others if not committed, the Court may order the person's commitment to the Department or to any other facility, hospital, or mental health provider that the Court believes is the least restrictive alternative consistent with the best interests of the person and the public. An order of commitment issued pursuant to this paragraph shall be for a period of one year.	None

Florida	FLA. STAT. § 394.467(1)(b) (2019)	A person may be ordered for involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that . . . [a]ll available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.	None
Georgia	GA. CODE ANN. § 37-4-121 (2019)	It is the policy of the state that the least restrictive alternative placement be secured for every client at every stage of his habilitation. It shall be the duty of the facility to assist the client in securing placement in non-institutional community facilities and programs.	GA. CODE ANN. § 37-3-1 (2019): “Least restrictive alternative,” “least restrictive environment,” or “least restrictive appropriate care and treatment” means that which is the least restrictive available alternative, environment, or care and treatment, respectively, within the limits of state funds specifically appropriated therefor.

Hawaii	HAW. REV. STAT. § 334-60.2 (2019)	A person may be committed to a psychiatric facility for involuntary hospitalization, if the court finds: (1) That the person is mentally ill or suffering from substance abuse; (2) That the person is imminently dangerous to self or others; and (3) That the person is in need of care or treatment, or both, and there is no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization.	None
Idaho	IDAHO CODE § 66- 329(11) (2019)	[T]he court shall order the proposed patient committed to the custody of the department director for observation, care and treatment for an indeterminate period of time not to exceed one (1) year. The department director, through his dispositioner, shall determine within twenty-four (24) hours the least restrictive available facility or outpatient treatment , consistent with the needs of each patient committed under this section for observation, care, and treatment.	None
Illinois	405 ILL. COMP. STAT. 5/3- 811(a) (2019)	If any person is found subject to involuntary admission on an inpatient basis, the court shall consider alternative mental health facilities which are appropriate for and available to the respondent, including but not limited to hospitalization. The court may order the respondent to undergo a program of hospitalization in a mental health facility designated by the Department, in a licensed private hospital or private mental health facility if it agrees, or in a facility of the United States Veterans Administration if it agrees. If any person is found subject to involuntary admission on an outpatient basis, the court may order the respondent to undergo a program of alternative treatment; or the court may place the respondent in the care and custody of a relative or other person willing and able to properly care for him or her. The court shall order the least restrictive alternative for treatment which is appropriate.	None

Indiana	<i>See generally</i> IND. CODE § 12-26 (2019)	Consideration of LRE not explicitly required by civil commitment statute (IND. CODE § 12-26-6) Note: LRE standard for commitment adopted by case law as “least restrictive environment suitable for [] treatment.” <i>In re Commitment of T.K. v. Dep’t of Veteran Affairs</i> , 993 N.E.2d 245, 251 (Ind. 2013). LRE standard is present only in statute regarding suitability of facility: “The court may order temporary placement of the individual in the least restrictive suitable facility pending admission to a facility.” IND. CODE § 12-26-10-2 (2019).	None
Iowa	<i>See</i> IOWA CODE R. 13.24	Consideration of LRE not explicitly required by civil commitment statute (IOWA CODE § 299). The most relevant mention in Evaluation report court rules (IOWA CODE R. 13.24) is: “The evaluation also shall specify the basis for the attending physician’s conclusions concerning recommended treatment and the basis for the judgment that the recommended treatment is the least restrictive alternative possible for the respondent pursuant to options (1), (2), (3), or (4) of Iowa Code section 125.84.”	None
Kansas	KAN. STAT. ANN. § 59-2961(b) (2019)	Such report shall state that the examiner has made an examination of the proposed patient and shall state the opinion of the examiner on the issue of whether or not the proposed patient is a mentally ill person subject to involuntary commitment for care and treatment under the act and the examiner’s opinion as to the least restrictive treatment alternative which will protect the proposed patient and others and allow for the improvement of the proposed patient if treatment is ordered.	None

Kentucky	KY. REV. STAT. ANN. § 202B.040 (West 2019)	<p>When a person who is alleged to be an individual with an intellectual disability is involuntarily admitted, there shall be a determination that:</p> <p>(1) The person is an individual with an intellectual disability;</p> <p>(2) The person presents a danger or a threat of danger to self, family, or others;</p> <p>(3) The least restrictive alternative mode of treatment presently available requires placement in an ICF/ID; and</p> <p>(4) Treatment that can reasonably benefit the person is available in an ICF/ID.</p>	<p>KY. REV. STAT. ANN. § 202B.010 (West 2019):</p> <p>“Least restrictive alternative mode of treatment” means that treatment given in the least confining setting which will provide an individual with an intellectual disability appropriate treatment or care consistent with accepted professional practice. For purposes of this section, least restrictive alternative mode of treatment may include an institutional placement[.]</p>
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Louisiana	LA. STAT. ANN. § 28:55(e)(1) (2019)	If the court finds by clear and convincing evidence that the respondent is dangerous to self or others or is gravely disabled, as a result of a substance-related or addictive disorder or mental illness, it shall render a judgment for his commitment. After considering all relevant circumstances, including clinical recommendations and any preference of the respondent or his family, the court shall determine whether the respondent should be committed to a treatment facility which is medically suitable and least restrictive of the respondent's liberty . However, if the placement determined by the court is unavailable, the court may commit the respondent to the Louisiana Department of Health for appropriate placement subject to availability of department resources until such time as an opening is available for transfer to the treatment facility determined by the court. If the department is not the petitioner, the parties shall first consult with the department or its counsel before entering into a judgment stipulating to a commitment of the respondent to the department.	None
Maine	ME. STAT. tit. 34-B, § 3864(5)(E) (2019)	In addition to proving that the patient is a mentally ill individual, the applicant must show: (1) By evidence of the patient's recent actions and behavior, that due to the patient's mental illness the patient poses a likelihood of serious harm; and (2) That, after full consideration of less restrictive treatment settings and modalities , inpatient hospitalization is the best available means for the treatment of the person.	None

Maryland	MD. CODE ANN., HEALTH-GEN. § 10-632(e) (2019)	The hearing officer shall . . . order the release of the individual from the facility unless the record demonstrates by clear and convincing evidence that at the time of the hearing each of the following elements exist as to the individual whose involuntary admission is sought: (i) The individual has a mental disorder; (ii) The individual needs in-patient care or treatment; (iii) The individual presents a danger to the life or safety of the individual or of others; (iv) The individual is unable or unwilling to be voluntarily admitted to the facility; (v) There is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual [.]	None
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<p>Massachusetts</p>	<p>See MASS. ABUSE PREVENTION PROCEEDING GUIDELINE 10:06</p>	<p>Consideration of LRE not directly required by civil commitment statute (MASS GEN. LAWS ch. 123, § 12 (2019))</p> <p>The most relevant mention in Commentary on proceeding guidelines (MASS. ABUSE PREVENTION PROCEEDING GUIDELINE 10:06) is: “On occasion, the behavior of a party involved in a c. 209A action is such that involuntary civil commitment may be appropriate. The standard for such commitment is: (1) the party suffers from a ‘mental illness,’ which for the purposes of involuntary commitment is defined as ‘a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism or substance abuse which is defined in G.L. c. 123, § 35,’ 104 Code Mass. Regs. § 27.05(1) (promulgated by the Department of Mental Health); (2) poses a danger of serious harm, either to the person himself or to others; and (3) there is no less restrictive alternative to commitment available.”</p>	<p>None</p>
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Michigan	MICH. COMP. LAWS § 330.1708(3) (2019)	Mental health services shall be offered in the least restrictive setting that is appropriate and available.	None
Minnesota	MINN. STAT. § 253B.18(a) (2019)	The court shall commit the patient to a secure treatment facility unless the patient establishes by clear and convincing evidence that a less restrictive treatment program is available that is consistent with the patient's treatment needs and the requirements of public safety.	None
Mississippi	MISS. CODE ANN. § 41-21-73(6) (2019)	The court shall state the findings of fact and conclusions of law that constitute the basis for the order of commitment. The findings shall include a listing of less restrictive alternatives considered by the court and the reasons that each was found not suitable.	None

Missouri	MO. REV. STAT. § 632.350(5) (2019)	At the conclusion of the hearing, if the court or jury finds that the respondent, as the result of mental illness, presents a likelihood of serious harm to himself or to others, and the court finds that a program appropriate to handle the respondent's condition has agreed to accept him, the court shall order the respondent to be detained for involuntary treatment in the least restrictive environment for a period not to exceed ninety days or for outpatient detention and treatment under the supervision of a mental health program in the least restrictive environment for a period not to exceed one hundred eighty days.	MO. REV. STAT. § 630.005 (2019): “Least restrictive environment”, a reasonably available setting or mental health program where care, treatment, habilitation or rehabilitation is particularly suited to the level and quality of services necessary to implement a person's individualized treatment, habilitation or rehabilitation plan and to enable the person to maximize his or her functioning potential to participate as freely as feasible in normal living activities, giving due consideration to potentially harmful effects on the person and the safety of other facility or program clients and public safety
Montana	MONT. CODE ANN. § 53-21-120(1) (2019)	A person detained pursuant to this part must be detained in the least restrictive environment required to protect the life and physical safety of the person detained or members of the public; in this respect, prevention of significant injury to property may be considered.	None

Nebraska	NEB. REV. STAT. § 71-925(1) (2019)	The state has the burden to prove by clear and convincing evidence that (a) the subject is mentally ill and dangerous and (b) neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the mental health board are available or would suffice to prevent the harm.	None
Nevada	NEV. REV. STAT. § 433A.310(6) (2019)	Before issuing an order for involuntary admission or a renewal thereof, the court shall explore other alternative courses of treatment within the least restrictive appropriate environment , including involuntary admission to a program of community-based or outpatient services, as suggested by the evaluation team who evaluated the person, or other persons professionally qualified in the field of psychiatric mental health, which the court believes may be in the best interests of the person.	None

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New Hampshire	None	<p>Consideration of LRE not directly required by involuntary civil commitment statute (N.H. REV. STAT. ANN. § 135-C:27 (2019))</p> <p>The most relevant mention is in “Purpose and Policy” provision (N.H. REV. STAT. ANN. § 135-C:1):</p> <p>“It is the policy of this state to provide to persons who are severely mentally disabled adequate and humane care which, to the extent possible while meeting the purposes of habilitation and treatment, is. . . [l]east restrictive of the person’s freedom of movement and ability to function normally in society while being appropriate to the person’s individual capacity.”</p>	None
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New Jersey	N.J. STAT. ANN. § 30:4-27.15a(a) (West 2019)	In determining the commitment placement, the court shall consider the least restrictive environment for the patient to receive clinically appropriate treatment that would ameliorate the danger posed by the patient and provide the patient with appropriate treatment.	N.J. STAT. ANN. § 30:4-27.2(gg) (2019): “Least restrictive environment” means the available setting and form of treatment that appropriately addresses a person’s need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person’s interests in freedom of movement and self-direction.
New Mexico	None	Consideration of LRE not directly required by involuntary civil commitment statute (N.M. STAT. ANN. § 43-1-11 (2019)). The most relevant mention is in “Individualized Treatment and Habilitation Plans” provision (N.M. STAT. ANN. § 43-1-9): “Each individualized treatment or habilitation plan shall include . . . a statement of the least restrictive conditions necessary to achieve the purposes of treatment or habilitation . . . [and] criteria for release to less restrictive settings for treatment or habilitation.”	None

New York	None	<p>Consideration of LRE not directly required by involuntary civil commitment statute for inpatient treatment (N.Y. MENTAL HYG. LAW § 9.33 (McKinney 2019)).</p> <p>The most relevant mention is in “Assisted Outpatient Treatment” provision (N.Y. MENTAL HYG. LAW § 9.60(h)(4)):</p> <p>“A physician who testifies pursuant to paragraph two of this subdivision shall state: (i) the facts which support the allegation that the subject meets each of the criteria for assisted outpatient treatment, (ii) that the treatment is the least restrictive alternative”</p>	None
North Carolina	None	<p>Consideration of LRE not directly required by involuntary civil commitment statute (N.C. GEN. STAT. § 122C-261 through 280 (2019)).</p> <p>The most relevant mention is in “Declaration of Policy” provision regarding voluntary commitment (N.C. GEN. STAT. § 122C-201):</p> <p>“It is further State policy that, except as provided in G.S. 122C-212(b), individuals who have been voluntarily admitted shall be discharged upon application and that involuntarily committed individuals shall be discharged as soon as a less restrictive mode of treatment is appropriate.”</p>	None

North Dakota	N.D. CENT. CODE § 25- 01.2-012 (2019)	All individuals with developmental disabilities have a right to appropriate treatment, services, and habilitation for those disabilities. Treatment, services, and habilitation for individuals with a developmental disability must be provided in the least restrictive appropriate setting.	N.D. CENT. CODE § 25-01.2-01 (2019): “Least restrictive appropriate setting” means that setting that allows an individual with a developmental disability to develop and realize the individual’s fullest potential and enhances the individual’s ability to cope with the individual’s environment without unnecessarily curtailing fundamental personal liberties.
Ohio	OHIO REV. CODE ANN. § 5122.15(E) (West 2019)	[C]ourt shall consider the diagnosis, prognosis, preferences of the respondent and the projected treatment plan for the respondent and shall order the implementation of the least restrictive alternative available and consistent with treatment goals. If the court determines that the least restrictive alternative available that is consistent with treatment goals is inpatient hospitalization, the court’s order shall so state.	None

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Oklahoma	OKLA. STAT. tit. 43A, § 5-415(E) (2019)	<p>After the hearing, when the court determines the person to be a person requiring treatment, the court shall order the person to receive the least restrictive treatment consistent with the treatment needs of the person and the safety of the person and others.</p> <p>(1)The court shall not order hospitalization without a thorough consideration of available treatment alternatives to hospitalization and may direct the submission of evidence as to the least restrictive treatment alternative or may order a mental health examination.</p>	None
Oregon	OR. REV. STAT. § 427.306(2) (2019)	<p>The person shall be detained in the least restrictive setting consistent with the person's emotional and physical needs and the protection of others.</p>	None

<p>Pennsylvania</p>	<p>50 PA. CONS. STAT. § 7304(f) (2019)</p>	<p>Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and subject to subsection (a), an order shall be entered directing treatment of the person in an approved facility as an inpatient or an outpatient, or a combination of such treatment as the director of the facility shall from time to time determine. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. Investigation of treatment alternatives shall include consideration of the person’s relationship to his community and family, his employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment shall include findings on this issue.</p>	<p>55 PA. CODE § 5100.2 (2019): <i>Least restrictive alternate</i> — The least restrictive placement or status available and appropriate to meet the needs of the patient and includes both restrictions on personal liberty and the proximity of the treatment facility to the person’s natural environment.</p>
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Rhode Island	40.1 R.I. GEN. LAWS § 40.1-5-8(j) (2019)	<p>If the court at a final hearing finds by clear and convincing evidence that the subject of the hearing is in need of care and treatment in a facility, and is one whose continued unsupervised presence in the community would, by reason of mental disability, create a likelihood of serious harm, and that all alternatives to certification have been investigated and deemed unsuitable, it shall issue an order committing the person to the custody of the director for care and treatment or to an appropriate facility. In either event, and to the extent practicable, the person shall be cared for in a facility that imposes the least restraint upon the liberty of the person consistent with affording him or her the care and treatment necessary and appropriate to his or her condition. No certification shall be made under this section unless and until full consideration has been given by the certifying court to the alternatives to in-patient care, including, but not limited to, a determination of the person's relationship to the community and to his or her family, of his or her employment possibilities, and of all available community resources, alternate available living arrangements, foster care, community residential facilities, nursing homes, and other convalescent facilities.</p>	None
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South Carolina	None	Consideration of LRE not directly required by involuntary civil commitment statute (S.C. CODE ANN. § 44-17-410).	None
South Dakota	S.D. CODIFIED LAWS § 27A-10-9.1 (2019)	Upon completion of the hearing provided in § 27A-10-8, the board of mental illness may order the involuntary commitment of the person for an initial period not to exceed ninety days if a majority of the board finds by clear and convincing evidence, supported by written findings of fact and conclusions of law, that: (1) The person meets the criteria in § 27A-1-2; (2) The person needs and is likely to benefit from the treatment which is proposed; and (3) The commitment is to the least restrictive treatment alternative .	S.D. CODIFIED LAWS § 27A-1-1(15) (2019): “Least restrictive treatment alternative, the treatment and conditions of treatment which, separately and in combination, are no more intrusive or restrictive of mental, social, or physical freedom than necessary to achieve a reasonably adequate therapeutic benefit. In determining the least restrictive alternative, considerations shall include the values and preferences of the patient, the environmental restrictiveness of treatment settings, the duration of treatment, the physical safety of the patient and others, the psychological and physical restrictiveness of treatments, the relative risks and benefits of treatments to the patient, the proximity of the treatment program to the patient’s residence, and the availability of family and community resources and support.

Tennessee	TENN. CODE. ANN. § 33-6-403 (2019)	Involuntary civil commitment statute does not use LRE language, but incorporates the concept. TENN. CODE. ANN. § 33-6-403: “If and only if . . . all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person . . . then [] the person may be admitted and detained by a hospital or treatment resource for emergency diagnosis, evaluation.”	None
Texas	TEX. HEALTH & SAFETY CODE ANN. § 571.036(d) (2019)	The judge shall order the mental health services provided in the least restrictive appropriate setting available.	TEX. HEALTH & SAFETY CODE ANN. § 571.004 (2019): “The least restrictive appropriate setting for the treatment of a patient is the treatment setting that: (1) is available; (2) provides the patient with the greatest probability of improvement or cure; and (3) is no more restrictive of the patient’s physical or social liberties than is necessary to provide the patient with the most effective treatment and to protect adequately against any danger the patient poses to himself or others”

Utah	UTAH CODE ANN. § 62A-15-631(16)(d) (West 2019)	The court shall order commitment of a proposed patient who is 18 years of age or older to a local mental health authority if, upon completion of the hearing and consideration of the information presented in accordance with Subsection (15)(d), the court finds by clear and convincing evidence that . . . there is no appropriate less-restrictive alternative to a court order of commitment[.]	None
Vermont	VT. STAT. ANN. tit. 18, § 7617(c) (2019)	Involuntary civil commitment statute does not use LRE language, but incorporates concept. VT. STAT. ANN. tit. 18, § 7617(c): “Prior to ordering any course of treatment, the court shall determine whether there exists an available program of treatment for the person which is an appropriate alternative to hospitalization. The court shall not order hospitalization without a thorough consideration of available alternatives.”	None
Virginia	VA. CODE ANN. § 37.2-817(c) (2019)	If the judge or special justice finds by clear and convincing evidence that . . . all available less restrictive treatment alternatives to involuntary inpatient treatment, pursuant to subsection D, that would offer an opportunity for the improvement of the person’s condition have been investigated and determined to be inappropriate[.]	None

Washington	WASH. REV. CODE § 71.05.230(4)(a)(i)(B)(ii) (2018)	If involuntary detention is sought the petition shall state facts that support the finding that such person, as a result of a mental disorder or substance use disorder, presents a likelihood of serious harm, or is gravely disabled and that there are no less restrictive alternatives to detention in the best interest of such person or others. The petition shall state specifically that less restrictive alternative treatment was considered and specify why treatment less restrictive than detention is not appropriate.	WASH. REV. CODE § 71.05.020 (2019): “Less restrictive alternative treatment” means a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.05.585.
West Virginia	W. VA. CODE § 27-5-4(k)(1)(D) (2019)	Whether there is a less restrictive alternative than commitment appropriate for the individual. The burden of proof of the lack of a less restrictive alternative than commitment is on the person or persons seeking the commitment of the individual.	None

Wisconsin	WIS. STAT. § 51.61(1)(e) (2019)	[E]ach patient shall . . . [e]xcept in the case of a patient who is admitted or transferred under s. 51.35(3) or 51.37 or under ch. 971 or 975, have the right to the least restrictive conditions necessary to achieve the purposes of admission, commitment or protective placement.	WIS. ADMIN. CODE DHS § 94.02(27): “Least restrictive treatment” means treatment and services which will best meet the patient’s treatment and security needs and which least limit the patient’s freedom of choice and mobility.
Wyoming	WYO. STAT. ANN. § 25-10-110(j) (2019)	If, upon completion of the hearing and consideration of the record, the court or the jury finds by clear and convincing evidence that the proposed patient is mentally ill the court shall consider the least restrictive and most therapeutic alternatives .	None

**APPENDIX B:
AT-A-GLANCE LRE STATUTORY LANGUAGE**

AL	ALA. CODE § 22-52-10.1 (2019)	Least restrictive alternative necessary and available
AK	ALASKA STAT. § 47.30.755(b) (2019)	Less restrictive alternative available
AZ	ARIZ. REV. STAT. ANN. § 36-540(b) (2019)	Least restrictive appropriate setting
AR	ARK. CODE ANN. § 20-47-214(c) (2019)	Least restrictive treatment alternative available / Available and appropriate
CA	CAL. WELF. & INST. CODE § 6509(a) (West 2019)	Least restrictive residential placement necessary
CO	COLO. REV. STAT. § 27-65-116(1)(a) (2019)	Least restrictive environment
CT	CONN. GEN. STAT. § 17a-498(c)(3) (2019)	Less restrictive placement is available
DE	DEL. CODE ANN. tit.16, § 5005(a) (2019)	Less restrictive alternatives have been considered and determined to be clinically inappropriate
D.C.	D.C. CODE § 21-545(b)(2) (2019)	Least restrictive alternative consistent with the best interests of the person and the public
FL	FLA. STAT. § 394.467(1)(b) (2019)	Available less restrictive treatment alternatives
GA	GA. CODE ANN. § 37-4-121 (2019)	Least restrictive alternative

HI	HAW. REV. STAT. § 334-60.2 (2019)	No suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization
ID	IDAHO CODE § 66-329(11) (2019)	Least restrictive available facility or outpatient treatment
IL	405 ILL. COMP. STAT. 5/3-811(a) (2019)	Least restrictive alternative for treatment which is appropriate / Appropriate for and available to the respondent
IN	None	None
IA	See IOWA CODE R. 13.24	Least restrictive alternative possible
KS	KAN. STAT. ANN. § 59-2961(b) (2019)	Least restrictive treatment alternative
KY	KY. REV. STAT. ANN. § 202B.040 (West 2019)	Least restrictive alternative mode of treatment presently available
LA	LA. STAT. ANN. § 28:55(e)(1) (2019)	Medically suitable and least restrictive of the respondent's liberty / Appropriate placement subject to availability of department resources
ME	ME. STAT. tit. 34-B, § 3864(5)(E) (2019)	Less restrictive treatment settings and modalities / Best available means for treatment
MD	MD. CODE ANN., HEALTH-GEN. § 10-632(e) (2019)	No available less restrictive form of intervention
MA	See MASS. ABUSE PREVENTION PROCEEDING GUIDELINE 10:06	No less restrictive alternative to commitment available
MI	MICH. COMP. LAWS § 330.1708(3) (2019)	Least restrictive setting that is appropriate and available
MN	MINN. STAT. § 253B.18(a) (2019)	Less restrictive treatment program is available
MS	MISS. CODE ANN. § 41-21-73(6) (2019)	Less restrictive alternatives

MO	MO. REV. STAT. § 632.350(5) (2019)	Least restrictive environment
MT	MONT. CODE ANN. § 53-21-120(1) (2019)	Least restrictive environment required to protect the life and physical safety
NE	NEB. REV. STAT. § 71-925(1) (2019)	Treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the mental health board are available or would suffice
NV	NEV. REV. STAT. § 433A.310(6) (2019)	Least restrictive appropriate environment
NH	None	Least restrictive of the person's freedom of movement and ability to function normally in society while being appropriate to the person's individual capacity
NJ	N.J. STAT. ANN. § 30:4-27.15a(a) (West 2019)	Least restrictive conditions necessary / Less restrictive settings
NM	None	Less restrictive settings for treatment
NY	See N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2019)	Least restrictive alternative
NC	See N.C. GEN. STAT. § 122C-201 (2019)	Less restrictive mode of treatment is appropriate
ND	N.D. CENT. CODE § 25-01.2-012 (2019)	Least restrictive appropriate setting
OH	OHIO REV. CODE ANN. § 5122.15(E) (West 2019)	Least restrictive alternative available and consistent with treatment goals
OK	OKLA. STAT. tit. 43A, § 5-415(E) (2019)	Least restrictive treatment consistent with the treatment needs of the person and the safety of the person and others / Least restrictive treatment alternatives
OR	OR. REV. STAT. § 427.306(2) (2019)	Least restrictive setting consistent with the person's emotional and physical needs and the protection of others
PA	50 PA. CONS. STAT. § 7304(f) (2019)	Less restrictive alternatives

RI	40.1 R.I. GEN. LAWS § 40.1-5-8(j) (2019)	All alternatives to certification have been investigated and deemed unsuitable / The least restraint upon the liberty of the person consistent with affording him or her the care and treatment necessary and appropriate
SC	None	None
SD	S.D. CODIFIED LAWS § 27A-10-9.1 (2019)	Least restrictive treatment alternative
TN	TENN. CODE. ANN. § 33-6-403 (2019)	Available less drastic alternatives
TX	TEX. HEALTH & SAFETY CODE ANN. § 571.036(d) (2019)	Least restrictive appropriate setting available
UT	UTAH CODE ANN. § 62A-15-631(16)(d) (West 2019)	Appropriate less-restrictive alternative
VT	VT. STAT. ANN. tit. 18, § 7617(c) (2019)	Available program of treatment for the person which is an appropriate alternative to hospitalization
VA	VA. CODE ANN. § 37.2-817(c) (2019)	Available less restrictive treatment alternatives
WA	WASH. REV. CODE § 71.05.230(4)(a)(i)(B)(ii) (2018)	Less restrictive alternative treatment
WV	W. VA. CODE § 27-5-4(k)(1)(D) (2019)	Less restrictive alternative
WI	WIS. STAT. § 51.61(1)(e) (2019)	Least restrictive conditions necessary
WY	WYO. STAT. ANN. § 25-10-110(j) (2019)	Least restrictive and most therapeutic alternatives

Note: Not all the LRE language listed on the shorthand chart are direct requirements for involuntary commitment. Relevant mentions included in the commitment statute are included here as well (*e.g.*, LRE language related to the choice of facility)