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NOTES

“IN THE MOST APPROPRIATE SETTING”: THE RIGHTS OF MENTALLY DISABLED INDIVIDUALS UNDER THE AMERICANS WITH DISABILITIES ACT IN THE WAKE OF *OLMSTEAD V. L.C.*

Neil S. Butler⁺

In the institution, you can't do anything. Just eat and sleep, eat and sleep Now I go to a day program every day. I am learning to count money, to multiply and divide. And I'm learning to cook. The institution was not for me. I didn't feel I belonged there.

— Statement of Elaine Wilson, plaintiff in *Olmstead v. L.C.*¹

A century ago, treatment of the mentally disabled typically involved criminal or civil commitment to one of the mental hospitals or insane asylums established in the early 1700s.² The turbulent social and political context of the 1960s and 1970s, however, contributed to a gradual decline in the systematic isolation of mentally ill individuals from the rest of the population through a process known as deinstitutionalization.³ In

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1. David G. Savage, *A Sense of Normalcy: Advocates for the mentally disabled say the ADA may require their care outside large facilities*, A.B.A. J., May 1999, at 34 (discussing the grant of certiorari to, and impending oral arguments for, *Olmstead v. L.C.* and the potential impact of the case on mental hospitals and institutions across the country).

2. See 1 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* § 2A-2.1b (2d ed. 1999) (recounting the history of the mentally disabled and attitudes toward civil commitment in the United States from colonial America to the present).

3. See Dana M. Bessette, Note, *Reinterpreting the ADA: Finding a Freedom from Unnecessary Segregation*, 24 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 131, 131-32 (1998) (considering the shift in society's attitudes toward individuals with disabilities over the past sixty years). Deinstitutionalization is “the process of closing state mental hospitals and providing community-based residential services.” *Id.* at 154. As a result of deinstitutionalization, many large, warehouse-type institutions closed and many individuals with disabilities moved to community residential settings. See *id.* at 154-55.

particular, the civil rights movement extended beyond the rights of women and minorities to include the rights of individuals with mental disabilities, which helped shift society's attitude concerning the mentally ill from one of isolation to one of inclusion.⁴ Unfortunately, the statutory enactment of civil rights provisions protecting the rights of individuals with mental disabilities trailed far behind the passage of laws reflecting society's corresponding change in attitudes toward women and minorities.⁵

The deinstitutionalization of mentally disabled individuals began in earnest in the 1950s,⁶ but Congress did not address the rights of the mentally disabled until the passage of the Developmentally Disabled Assistance and Bill of Rights Act⁷ and Section 504 of the Rehabilitation Act of 1973.⁸ Section 504 of the Rehabilitation Act of 1973 prevented recipients of federal funds, including government agencies, from denying individuals with disabilities the opportunity to participate in a program or activity on the basis of that disability.⁹

4. See *id.* at 132 (citing ROBERT D. MILLER, M.D., PH.D., *INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL IN THE POST-REFORM ERA* vii (1987)).

5. See Senator Larry E. Craig, *The Americans with Disabilities Act: Prologue, Promise, Product, and Performance*, 35 IDAHO L. REV. 205, 207-08 (1999) (noting that despite the continued growth of disability rehabilitation programs in the 1960s and the striking similarities between those rehabilitation programs and the Civil Rights movement, the three major civil rights bills of that decade failed to include any provisions for the disabled). In 1964, Congress passed Title VI of the Civil Rights Act which prohibits discrimination on the basis of "race, color, or national origin" in federally supported programs. Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241, 252-53 (1964) (codified as amended at 42 U.S.C. §§ 2000d to 2000d-4a (1994)). Section 504 of the Rehabilitation Act of 1973, which extended such protection to the mentally and physically disabled, was not passed by Congress until 1973. Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794 (1994).

6. See ROBERT M. LEVY & LEONARD S. RUBENSTEIN, *THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES* 19 (Norman Dorsen ed., 1996) (tracing the deinstitutionalization trend in the United States and analyzing the forces underlying the trend).

7. Developmental Disabilities Assistance and Bill of Rights Act, Pub. L. 95-602, 92 Stat. 3003 (1978) (codified as amended in scattered sections of 42 U.S.C.). The Act set up general standards and guidelines for all state-run programs and helped create and provide funding for protecting the rights of the mentally disabled. See 42 U.S.C. § 6000(b) (1994). Section 6009 of the Act provides that "[i]ndividuals with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities." *Id.* § 6009(1). The Act also requires that the treatment be provided in the "setting that is least restrictive of the individual's personal liberty." *Id.* § 6009(2).

8. Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355 (codified as amended at 29 U.S.C. § 794 (1994)).

9. 29 U.S.C. § 794(a). Section 504, as enacted, provides that "[n]o otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial

For the next twenty years, the legal rights of mentally disabled individuals remained uncertain as these statutes were interpreted on a case-by-case basis that varied according to jurisdiction.¹⁰ State interpretations of the acts were based on individuals' needs and rights to treatment and accommodation.¹¹ The passage of the Americans with Disabilities Act

assistance . . ." *Id.*

10. See Bessette, *supra* note 3, at 139 (noting that a circuit split ultimately developed because Section 504 was unclear as to the right to treatment in the least restrictive environment and the right to be free from unnecessary segregation). Bessette cites to case law illustrating this circuit split. See *id.* at n.57. Examples include:

Ciampa v. Massachusetts Rehabilitation Comm'n, 718 F.2d 1, 5 (1st Cir. 1983) (holding that a health care provider did not violate section 504, because it did not discriminate when it failed to develop greater capacity to treat disabilities) . . . *Conner v. Branstad*, 839 F. Supp. 1346 (S.D. Iowa 1993) (holding that individuals in facilities for people with mental disabilities do not have a right under section 504 to create community-based treatment services) . . . *Garrity v. Gallen*, 522 F. Supp. 171 (D.N.H. 1981) (holding that section 504 cannot be so broadly construed as to require deinstitutionalization of all individuals with disabilities, but that the state violated the law by assuming that individuals with profound mental disabilities would not benefit from some form of community based services as an institutional alternative). *But see Jackson v. Fort Stanton Hosp. & Training Sch.*, 757 F. Supp. 1243 (D.N.M. 1990) (observing that defendant's failure to integrate individuals with severe developmental disabilities into the community, while developing community placement for less disabled individuals, violated section 504)

Id.

11. See, e.g., *Youngberg v. Romeo*, 457 U.S. 307, 319 (1982) (holding that an individual's liberty interests required the State to provide "minimally adequate or reasonable training to ensure safety and freedom from undue restraint" and that such training may be defined as that "which is reasonable in light of identifiable liberty interests and the circumstances of the case"). The Court's decision in *Youngberg* forced other courts to consider the rights and needs of the individual on a case-by-case basis. See Stacy E. Seicshnaydre, Comment, *Community Mental Health Treatment for the Mentally Ill—When Does Less Restrictive Treatment Become a Right?*, 66 TUL. L. REV. 1971, 1979 (1992) (relying on *Youngberg* to state that "courts must start with the generalization that a right to minimally adequate training exists and then focus on the particular facts and circumstances of the case").

For example, in *Association for Retarded Citizens of N.D. v. Olson*, the United States District Court for the District of North Dakota found that the right to minimally adequate training is "a right to reasonable training which enables the resident to acquire or maintain *minimum* self-care skills." 561 F. Supp. 473, 487 (D.N.D. 1982). In *Olson*, the Association for Retarded Citizens of North Dakota and six mentally retarded citizens of North Dakota filed a class action suit seeking declaratory and injunctive relief against certain public officials regarding treatment and conditions at two state-run mental facilities. *Id.* at 475. Following in the immediate wake of the *Youngberg* decision, the *Olson* court did not hesitate to find the existence of a right to reasonable training enabling a mentally disabled individual to acquire or maintain certain self-care skills. See *id.* at 487. The court relied heavily upon the language of Justice Blackmun's concurrence in *Youngberg* which stated that "[f]or many mentally retarded people, the difference between the capacity to do things for themselves within an institution and total dependence on the institution for all of their needs is as much liberty as they will ever know." *Id.* (quoting *Youngberg*, 457

("ADA" or the "Act") in 1990¹² marked the statutory codification of the patchwork of case law that interpreted and expanded the statutory rights granted initially to the mentally disabled under the Rehabilitation Act of 1973.¹³ Among the provisions defining the rights of the disabled,¹⁴ the ADA finally provided that a mentally disabled individual could not be denied the benefits of the services of, or be subjected to discrimination by, any public entity.¹⁵

After the passage of the ADA, the isolation of mentally disabled people from general society through involuntary civil commitment became a leading area of litigation.¹⁶ Although the statute appears to prohibit discrimination against individuals with disabilities, various circuit courts have been unable to reach a uniform level of judicial enforcement of these rights.¹⁷ In *Helen L. v. DiDario*,¹⁸ the United States Court of Appeals for the Third Circuit ordered Pennsylvania's Department of Public Welfare to provide a woman with nursing care in her own home rather than in a state-run nursing facility.¹⁹ The appeals court found that the lack of funding for providing treatment to an individual in her own home was insufficient to prove an undue burden exempting the State from

U.S. at 327 (Blackmun, J., concurring)). The *Olson* court regarded the acquisition and maintenance of these skills as vital to the exercise of an individual's basic liberties, especially in light of the difference such skills make in the lives of most mentally ill individuals. *See id.* at 487.

12. Americans with Disabilities Act of 1990, Pub. L. 101-336, 104 Stat. 327 (1990) (codified as amended in scattered sections of 42 U.S.C.).

13. *See* Bessette, *supra* note 3, at 149-51 (discussing how the ADA represents more than a mere extension of the Rehabilitation Act of 1973 and its corresponding case law). Some judges have even argued that "deference should be given to decisions made under the preexisting Rehabilitation Act of 1973, as the ADA is merely an extension of the federal rights enumerated in section 504 of the Rehabilitation Act to state and local entities." *Id.* at 149. *See, e.g.,* *Easley v. Snider*, 36 F.3d 297, 300-01 (3d Cir. 1994) ("Congress enacted the ADA to eliminate discrimination against handicapped individuals by extending the non-discrimination principles required at institutions receiving federal funds . . . to a much wider array of institutions and businesses, including services provided by states and municipalities.").

14. *See* 42 U.S.C. § 12101 (1994). The Act attempted to correct discrimination against individuals with disabilities "in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services[.]" *Id.* § 12101(a)(3).

15. *See id.* § 12132 ("[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.").

16. *See* Bessette, *supra* note 3, at 158, 162.

17. *See id.* at 162 (discussing differing court interpretations of the ADA).

18. 46 F.3d 325 (3d Cir. 1995).

19. *See id.* at 338-39.

providing such treatment.²⁰

In *L.C. v. Olmstead*,²¹ the Court of Appeals for the Eleventh Circuit came to a different, broader conclusion.²² The *Olmstead* court held that the ADA may require a state to expend additional funds to integrate mentally disabled individuals into community-based services, rather than merely placing them into an institution.²³ The court remanded the case to the district court to determine whether forcing a state to transfer funds between institutionalized care and community-based care programs would be unreasonable.²⁴

Ultimately, the Supreme Court granted certiorari to the *Olmstead* case to resolve this circuit split,²⁵ and held that mentally disabled individuals are entitled to community-based treatment once a health care professional determines that the individual is qualified for such services, unless such treatment would be iniquitable.²⁶ The vague and ambiguous language of the Court's decision, however, may not adequately protect the ability of individuals with mental disabilities to receive treatment in a community-based treatment program.²⁷ Instead, states may interpret the

20. *See id.*

21. 138 F.3d 893 (11th Cir. 1998) (*Olmstead II*).

22. *Compare DiDario*, 46 F.3d at 338-39 (holding that the Commonwealth's decision to provide services to the plaintiff under the ADA requires the Commonwealth to do so in a manner which meets the requirements of that statute, regardless of budgetary restraints and costs), *with Olmstead II*, 138 F.3d at 905 (stating that the court's decision may "requir[e] the State to treat L.C. and E.W. in a community-based program [which] will require additional expenditure of state funds").

23. *See Olmstead II*, 138 F.3d at 904-05.

24. *See id.* at 905.

25. *See Olmstead v. L.C.*, 525 U.S. 1054, 1062 (1998).

26. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 607 (1999) (*Olmstead III*); *see also ADAPT Declares Victory in Disability Lawsuit*, U.S. Newswire, June 22, 1999, available in 1999 WL 4637033 (observing that by upholding the ADA's integration mandate the Supreme Court "reinforced the fundamental intent of the ADA, which is to prevent discrimination and promote the integration of people with disabilities into our communities").

27. *See Olmstead III*, 527 U.S. at 602-03 (finding that mentally disabled individuals were "qualified" for non-institutional care where a state's own professionals determined that community-based treatment would be appropriate). *But cf.* Lucille D. Wood, Note, *Costs and the Right to Community-Based Treatment*, 16 YALE L. & POL'Y REV. 501, 518-19 (1998) (discussing the inappropriateness of the Tenth Circuit's holding in *Jackson v. Fort Stanton Hospital*, 964 F.2d 980 (10th Cir. 1992), that "'there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions [regarding treatment in the community]'"). The *Olmstead* Court appears to leave the determination of eligibility for treatment on a whole, as well as community-based treatment, firmly in the hands of the state's own healthcare officials. *See Olmstead III*, 527 U.S. at 602-03. In such circumstances, Wood hypothesizes that it is possible to envision lean budgetary periods when the pressure to withhold spending recommenda-

Court's ambiguous decision as limiting the number of individuals eligible for community-based treatment.²⁸

This Note examines the constitutional right to treatment that exists for individuals with mental disabilities in the wake of *Olmstead v. L.C.* Part I of this Note provides a historical review of the statutory and common law rights of the mentally disabled in American jurisprudence. Part II examines the evolution of the circuit split regarding the costs of implementing community-based treatment and the Supreme Court's resolution of this issue. Part III analyzes the impact of the *Olmstead* decision on mentally disabled individuals, including the decision's potential effect on state and community funding for individuals with disabilities. Finally, this Note concludes that the Supreme Court's decision in *Olmstead*, although well intentioned, may fail to provide uniform enforcement of the ADA's non-discrimination mandate.

I. FIRMLY ROOTED IN THE CIVIL RIGHTS ERA: THE STATUTORY AND CASE LAW FRAMEWORK THAT DEVELOPED THE RIGHTS OF MENTALLY DISABLED INDIVIDUALS TO BE FREE FROM UNNECESSARY SEGREGATION

The development of legal rights for individuals with mental disabilities closely mirrors the development of legal rights for other minorities in American society.²⁹ Courts slowly recognized certain rights of the mentally disabled,³⁰ and these individuals gradually received more egalitarian treatment through certain statutory mandates.³¹ However, the mentally disabled finally realized true integration into society when Congress passed the Americans with Disabilities Act in 1990.³²

tions would far outweigh a state healthcare professional's duty to his patient. See Wood, *supra*, at 518-19.

28. See, e.g., *Rodriguez v. City of New York*, 197 F.3d 611, 619 (2d Cir. 1999) (relying on the *Olmstead* decision to find that New York's failure to provide certain services for the disabled did not constitute discrimination). The Court of Appeals for the Second Circuit found that "*Olmstead* does not, therefore, stand for the proposition that states must provide disabled individuals with the opportunity to remain out of institutions." *Id.* Instead, the Court found the *Olmstead III* decision to hold only that "[s]tates must adhere to the ADA's non-discrimination requirement with regard to the services *they in fact provide.*" *Id.* (quoting *Olmstead III*, 119 S. Ct. 2176, 2188 n.14 (1999)).

29. See Craig, *supra* note 5, at 207-08.

30. See discussion *infra* Parts I.A.1-2.

31. See discussion *infra* Part I.A.3.

32. See discussion *infra* Parts I.A.3, I.B.

A. *The Gradual Evolution of the Americans with Disabilities Act in Statutes and Common Law*

The last half of the twentieth century experienced a dramatic shift in societal attitudes toward the care and treatment of individuals with mental disabilities.³³ Traditionally, care for the mentally ill rested with the family or surrounding community, but gradually society has shifted such responsibility to the government.³⁴ Although hospitals and institutions for the mentally ill have existed for hundreds of years in England, it was not until the mid-1700s that Parliament began to regulate the horrendous conditions surrounding the institutionalization of mentally ill individuals.³⁵ In the late 1800s and early 1900s, care for the mentally disabled in America still rested primarily with family members and local communities.³⁶

From approximately the late 1920s until the early 1970s, however, a series of societal changes led to the gradual implementation of governmental responsibility for the care of the disabled.³⁷ Despite these

33. See generally David A. Rochefort, *Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963*, 9 J. HEALTH POL. POL'Y & L. 1 (1984) (tracing the shift in national policy toward the mentally disabled, which grew out of changing perceptions of the nature of mental illness, through an analysis of policymakers, professional groups, and the general public in the post-World War II era). In the mid-1950s, psychoactive drugs became common in large institutions that housed seriously mentally ill individuals in this country. See Grant H. Morris, *The Supreme Court Examines Civil Commitment Issues: A Retrospective and Prospective Assessment*, 60 TUL. L. REV. 927, 927 (1986). Acceptance of these drugs helped institutions to "unlock their doors" and caused community mental health centers to become the main source of treatment. *Id.* In 1963, Congress enacted the Community Mental Health Centers Act in an effort to provide federal aid and intervention in the mental health area. Community Mental Health Centers Act, Pub. L. No. 88-164, §§ 200-07, 77 Stat. 290, 290-94 (1963) (sections 201-06 repealed 1981, section 207 superseded by Pub. L. No. 94-63, Title III, § 303, 89 Stat. 309). Community mental health centers were required to provide five types of service: "in-patient, out-patient, partial hospitalization, emergency, and consultation-education services." Morris, *supra*, at 927 n.3.

34. See LEVY & RUBENSTEIN, *supra* note 6, at 17-18.

35. See PERLIN, *supra* note 2, § 2A-2.1a, at 47-51.

36. See LEVY & RUBENSTEIN, *supra* note 6, at 17-18 ("People with mental disabilities were expected to look to their families for support . . . or confined in almshouses and jails, while others were banished from towns along with paupers and wandered the countryside.").

37. See Rochefort, *supra* note 33, at 2-12. Following the emergence of psychoanalysis in the 1910s and 1920s, the problem of psychiatric casualties among servicemen in World War II caused the military to experiment with new methods of psychiatric treatment, which led to major therapeutic advances. See *id.* In particular, "the use of psychotropic (conduct controlling) drugs was developed and expanded." Association for Retarded Citizens of N.D. v. Olson, 561 F. Supp. 473, 476 (1982). Essentially, the states attempted to minimize suffering of the mentally ill, and then provided them with custodial care for the remainder of their lives. See *id.* However, the existence of large numbers of

changes, courts continued to reject the argument that people with mental disabilities possessed a constitutional right to receive treatment in a non-segregated manner.³⁸ Instead, the concept of a constitutional right to community-based treatment slowly developed through a series of judicial decisions that described vague rights resembling the right to treatment in the “least restrictive environment.”³⁹

1. O'Connor v. Donaldson: The Right of the Mentally Disabled To Be Free From Unjustified Confinement in an Institution

The first case to recognize constitutional rights belonging to civilly

physically healthy, yet mentally disturbed, young men contributed to a more humanist attitude toward emotional breakdowns among the general population. See Rochefort, *supra* note 33, at 2-3. Behavioral scientists have long advocated the “developmental model” of treatment for the mentally disabled—a concept advocating that the mentally disabled can improve their skills and learn new skills through proper care and training. *Olson*, 561 F. Supp. at 476.

38. See *Lelsz v. Kavanagh*, 807 F.2d 1243, 1249 (5th Cir. 1987) (expressing the idea that the “constitutionally-based rights to enjoy safe conditions and to be free from harm, the right to be free from unnecessary institutionalization, and to have commitment bear some reasonable relation to its purpose” do not equate to a constitutional right to receive treatment in the least restrictive environment); see also *Society for Good Will to Retarded Children, Inc. v. Cuomo*, 737 F.2d 1239, 1248 (2d Cir. 1984) (holding that placement of mentally retarded individuals in the Suffolk Development Center did not violate any entitlement to community placement or a “least restrictive environment” because no such right to treatment existed); *Phillips v. Thompson*, 715 F.2d 365, 368 (7th Cir. 1983) (holding that plaintiffs were not denied their constitutional right to liberty of movement because their liberty was “limited only by the reasonable requirements of caring for a large number of handicapped people in an institutional setting as such requirements were determined by the professionals who directed the operations of these institutions”).

39. *Lake v. Cameron*, 364 F.2d 657, 660-61 (D.C. Cir. 1966) (holding that a person whose mental condition meets the criteria for civil involuntary commitment may not be confined in a mental institution if alternative treatment is available that is less restrictive of the individual’s liberty). Chief Judge Bazelon, announcing the opinion for the majority, placed the burden of exploring possible alternatives to institutional placement on the government. See *id.* at 660. In *Bolton v. Harris*, the same court granted individuals acquitted of crimes by reason of insanity the same procedural safeguards to govern their criminal commitment procedures as those used for civil commitment. *Bolton v. Harris*, 395 F.2d 642, 650-51 (D.C. Cir. 1968). The court construed the District of Columbia’s mandatory commitment statute to authorize only a temporary detention of the acquitted to examine the individual’s current mental health. See *id.* The court required a further hearing after the examination to determine whether the individual’s mental condition warranted involuntary confinement per the jurisdiction’s civil commitment criteria. See *id.* at 651-52. In 1972, the procedural protections connected to the civil commitment process were expanded by the decision in *Lessard v. Schmidt* to include the right to notice and opportunity to be heard, a probable cause hearing within forty-eight hours of detention, a burden of proof beyond a reasonable doubt, right to counsel, the privilege against self-incrimination, and the exclusion of hearsay evidence among the protections to which an individual is entitled during the civil commitment process. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1090-103 (E.D. Wis. 1972).

committed, mentally disabled individuals was *O'Connor v. Donaldson* in 1975.⁴⁰ Kenneth Donaldson, a long-term patient in a Florida mental institution, brought suit against the hospital's superintendent and other hospital officials, alleging that he was not mentally ill and that he was not receiving any treatment for his supposed illness.⁴¹ Donaldson argued that his confinement within the walls of a mental institution was an intentional and malicious deprivation of his constitutional right to liberty.⁴² After providing substantial testimony in support of this argument,⁴³ the jury returned a verdict for Donaldson and awarded him \$38,500 in damages.⁴⁴ On appeal, the United States Court of Appeals for the Fifth Circuit concurred with the findings of the trial court, stating that a patient

40. 422 U.S. 563 (1975) (*Donaldson II*). *Donaldson II* was "the first case since 1901 in which the Supreme Court dealt with the rights of an involuntarily civilly committed mental patient who had engaged in no criminal activity." Morris, *supra* note 33, at 934 (footnote omitted); see also Simon v. Craft, 182 U.S. 427, 435-36 (1901) (providing that a person is not deprived of due process when found to be a lunatic in his absence, so long as the sheriff can take possession of his person and have him present at the trial if it is consistent with the individual's health and welfare).

41. See *Donaldson II*, 422 U.S. at 565. Donaldson's father initiated his son's commitment because he felt his son was delusional. See *id.* The suit was originally filed by Donaldson himself, prior to his release from the institution, as a class action on behalf of all patients in Donaldson's unit at the state hospital. See *id.* at 565 n.1. The complaint sought habeas corpus relief ordering Donaldson's release, in addition to declaratory and injunctive relief and monetary damages. See *id.* The trial court denied class certification, and the plea for equitable relief was dropped prior to trial. See *id.*

42. See *id.* at 565.

43. See *Donaldson v. O'Connor*, 493 F.2d 507, 513-14 (5th Cir. 1974), *vacated on other grounds*, 422 U.S. 563 (1975) (*Donaldson I*) (finding that the plaintiff was unjustifiably denied at least three forms of treatment and that the defendants "wantonly, maliciously and oppressively blocked" efforts by others to have the plaintiff released into their care). The trial court found that Donaldson had been denied basic treatment, such as grounds privileges, occupational therapy, and verbal interaction with a psychiatrist. See *id.* Evidence introduced during trial showed that "[s]hortly after his first mental examination, Donaldson . . . refused to take any medication or to submit to electroshock treatments, and he consistently refused to submit to either of these forms of therapy." *Id.* at 511. In response to this accusation, one of the co-defendants listed "recreational" and "religious" therapy among the forms of treatment given to the plaintiff. *Id.* However, the court found this amounted to little more than allowing Donaldson to attend church and engage in recreational activities, privileges that would be available in prison. See *id.* The court found even less convincing the argument advanced on appeal that Donaldson had been subjected to "milieu therapy." *Id.* Such therapy, the court found, "was nothing more than keeping Donaldson in a sheltered hospital 'milieu' with other mental patients." *Id.*

44. See *Donaldson II*, 422 U.S. at 572. The jury awarded damages of \$38,500 against O'Connor and a co-defendant, including a reward of \$10,000 in punitive damages. See *id.* The holding notes that the "trial judge had instructed the jury prior to the verdict that punitive damages should be awarded only if 'the act or omission of the Defendant or Defendants which proximately caused injury to the Plaintiff was maliciously or wantonly or oppressively done.'" *Id.* at 572 n.7.

confined against his will in a state mental institution possessed "a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition."⁴⁵

The Supreme Court limited its review of the case to the question of what circumstances justified Donaldson's continued confinement.⁴⁶ Establishing the constitutional boundaries of one's right to freedom, the Court found that a state cannot confine an individual who is capable of surviving by himself or with the help of family members and friends.⁴⁷ The mere existence of a mental illness, the Court reasoned, "does not disqualify a person from preferring his home to the comforts of an institution . . . [and] [m]ere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty."⁴⁸ In more recent decisions, the Court has reaffirmed that non-dangerous individuals have a constitutional right to freedom from involuntary institutionalization.⁴⁹ The significance of the *Donaldson* decision is its explicit denial of the ability of mental health professionals to confine, without justification, mentally ill individuals no longer in need of custodial confinement.⁵⁰ The court, however, received harsh criticism for its failure to announce a definitive "right to treatment."⁵¹

45. *Donaldson I*, 493 F.2d at 520.

46. *See Donaldson II*, 422 U.S. at 573-74 (declining to "decide whether, when, or by what procedures, a mentally ill person may be confined by the State on any of the grounds . . . advanced to justify involuntary commitment").

47. *See id.* at 576.

48. *Id.* at 575.

49. *See Jones v. United States*, 463 U.S. 354, 368 (1983) (noting that an individual is committed after an insanity acquittal for the dual purpose of treating the individual's mental illness and protecting society from potential danger, but that the individual should be released once his sanity is established); *see also Zinermon v. Burch*, 494 U.S. 113, 133-34 (1990) ("The involuntary placement process serves to guard against the confinement of a person who, though mentally ill, is harmless and can live safely outside an institution [and] [c]onfinement of such a person . . . is unconstitutional."). In *Zinermon*, a patient who was admitted to a state mental health institution based solely on the strength of admissions forms he signed while heavily medicated and disoriented, brought suit against the facility and others for violations of his civil rights. *Id.* at 118-21. The *Zinermon* Court relied on its previous decision in *Donaldson II*, and found that the confinement of a mentally ill individual who is capable of living safely outside an institution is unconstitutional. *See id.* at 134. Specifically, the Court found that confinement of an individual who has been deprived of his due process rights is unconstitutional because it is at least possible that if the individual "had had an involuntary placement hearing, he would not have been found to meet the statutory standard for involuntary placement." *Id.*

50. *See Morris*, *supra* note 33, at 935 (stating that *Donaldson II* is important "for declaring to the mental health professions that decisions to confine and retain mentally ill persons involuntarily involve societal judgments that are not within the discretionary authority of mental health professionals").

51. *Id.* at 934 (noting that the Court declined the opportunity to announce a "broadly

2. Rouse v. Cameron: *The Development of a Right to Treatment in a "Humane Environment"*

As early as 1966, court decisions indicated the existence of some constitutional right to treatment in a "least restrictive environment."⁵² In *Rouse v. Cameron*,⁵³ the Circuit Court for the District of Columbia held that the District's civil commitment law must be interpreted to guarantee that individuals meeting the legal criteria for involuntary hospitalization will be provided treatment that is "adequate in light of present knowledge."⁵⁴ Chief Judge Bazelon declared that because the purpose of involuntary civil commitment is treatment, not punishment, mental institutions have a duty to furnish adequate treatment, and the patient has a legal right to receive such treatment.⁵⁵

A few years later, the Fifth Circuit recognized the existence of a right to live in a humane environment.⁵⁶ In *Wyatt v. Aderholt*, the United States Court of Appeals for the Fifth Circuit considered a class action suit alleging inadequate treatment brought on behalf of all patients at an Alabama mental hospital.⁵⁷ The court announced a constitutional basis for the right to treatment and issued a decree implementing a minimum

based 'right to treatment,'" and elected to decide the case on much narrower grounds).

52. Bessette, *supra* note 3, at 155-58 (discussing the decision in *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966), a case that dealt with the right to treatment in a least restrictive environment).

53. 373 F.2d 451 (D.C. Cir. 1966).

54. *Id.* at 456.

55. *See id.* at 452-53.

56. *See Wyatt v. Aderholt*, 503 F.2d 1305, 1312 (5th Cir. 1974) (discussing its 1974 holding in *Donaldson I* that "where the justification for commitment was treatment, it offended the fundamentals of due process if treatment [was] not in fact provided"). This litigation presents a sad reality concerning the enforcement of the civil rights of the mentally disabled. *See generally Wyatt v. Rogers*, 985 F. Supp. 1356, 1360-83 (M.D. Ala. 1997) (detailing the voluminous procedural history of the litigation). The court's published decision alone spans 90 incredible, voluminous pages. *See id.* at 1356-1436. The class-action lawsuit began in 1970 and endured nearly 26 years of court battles in search of an amicable resolution. *See id.* at 1356, 1361. In 1986, the court entered a consent decree that resolved the parties' continued disagreements over the defendants' compliance with orders dating back to the early 1970s. *See id.* at 1360. The orders required the defendants to bring their mental health facilities into compliance with certain minimal constitutional standards that had been the subject of the initial litigation. *See id.* at 1361. In 1991, a new round of litigation started, parties filed subsequent motions, and in 1995 the court finally heard these motions over a period of several months, followed by extensive briefing by each side. *See id.* at 1360. The court ultimately determined, in a decision announced as *Wyatt v. Rogers*, that the parties would be released from the 1986 consent decree, but would be subject to further periodic compliance hearings. *See id.* at 1435-36.

57. *Wyatt v. Stickney*, 344 F. Supp. 373, 374 (M.D. Ala. 1972), *enforcing* 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd in relevant part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

constitutional standard designed to establish a humane psychological and physical environment.⁵⁸

The slow, vague development of this bundle of rights for the mentally disabled, however, did not constitute a clear "right to treatment" in a community setting.⁵⁹ The development of a right to services in a nondiscriminatory, community-based setting hinged on the creation and enforcement of federal statutory entitlements to such services.⁶⁰

3. Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act: The Development of Statutory Rights for the Mentally Disabled

In 1972, an afterthought provision added to a vocational rehabilitation bill created an overarching anti-discrimination policy that galvanized the civil rights movement for the disabled.⁶¹ This provision, Section 504 of the Rehabilitation Act of 1973, contained only a single admonition: "[n]o otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . ."⁶² Over the course of time this original provision led to a comprehensive law providing for equal opportunity for individuals with disabilities,

58. See generally *Aderholt*, 503 F.2d at 1312-19.

59. Bessette, *supra* note 3, at 137-39.

60. See LEVY & RUBENSTEIN, *supra* note 6, at 226 (analyzing the options available to the mentally disabled in their efforts to gain an entitlement to services); see also Bessette, *supra* note 3, at 137 (noting that Congress enacted laws such as the Rehabilitation Act of 1973, the Developmental Disabilities Assistance and Bill of Rights Act of 1978, and the Individuals with Disabilities Education Act of 1975 in an effort to end discrimination and segregation against the disabled).

61. See Craig, *supra* note 5, at 208 (quoting Edward D. Berkowitz, *A Historical Preface to the Americans with Disabilities Act*, 6 J. POL'Y HIST. 96, 106 (1994)). In August 1972, a congressional staff member apparently suggested including a civil rights provision in the text of a vocational rehabilitation bill that was under discussion. See *id.* at 208. Another congressional staff member "hurried out of the room and came back with the wording of Title VI of the Civil Rights Act of 1964, thus creating Section 504." *Id.*

62. 29 U.S.C. § 794(a) (1994). Regulations implementing Section 504 clarified this directive by "generally requiring opportunities to participate and equal opportunities to achieve the same benefits, and by prohibiting the provision of different or separate assistance" to disabled individuals. Mark C. Weber, *Disability Discrimination by State and Local Government: The Relationship Between Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act*, 36 WM. & MARY L. REV. 1089, 1098 (1995); see also 2 BONNIE P. TUCKER & BRUCE A. GOLDSTEIN, *LEGAL RIGHTS OF PERSONS WITH DISABILITIES: AN ANALYSIS OF FEDERAL LAW* app. B (1st ed. 1991 & Supp. 1997) (listing federal agency regulations promulgated under Section 504 of the Rehabilitation Act of 1973).

otherwise known as the Americans with Disabilities Act of 1990.⁶³

Pursuant to the ADA, individuals with disabilities are granted the full extent of civil liberties generally recognized as already belonging to the rest of society.⁶⁴ Principally, the legislation attempts to correct the “physical structures, transportation, and telecommunication systems, and rules and policies that have the unintended effect of excluding people with disabilities from full participation” in society.⁶⁵ Additionally, the ADA reaches beyond mere oversight and neglect, and focuses intensively on intentional discrimination.⁶⁶ Congress intended “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities . . . [and] to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities[.]”⁶⁷

Although the disabled population as a whole benefited from the employment,⁶⁸ accessibility,⁶⁹ and housing provisions⁷⁰ of the new legislation,

63. See Bessette, *supra* note 3, at 151 (noting that Congress enacted the ADA “to continue to break down barriers to the integrated participation of people with disabilities in all aspects of community life”) (quoting H.R. REP. NO. 101-485, pt. 3, at 49-50 (1990)).

64. See *id.* at 153 (quoting *Discrimination on the Basis of Handicap, 1998: Hearing Before the Subcomm. on the Handicapped of the Comm. on Labor and Human Resources United States Senate and the Subcomm. on Select Educ. of the Comm. on Educ. and Labor House of Representatives*, 100th Cong. 932 (1990) (statement of Rep. Major R. Owens)) (noting that the original intent of the ADA was “grant[ing] full rights to Americans with disabilities and mov[ing] our great Nation from a respectable position of official compassion for those with impairments to a more laudable position of empowering disabled Americans”).

65. Leonard S. Rubenstein, *Ending Discrimination Against Mental Health Treatment in Publicly Financed Health Care*, 40 ST. LOUIS U. L.J. 315, 337 (1996). Specific rules and regulations promulgated under Title II of the ADA attempt to prevent both intentional and unintentional discrimination against the disabled in society. See *id.* at 336-38.

66. See *id.* at 339. The Congressional findings point to a history of attempts to “isolate and segregate individuals with disabilities [and to engage in] outright intentional exclusion.” *Id.* The ADA’s findings state that:

[I]ndividuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society[.]

42 U.S.C. § 12101(a)(7) (1994). The statute prohibits intentional exclusion of and discrimination against people with disabilities in all aspects of everyday life. See Rubenstein, *supra* note 65, at 339.

67. 42 U.S.C. § 12101(b)(1)-(2).

68. See *id.* § 12112(a) (stating as a general rule that “[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and

the provisions contained in Title II of the Act had the most important impact upon individuals with mental disabilities.⁷¹ Specifically, Title II provides that, “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”⁷² The Attorney General, as required by the provisions of the statute, promulgated a regulation designed to implement the statutory provisions of Title II.⁷³ Known as the integration mandate, it provides that “[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”⁷⁴ The mandate’s importance stems from its regulation of, among other public entities, the mental institutions that provide treatment to the mentally

privileges of employment.”). The statute defines a “covered entity” as “an employer, employment agency, labor organization, or joint labor-management committee.” *Id.* § 12111(2).

69. *See id.* § 12132 (“[N]o qualified individual with a disability shall . . . be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”); *see also id.* § 12182(a) (“No individual shall be discriminated against . . . in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.”). Courts have generally interpreted the accessibility requirements of the ADA to apply to both public and private entities. *See Cupolo v. Bay Area Rapid Transit*, 5 F. Supp. 2d 1078, 1083 (N.D. Cal. 1997) (finding that the “[f]ailure to make key stations in rapid rail and light rail systems ‘readily accessible to individuals with disabilities, including individuals who use wheelchairs,’ constitutes discrimination” under the ADA); *United States v. Morvant*, 843 F. Supp. 1092, 1094 (E.D. La. 1994) (concluding that a dentist could be subject to liability for violating the ADA in connection with his alleged refusal to treat patients who tested positive for HIV because his practice was a place of public accommodation and therefore subject to the ADA).

70. *See* 42 U.S.C. § 12182(a) (prohibiting public accommodations from discriminating against an individual on the basis of disability in “the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations”). Furthermore, under the law, the failure to remove an architectural barrier is a violation if the removal of such barrier is “readily achievable.” *Id.* § 12182(b)(2)(A)(iv).

71. *See* Rubenstein, *supra* note 65, at 319 (noting that “Title II of the ADA provides a firm basis for challenging deliberate efforts by state and local entities to restrict coverage of mental health services for people with psychiatric disabilities in Medicaid and other publicly-financed health care programs”). Rubenstein contends that Title II of the ADA, contrary to its predecessor Section 504, can guarantee more equal disbursement of public health resources through the application of “intentional discrimination.” *See id.*

72. 42 U.S.C. § 12132.

73. *See id.* § 12134(a) (requiring the Attorney General to issue regulations implementing §§ 12131-12133—the sections covering discrimination by public entities—no later than one year after July 26, 1990, the effective date of the legislation).

74. 28 C.F.R. § 35.130(d) (1999).

disabled.⁷⁵

Consistent with the provisions of Section 504, Title II of the ADA provides no immediate right to deinstitutionalization.⁷⁶ The legislative history, however, emphasizes that the Act's purpose was to eradicate the isolation and segregation of individuals with disabilities, as well as the discrimination that persisted in institutionalization.⁷⁷ The ADA integration mandate was clearly designed to "prohibit segregation and other actions based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes about what a class of individuals with disabilities

75. See *id.* § 35.104 (defining the term public entity to be: "(1) [a]ny State or local government; (2) [a]ny department, agency, special purpose district, or other instrumentality of a State or States or local government; and (3) [t]he National Railroad Passenger Corporation and any commuter authority").

76. See Antony B. Klapper, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739, 776 (1993) (arguing that the ADA does not incorporate language dictating the creation of a positive right to community-based treatment). Klapper recognizes that some scholars claim the ADA indicates an affirmative right to community-based treatment. See *id.* at 775. Rather than creating a positive right, however, Klapper argues that the language of the Act is negative and dictates what Congress and the states cannot do, as opposed to what they must do. See *id.* at 776. Klapper argues that to construe the ADA as a means of compelling the construction of community facilities would ignore the lessons learned from previous litigation. See *id.* Finally, Klapper notes that the ADA is not meant to ensure that the development of services for the mentally ill, rather it is meant to ensure that the services already in existence are open to them. See *id.*

Courts have also taken issue with the idea that the ADA integration mandate creates an obligation for states to provide community based programs for mentally disabled individuals. See, e.g., *Conner v. Branstad*, 839 F. Supp. 1346, 1357 (S.D. Iowa 1993) ("[N]either the explicit language of the ADA nor its legislative history call for or require deinstitutionalization of mentally disabled individuals."). The *Conner* court, for instance, based its conclusion that the development of community-based programs was not required by Title II on the "dearth of support in the text and legislative history of the ADA." *Id.* The court further based its conclusion on the existing legislative history of the Act, which stated that 42 U.S.C. § 12132 was intended to:

[E]xtend[] the nondiscrimination policy in section 504 of the Rehabilitation Act of 1973 to cover all State and local governmental entities. Specifically, section [12132] provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination by a department, agency, special purpose district, or other instrumentality of a State or local government.

The Committee has chosen not to list all the types of actions that are included within the term "discrimination," as was done in titles I and III, because this title essentially simply extends the antidiscrimination prohibition embodied [sic] in section 504 to all actions of state and local governments Finally, it is the Committee's intent that section [12132] also be interpreted consistent with *Alexander v. Choate*, 469 U.S. 287 (1985).

Id. (citations omitted) (quoting H.R. REP. NO. 101-485(II), at 84 (1990), reprinted in 1990 U.S.C.C.A.N. 267, 303, 367 (1990)).

77. See *Bessette*, *supra* note 3, at 154 (quoting S. REP. NO. 101-116, at 8 (1989)).

can or cannot do.”⁷⁸ A question remained, however, as to whether the mandate would end the isolation of the mentally disabled from the rest of society.⁷⁹

B. Deinstitutionalization, Treatment Costs, and the ADA's Title II "Least Restrictive Environment" Provision

The ADA appears to provide a mechanism to end the separation of individuals with mental disabilities from society.⁸⁰ The passage of the ADA, however, forced state and federal courts to determine whether there is, in fact, a federal statutory right to treatment in the “least restrictive environment,” or at least some right for the civilly committed to be free from unnecessary segregation from the rest of the population.⁸¹ Discrimination litigation brought by individuals with mental disabilities in the post-ADA era focuses primarily on the resolution of this question.⁸²

Although the ADA holds great promise for those mentally disabled individuals who fall under the scope of the Act, fewer individuals qualify

78. Seicshnaydre, *supra* note 11, at 1991.

79. See Bessette, *supra* note 3, at 170 (expressing concern that many courts have yet to address the interpretation of the ADA's integration mandate).

80. See LEVY & RUBENSTEIN, *supra* note 6, at 230-31. Congress clearly states its intent to end the separation of the mentally disabled in the ADA. See 42 U.S.C. § 12101(b) (1994). Specifically, the Act's purpose is:

- (1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
- (2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
- (3) to ensure that the Federal Government plays a central role in enforcing the standards established in this chapter on behalf of individuals with disabilities; and
- (4) to invoke the sweep of congressional authority, including the power to enforce the Fourteenth Amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

Id.

81. Bessette, *supra* note 3, at 160-62 (applauding the Third Circuit's ruling on the right of disabled individuals to treatment in the “least restrictive environment” as the proper analysis of the intent and enforcement of the ADA, and noting that conflicting opinions will continue to arise in the lower courts until the Supreme Court addresses the issue).

82. See, e.g., *Messier v. Southbury Training Sch.*, 916 F. Supp. 133, 140-42 (D. Conn. 1996) (prohibiting a Connecticut institution for the mentally disabled from refusing to consider certain patients for potential community placement due to the severity of their disabilities); *Charles Q. v. Houstoun*, No. CIV.A.1:CV-95-280, 1996 WL 447549, at *2-*6 (M.D. Pa. 1996) (granting summary judgment to civilly committed patients who brought an ADA claim of right to be treated in the most integrated setting after psychiatric professionals recommended they be discharged from the hospital and treated in a community-based program because they no longer needed to reside in the hospital).

for coverage under the statute today than might have qualified fifty years ago.⁸³ In 1950, there were approximately 600,000 individuals with mental disabilities in state custody living within the confines of state mental institutions.⁸⁴ Presently, that number is approximately 100,000.⁸⁵ Furthermore, individuals not in state custody have neither constitutional rights to state social services,⁸⁶ nor constitutional protection against possible state and local government funding cuts for existing community-based services.⁸⁷ Post-ADA discrimination litigation, therefore, was examined solely in terms of extending the level and form of services, rather than expanding these services to cover a larger percentage of those suffering from some form of mental disability.⁸⁸

A primary concern of the courts regarding the treatment of individuals in community-based residential programs, rather than institutionalized

83. See Rubenstein, *supra* note 65, at 322 (finding that of the estimated three to four million people with serious mental illnesses, fewer than 100,000 are currently living in mental health institutions).

84. See LEVY & RUBENSTEIN, *supra* note 6, at 19 (citing STANLEY S. HERR, RIGHTS AND ADVOCACY FOR RETARDED PEOPLE 43 (1983)).

85. See *id.*

86. See *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 194-97 (1989) (finding that Due Process Clause protections are triggered only when a state takes the affirmative action of restraining an individual's freedom to act on his own behalf, not when it fails to act to protect the individual's liberty interests against harm inflicted by other means). But see *Youngberg v. Romeo*, 457 U.S. 307, 314-25 (1982) (holding that the Due Process Clause requires states to furnish involuntarily committed mental patients with services that will ensure their "reasonable safety" from themselves and others).

87. See *Philadelphia Police and Fire Ass'n v. City of Philadelphia*, 874 F.2d 156, 166-67 (3d Cir. 1989) (finding that mentally retarded individuals living at home possessed no substantive due process right to challenge cutbacks and elimination of services provided to them by the state because the state had taken no affirmative action to restrain their freedom); see also *McNamara v. Dukakis*, CIV.A.No.90-12611-Z, 1990 WL 235439, at *1-*10 (D. Mass. 1990) (denying plaintiffs' motion for a preliminary injunction to prevent defendants from implementing potential staff and program cuts in mental health services).

88. See Rubenstein, *supra* note 65, at 322 (noting that although "right to treatment" suits will continue to appear, they will address an increasingly smaller portion of the greater problem due to the declining number of people in institutions). As Rubenstein wisely notes, the right to treatment cases do not even address the central issue regarding discrimination against mentally disabled individuals in the United States today. See *id.* The key issue in mental disability law today is the unequal and unfair financing of public health services in this country, which ultimately results in providing unintentional, yet discriminatory, services to the disabled. See *id.* Furthermore, the potential of "cost-conscious and litigation-averse state legislatures" further reducing the level of benefits they provide and rewriting their state codes in an effort to preclude discrimination litigation increases with every success for the mentally disabled in "right to treatment" suits. *Id.*

individuals, is the cost of services.⁸⁹ Shortly after the ADA's passage, state courts developed three distinct lines of analysis in an attempt to determine how to approach the competing issues of cost as a burden on the state and the clear integration mandate of the ADA.⁹⁰ The pure "no-costs approach" advocates that integration should be pursued regardless of the cost incurred by the state.⁹¹ The "efficiency approach," requires states to take "those integrative steps that are more cost-efficient than their segregative counterparts."⁹² The third approach advocates a strict separation of powers.⁹³ This approach urges courts to reject any claim that requires the reallocation of previously allocated state funds, regardless of the efficiency of their allocation.⁹⁴

89. See Bessette, *supra* note 3, at 163. Arguments exist regarding whether it is cheaper to close down the large mental institutions and operate community-based residential programs or whether it is less expensive and more effective to treat individuals with mental disabilities in an institutional setting. See *id.* The deinstitutionalization movement of the 1960s, and subsequent transition of many long-term institutional patients in the community, have resulted in an increased demand on existing housing resources and a growing demand for new services capable of accommodating those patients with greater needs. See *id.* (quoting Janet Ford et al., *Needs Assessment for Persons with Severe Mental Illness: What Services are Needed for Successful Community Living?*, 28 COMMUNITY MENTAL HEALTH J. 491, 492 (1992)).

90. See Wood, *supra* note 27, at 508-15.

91. *Id.* at 508.

92. *Id.* The United States District Court for the District of Maryland utilized the "efficiency" approach in *Williams v. Wasserman*. *Williams v. Wasserman*, 937 F. Supp. 524, 528 (D. Md. 1996). In *Wasserman*, developmentally disabled residents of state institutions challenged Maryland's failure to place the residents in community-based care after state health care professionals determined the residents were eligible for such treatment. *Id.* at 526. The state argued that the relief the plaintiffs sought was a complete redesign of the state's mental health care system requiring the creation of hundreds of community treatment slots. See *id.* at 528. The plaintiffs contended that they were not seeking a "fundamental alteration" of Maryland's mental health care system but merely "admission to an existing program of treatment on behalf of plaintiffs for whom such treatment is recommended." *Id.* The court denied the defendants' motion for summary judgment because it found that material facts were in dispute regarding the costs of institutionalization and community-based treatment. See *id.* The determination of such costs was necessary, the court held, to assess the presence or absence of an "undue financial burden." *Id.*

93. See Wood, *supra* note 27, at 508.

94. See *id.* at 508-09. The Massachusetts Supreme Court employed the "separation of powers" approach in *Williams v. Secretary of the Executive Office of Human Services*, 609 N.E.2d 447 (Mass. 1993). In *Williams*, the plaintiffs were mentally disabled homeless individuals who contended that Massachusetts's Department of Mental Health (DMH) failed to provide sufficient integrated housing under the requirements of the ADA integration mandate. *Id.* at 452. The court found that DMH did not violate the ADA because "nothing in the ADA requires that a specific proportion of housing placements provided by a public mental health service be in 'integrated' housing." *Id.* Relying on the Supreme Court's decision in *Alexander v. Choate*, the *Williams* court held that its clear duty was to keep the effect of the ADA within "manageable bounds." *Id.* at 453 (citing

II. THE "LEAST RESTRICTIVE ENVIRONMENT" CIRCUIT SPLIT: THE CONFLICT BETWEEN THE *DiDARIO* AND *OLMSTEAD* COURTS

A definitive split developed between circuits over the proper approach of enforcing Congress's integration mandate as it was intended under the ADA. The conflict between the Third Circuit's holding in *Helen L. v. DiDario* and the Eleventh Circuit's holding in *Olmstead v. L.C.* represents differing approaches to this issue.

A. *The Third Circuit's Resolution of the Cost Issue in Helen L. v. DiDario*

In *DiDario*, a nursing home resident brought an action against Pennsylvania's Department of Public Welfare, alleging that the State violated the ADA's integration mandate by requiring her to receive necessary medical care in a nursing facility rather than in her own home.⁹⁵ The plaintiff, Idell S., was a 43-year-old mother of two whose contraction of meningitis in 1989 left her paralyzed from the waist down.⁹⁶ Due to her disability, Idell S. required the use of a wheelchair and assistance with daily activities.⁹⁷ The parties to the action stipulated that although the plaintiff was not capable of independent, unassisted living, she was not incapacitated to the point of needing nursing home custodial care.⁹⁸ Due to a lack of funding, however, the State maintained that it had no choice but to place Idell S. on a waiting list for its attendant care program and leave her in the nursing home, separated from her family and friends.⁹⁹

The Third Circuit rejected the State's argument that shifting funds from nursing home care appropriations to the attendant care program

Alexander v. Choate, 469 U.S. 287, 299 (1985)). Although the plaintiffs repeatedly referenced Wisconsin's mental health care services system as a more efficient and practical structure for the provision of care to the mentally ill, the court flatly refused to consider the efficiency arguments advanced by the plaintiffs. *See id.* at 455 n.7. As the court stated: "That another State, through legislation, allegedly applies its resources more effectively is an argument better made to the Legislature, not to the courts." *Id.*

95. *Helen L. v. DiDario*, 46 F.3d 325, 327-28 (3d Cir. 1995).

96. *See id.* at 328. As a result of the paralysis, the plaintiff was a patient at the Philadelphia Nursing Home from December 1989 until the time of the lawsuit. *See id.*

97. *See id.* The court noted that the plaintiff required assistance with activities such as bathing, laundry, shopping, and house cleaning, but that she was able to cook, and perform personal hygiene and grooming. *See id.*

98. *See id.*

99. *See id.* at 329. The Pennsylvania Department of Public Welfare (DPW) funded a nursing home residence through the Medical Assistance program (Medicaid) and an "attendant care program" that provided the basic services necessary to allow an individual with physical disabilities to live in his or her home and community, rather than in an institution. *Id.* at 328-29.

would constitute a fundamental alteration of the program.¹⁰⁰ The court held that a lack of funding for a certain kind of treatment was insufficient to prove an undue burden exempting the State from providing that type of treatment.¹⁰¹ The court concluded that Pennsylvania was under no obligation to provide the plaintiff with any care; however, because the State had chosen to provide treatment under the ADA, "it must do so in a manner which comports with the requirements of that statute."¹⁰² The court ordered Pennsylvania to provide the plaintiff with nursing care in her home rather than in the state nursing home, regardless of the availability of funds.¹⁰³

B. The Eleventh Circuit's Approach to Costs in L.C. v. Olmstead

In *L.C. v. Olmstead*, the Court of Appeals for the Eleventh Circuit came to a different conclusion.¹⁰⁴ L.C., a 27-year-old mentally retarded woman suffering from schizophrenia, brought suit against Tommy Olmstead, the Commissioner of the Georgia Department of Human Resources.¹⁰⁵ The state psychiatrists in charge of caring for the plaintiff determined that she no longer required inpatient psychiatric treatment, and that she would be most adequately cared for in a community residential and habilitation setting.¹⁰⁶ The State failed to place the plaintiff in community-based treatment, however, and the complaint alleged that her continued confinement in a state mental institution constituted a violation of her rights under Title II of the ADA.¹⁰⁷ E.W., a similarly situated,

100. See *id.* at 338.

101. See *id.*

102. *Id.* at 339.

103. See *id.* (vacating the order granting summary judgment in favor of the defendant and remanding the case to the district court "for entry of an order granting summary judgment to Idell S. and against [the Department of Public Welfare]").

104. *L.C. v. Olmstead*, 138 F.3d 893, 905 (11th Cir. 1998) (*Olmstead II*) (holding that the ADA may require the state to expend additional funds under certain conditions).

105. See *Zimring v. Olmstead*, No. CIV.A.1:95-CV-1210-MHS, 1997 WL 148674 at *2 (N.D. Ga. March 26, 1997) (*Olmstead I*).

106. See *id.* at *1. In May 1992, L.C. was voluntarily admitted to and confined for treatment in the psychiatric unit of Georgia Regional Hospital in Atlanta (GRH). See *L.C. v. Olmstead*, 527 U.S. 581, 593 (1999) (*Olmstead III*). When her condition stabilized in May of 1993, L.C.'s treatment team determined that her needs could adequately be met in one of the community-based programs supported by the State. See *id.* Despite this evaluation, Georgia kept L.C. institutionalized until February 1996, when she was placed in a community-based treatment program. See *id.* Similarly, "E.W.'s psychiatrist concluded that she could be treated appropriately in a community-based setting." *Id.* However, the State kept E.W. institutionalized until a few months after the District Court issued its 1997 judgment. See *id.*

107. See *Olmstead II*, 138 F.3d at 895. The plaintiffs' complaints alleged also that the

mentally disabled individual, later intervened in the action.¹⁰⁸

In granting partial summary judgment for the plaintiffs, the United States District Court for the Northern District of Georgia found that the State's failure to place L.C. in an appropriate community-based treatment program violated Title II of the ADA.¹⁰⁹ The court rejected the State's argument that inadequate funding, not discrimination against the plaintiffs "by reason of" their disabilities, was the cause of L.C.'s and E.W.'s continued retention in a state hospital.¹¹⁰ The court found that "unnecessary institutional segregation of the [mentally] disabled constitutes discrimination per se, which cannot be justified by a lack of funding."¹¹¹

On appeal, the Eleventh Circuit affirmed the judgment of the district court, but remanded the case for a reassessment of the State's cost-based defense.¹¹² The appeals court held that the ADA requires a state to ex-

defendants failed to provide L.C. and E.W. with "minimally adequate care and freedom from undue restraint, in violation of their rights under the Due Process Clause of the Fourteenth Amendment." *Olmstead III*, 527 U.S. at 588. However, both the district court and the Eleventh Circuit failed to reach a decision on the Fourteenth Amendment claims. *See id.*

108. *See Olmstead III*, 527 U.S. at 593. E.W. was a mentally retarded woman with a personality disorder and a history of treatment in institutional settings similar to L.C. *See id.* Voluntarily admitted to the hospital, E.W. was confined to the psychiatric unit for treatment in February 1995. *See id.* In March 1995, the state sought to discharge E.W. and send her to a homeless shelter, but withdrew that plan when her attorney threatened to file suit against the hospital. *See id.*

109. *See Olmstead I*, 1997 WL 148674, at *4. In *Olmstead I*:

[T]he court den[ie]d] defendant's motion for summary judgment and grant[ed] plaintiffs' motion for summary judgment on plaintiffs' ADA claim; declar[ed] that defendants' failure to place plaintiffs in an appropriate community-based treatment program violat[ed] the ADA . . . and order[ed] defendants to comply with the ADA by releasing E.W. to an appropriate, community-based treatment program and by providing L.C. with all appropriate services necessary to maintain her current placement in such a program.

Id.

110. *Id.* at *3. In reaching its decision, the court relied upon three factors. *See id.* First, the court held that Congress's intent in enacting the ADA was to eliminate "segregation" of individuals with disabilities, which is a form of discrimination. *See id.* Second, the court determined that the regulations the Attorney General passed in order to implement Title II strictly prohibit unnecessary institutionalization. *See id.* Finally, the court relied upon the prior precedent established in *Helen L. v. DiDario*, which rejected the argument that continued institutionalization may be justified by a lack of funding. *See id.* at *4.

111. *Id.* at *3. The court found no dispute existed regarding that the defendants existing programs that provided services to community services to persons like E.W. and L.C. *See id.* Furthermore, the court found it "undisputed that defendants can provide services to plaintiffs in the community at considerably less cost than is required to maintain them in an institution." *Id.* at *4.

112. *See Olmstead II*, 138 F.3d at 905. After the Supreme Court granted certiorari,

pend additional funds to integrate mentally disabled individuals into community-based services, rather than merely placing them in an institution.¹¹³ In situations where such funding is not readily available, the appeals court found that forcing a state to transfer funds between programs would be unreasonable.¹¹⁴

Under the Attorney General's Title II regulations, the court found that reasonable modifications were required but fundamental alterations were not demanded.¹¹⁵ Furthermore, upon review of the regulations and legislative history, the court noted that Congress "wanted to permit a cost defense only in the most limited of circumstances."¹¹⁶ The court found that such a cost justification would fail "[u]nless the State can prove that requiring it to [expend additional funds] . . . would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service [the State] provides."¹¹⁷ The appeals court concluded that the district court had never seriously considered the "lack of funding" justification, and remanded the case for consideration of whether "the additional expenditures necessary to treat L.C. and E.W. in community-based care would be unreasonable given the demands of the State's mental health budget."¹¹⁸ The Supreme Court granted certiorari to resolve the question of "whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions."¹¹⁹

III. ENFORCING THE "INTEGRATION MANDATE": THE SUPREME COURT'S BALANCING OF NON-DISCRIMINATION AND COSTS IN

the district court, on remand, again rejected the State's fundamental-alteration defense. *See Olmstead III*, 527 U.S. at 596 n.7. The district court declared the potential impact of its decision beyond L.C. and E.W. "irrelevant" and found that the yearly cost to the State of providing community-based treatment to the plaintiffs was not unreasonable. *Id.* That decision is now on appeal to the Eleventh Circuit. *See id.*

113. *See Olmstead II*, 138 F.3d at 905.

114. *See id.* at 904-05.

115. *See id.* at 904.

116. *Id.* at 902.

117. *Id.* at 905.

118. *Id.*

¹ 119. *L.C. v. Olmstead*, 527 U.S. 581, 587 (1999) (*Olmstead III*). Although twenty-two states originally sided with Georgia and were scheduled to submit amicus briefs to the Supreme Court, fourteen of these states ultimately pulled out of the case. *See* Tony Mauro, *States Drop Amici Roles in Suit Over Care of Mentally Disabled*, 156 N.J.L.J. 179 (1999) (attributing the states' last-minute refusal to participate to the grass-roots power of the disability community nationwide); *see also* Lynda de Jong, *Mass. to Withdraw from Disabilities Act Case*, THE BOSTON GLOBE, March 6, 1999, at B4 (theorizing that the sudden change-of-heart by the non-assenting states would persuade the Court that the states were not complete in their support of Georgia's position).

OLMSTEAD V. L.C.

Two issues relevant to the proper construction of the anti-discrimination provision contained in Title II of the ADA faced the Supreme Court.¹²⁰ The Justices first confronted the issue of whether the ADA required the provision of community-based treatment to the mentally disabled.¹²¹ The Court then considered the appropriate level of relief to grant to the plaintiffs.¹²²

A. *To Provide or Not To Provide: A Bright-Line Test for the Constitutional Right to Community-based Treatment*

The Supreme Court first addressed whether “the proscription of discrimination [requires] placement of persons with mental disabilities in community settings rather than in institutions.”¹²³ The Court upheld the decision of the Eleventh Circuit, finding that unjustified isolation in a mental institution is discrimination based on disability.¹²⁴ The Justices found that institutional placement of the mentally disabled, particularly those who are capable of benefiting from community settings, causes unfounded beliefs that such individuals are unfit to participate in community life.¹²⁵

The Court further found that institutional confinement greatly diminishes the daily activities of mentally disabled individuals, including their

120. See *Olmstead III*, 527 U.S. at 587. The Court found that the case presented no constitutional question as it came before them, even though the complaints originally filed by the plaintiffs-respondents included a Fourteenth Amendment Due Process Claim. See *id.* Because the courts below resolved the case solely on statutory grounds, the Court likewise limited its review to the Americans with Disabilities Act. See *id.*

121. See *id.* at 597-603.

122. See *id.* at 603-06.

123. *Id.* at 587.

124. See *id.* at 597. The State argued that the plaintiffs were not denied community placement on account of their disabilities and therefore did not encounter discrimination. See *id.* at 598. Furthermore, the State submitted, discrimination necessarily requires uneven treatment of similarly situated individuals, and the plaintiffs were unable to identify any similarly situated individuals given preferential treatment. See *id.*

125. See *id.* at 600. In making this assertion, Justice Ginsburg relied on the Court’s analagous, prior decisions regarding racial and sexual discrimination. See *id.* For example, the Court found previously that “[t]here can be no doubt that [stigmatizing injury often caused by racial discrimination] is one of the most serious consequences of discriminatory government action.” *Id.* (quoting *Allen v. Wright*, 468 U.S. 737, 755 (1984)). Similarly, in an earlier opinion, the Court decided that by “forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.” *Id.* (citing *Los Angeles Dep’t of Water and Power v. Manhart*, 435 U.S. 702, 707 (1978)).

family relations, social contacts, and general independence.¹²⁶ The Court was most persuaded, however, by the dissimilar treatment that results when patients with mental disabilities are forced to surrender their participation in the community in order to receive needed medical services, while persons without mental disabilities receive such services without such sacrifice.¹²⁷ In light of these findings, the Court held that isolating the mentally disabled in institutions constitutes discrimination under the ADA.¹²⁸ Similarly, nothing in the ADA condones the termination of institutional settings for those individuals unable to be placed in community settings.¹²⁹

The Court left the determination of an individual's eligibility for community treatment in the states' hands.¹³⁰ The Court held that, "the State generally may rely on the reasonable assessments of its own professionals in determining whether an individual 'meets the essential eligibility requirements' for habilitation in a community-based program. Absent such qualification, it would be inappropriate to remove a patient from the more restrictive setting."¹³¹

126. *See id.* at 601.

127. *See id.* Specifically, Justice Ginsburg contended that:

Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.

Id.

Justice Ginsburg was unconvinced by the defendants' argument that, despite what Congress stated as its findings within the ADA, the Medicaid statute indicates a congressional preference for institutional treatment over community treatment. *See id.* Since 1981, Medicaid has provided funding through a waiver program for placement of individuals in community-based treatment programs. *See id.* The waiver program reimburses states for the provisions of such services to those individuals who would otherwise require institutional care, so long as the average annual cost of these services is less than the annual cost of institutional care. *See id.* at 601 n.12.

128. *See id.*

129. *See id.* at 601-02 (noting that 42 U.S.C. § 12132 of the ADA provides that "qualified individual[s] with a disability" may not "be subjected to discrimination").

130. *See id.* at 602.

131. *Id.* The Court relied upon the holding in *School Board of Nassau County v. Arline*, which stated that "courts normally should defer to the reasonable medical judgments of public health officials." *Id.* (quoting *School Bd. of Nassau County v. Arline*, 480 U.S. 273, 288 (1987)). Additionally, the Court in *Olmstead III* noted that public entities are responsible for administering services and programs to individuals in "the most integrated setting appropriate." *Id.*; *see also* 28 C.F.R. § 35.130(d) (1999). The Court further noted that under Georgia law "[i]t 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 . . . secur[e] placement in noninstitutional community facilities and

In the case of *Olmstead*, no genuine dispute existed regarding L.C.'s and E.W.'s status as individuals "qualified" for non-institutional care.¹³² Georgia's state health care professionals admitted their previous evaluations and determined that E.W. and L.C. were eligible for community-based treatment, and that neither patient had opposed such treatment.¹³³ It should be noted, however, that in future litigation, the Court's decision to grant broad discretion to the states in their determination of patient eligibility for community treatment may provide a viable excuse for a state's failure to provide services to the mentally disabled.¹³⁴

B. "Reasonable Modifications" and the Cost Issue: Continuing Confusion and Disagreement

The Court failed to reach a majority decision on the second issue concerning the appropriate level of relief to be granted to E.W. and L.C.¹³⁵ The Eleventh Circuit's construction of the "reasonable-modifications" required by the ADA would leave the states defenseless once a plaintiff demonstrated the proper qualifications for the service or program desired.¹³⁶ Justice Ginsburg advocated a hybrid of the efficiency approach to resolve the cost issue and critically examined the Eleventh Circuit's decision to remand this issue.¹³⁷ The Court noted, with some concern, the wide range of facilities that states were required to maintain for the care and treatment of the mentally disabled, as well as the difficulty of administering these services equally.¹³⁸ Justice Ginsburg stated that, "[i]f

programs." *Olmstead III*, 527 U.S. at 602 n.13 (quoting Ga. Code Ann. § 37-3-121 (1995)).

132. *Olmstead III*, 527 U.S. at 602-03.

133. *See id.* at 603.

134. *See Rubenstein, supra* note 65, at 322 ("[T]he more firmly these state codes provide enforceable rights, the more likely the cost-conscious and litigation-averse state legislatures are to rewrite their codes to preclude such litigation.").

135. *See Olmstead III*, 527 U.S. at 587.

136. *Id.* at 603. The Court noted that the "reasonable-modifications" regulation requires states to make reasonable modifications to avoid discrimination against the disabled, but permits states to resist any modifications that would fundamentally alter services and programs offered by the state. *Id.* The Eleventh Circuit's interpretation permitted states to raise this defense in limited circumstances. *See Olmstead II*, 138 F.3d 893, 905 (11th Cir. 1998). The Court then remanded the case to the District Court for a determination of whether the cost of community-based treatment for the plaintiffs would be "unreasonable given the demands of the State's mental health budget." *Id.* Justice Ginsburg noted that permitting the states to raise the defense in limited circumstances makes it highly unlikely that a state could ever prevail. *See Olmstead III*, 527 U.S. at 603.

137. *See Olmstead III*, 527 U.S. at 596 (instructing the District Court to consider "not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities").

138. *See id.* at 605-06.

the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail."¹³⁹

The likelihood of a State defending itself successfully depends solely on a court's application of the fundamental-alteration defense and would be rare.¹⁴⁰ Nevertheless, the Court stated that the fundamental-alteration defense should allow the State to demonstrate that "immediate relief for the plaintiffs would be inequitable,"¹⁴¹ especially in light of the substantial responsibility placed on the State to care for a large and diverse population of mentally disabled individuals.¹⁴² The Court rejected the district court's grant of summary judgment based on a simple comparison which showed that community placements cost less than institutional placements.¹⁴³ Such a comparison fails to recognize costs that the State is unable to avoid, including that "a State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions."¹⁴⁴ Ultimately, the State must be granted leeway to demonstrate that the present denial of community placement had a rational basis and that the mentally disabled individual would eventually be placed in community treatment.¹⁴⁵ The Court held that under such circumstances, the reasonable-modifications defense would be successful, thereby leav-

139. *Id.* at 603.

140. *See id.* Justice Ginsburg contended that a comparison so simple "overlooks costs the State cannot avoid; most notably, a 'State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions.'" *Id.* at 604 (citing the Brief for United States as *Amicus Curiae* 21). The states might be capable of closing some institutions in response to an increasing number of community placements, but would still incur the cost of running partially full institutions. *See id.* at n.15.

141. *Id.* at 604.

142. *See id.* As Justice Kennedy stated in his concurrence, the states face a continuing challenge in fulfilling their special obligation of caring for the mentally disabled. *See id.* at 608 (Kennedy, J., concurring). Justice Kennedy noted that the states "operate and support facilities and programs, sometimes elaborate ones, to provide care. It is a continuing challenge, though, to provide the care in an effective and humane way, particularly because societal attitudes and the responses of public authorities have changed from time to time." *Id.* at 608-09 (Kennedy, J., concurring).

143. *See id.* at 604.

144. *Id.* (quoting Brief for United States as *Amicus Curiae* 21).

145. *See id.* at 605-06. Justice Ginsburg's argument is further strengthened by Justice Kennedy's concurrence, which notes, "if the principle of liability announced by the Court is not applied with caution and circumspection, States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition." *Id.* at 610 (Kennedy, J., concurring).

ing a court without justification to upset the State's current community placement process.¹⁴⁶

The Court was unable to reach a majority decision on the cost issue, however, primarily because Justices Stevens,¹⁴⁷ Kennedy,¹⁴⁸ Thomas, Scalia, and Chief Justice Rehnquist proposed different approaches as to the proper resolution of the cost issue.¹⁴⁹ A concern among some of the Justices appeared to be the federalism implications involved in dictating how the states should allocate available funds amongst treatment programs.¹⁵⁰

Justice Thomas, joined by Chief Justice Rehnquist and Justice Scalia, noted in his dissent that the principles of federalism place certain undeniable limits on the Federal government's ability to interfere with the workings of state governments.¹⁵¹ Specifically, these principles are appli-

146. See *id.* at 606. Unfortunately, rather than providing a bright-line test with regard to the fundamental-alteration defense, Justice Ginsburg restricted the Court's guidance on the issue to mere dicta by way of a hypothetical. See *id.* at 605. Specifically, Justice Ginsburg hypothesized that:

If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable modifications standard would be met. . . . In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.

Id. at 605-06 (footnote omitted).

147. See *id.* at 607 (Stevens, J., concurring). Justice Stevens concurred that "[u]njustified disparate treatment . . . constitutes discrimination under the Americans with Disabilities Act of 1990." *Id.* (Stevens, J., concurring). However, Justice Stevens noted that the court of appeals appropriately remanded the case for consideration of the State's fundamental-alteration defense, which the district court rejected on remand. See *id.* (Stevens, J., concurring). As a result, Justice Stevens noted, "[i]f the District Court was wrong in concluding that costs unrelated to the treatment of L.C. and E.W. do not support [the fundamental alterations] defense in this case, that arguable error should be corrected . . ." *Id.* (Stevens, J., concurring).

148. See *id.* at 612-13 (Kennedy, J., concurring) (concurring in the judgment but expressing a desire to remand the case for a further determination of whether a statutory violation was sufficiently alleged).

149. See *id.* at 624-25 (Thomas, J., dissenting) (arguing that Georgia's failure to place the plaintiffs in community-based treatment programs establishes nothing more than the fact that the state has limited resources).

150. See *id.* at 624 (Thomas, J., dissenting) (noting that there is "fear that the majority's approach imposes significant federalism costs, directing States how to make decisions about their delivery of public services").

151. See *id.* (Thomas, J., dissenting). See, e.g., *Printz v. United States*, 521 U.S. 898, 925 (1997) (declaring that "the Federal Government may not compel the States to implement, by legislation or executive action, federal regulatory programs"); *New York v. United States*, 505 U.S. 144, 149 (1992) (concluding that although "Congress has substan-

cable to questions concerning whether states are required to provide particular benefits.¹⁵² According to Justice Thomas, these questions are best resolved under a hybrid deferential-efficiency approach to the cost issue.¹⁵³ Justice Thomas insisted that the proper course for the Court would involve affirming the Court's traditional deference to the states as the dominant authorities responsible for providing services to the disabled.¹⁵⁴

Finally, Justice Kennedy, concurring in result but dissenting on the Court's resolution of costs, advocated the more traditional separation of powers approach to the cost issue.¹⁵⁵ Specifically, Justice Kennedy opined that it would be unfortunate if "funds for care and treatment of the mentally ill, including the severely mentally ill, are reduced in order to support programs directed to the treatment and care of other disabilities."¹⁵⁶ Justice Kennedy contended, however, that such a decision is a political one and not an appropriate concern of the Court.¹⁵⁷ Specifically, Justice Kennedy recognized that the Court "must be cautious when [it] seek[s] to infer specific rules limiting States' choices when Congress has used only general language in the controlling statute."¹⁵⁸

tial power under the Constitution to encourage the States to provide for the disposal of radioactive waste generated within their borders, the Constitution does not confer upon Congress the ability simply to compel the States to do so").

152. See *Olmstead III*, 527 U.S. at 624. (Thomas, J., dissenting). Justice Thomas's dissenting opinion relied on the Court's previous decision in *Alexander v. Choate* where, in rejecting a similar theory of States' liability under Section 504 of the Rehabilitation Act, the Court held "[n]othing . . . suggests that Congress desired to make major inroads on the States longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services . . ." *Id.* (Thomas, J., dissenting) (citing *Alexander v. Choate*, 469 U.S. 287, 307 (1985)). See also *Bowen v. American Hosp. Ass'n.*, 476 U.S. 610, 642 (1986) (plurality opinion) ("Nothing in [Section 504] authorizes [the Court] to commandeer state agencies . . . as [these] agencies are not field offices of the [Health and Human Services] bureaucracy, and they may not be conscripted against their will as the foot soldiers in a federal crusade." (footnote omitted)).

153. See *Olmstead III*, 527 U.S. at 625 (Thomas, J., dissenting).

154. See *id.* (Thomas, J., dissenting).

155. See *id.* at 608-09, 612-13 (Kennedy, J., concurring).

156. *Id.* at 612 (Kennedy, J., concurring). The statute, according to Justice Kennedy, does not require a state to create a community-placement program where one does not exist. See *id.* (Kennedy, J., concurring). "No State," Justice Kennedy noted, "has unlimited resources and each must make hard decisions on how much to allocate to treatment of diseases and disabilities." *Id.* (Kennedy, J., concurring).

157. See *id.* at 612-13 (Kennedy, J., concurring) (pointing out that serious constitutional concerns are raised when federal courts are authorized "to review the State's choices in basic matters such as establishing or declining to establish new programs"). Justice Kennedy stated that it is unreasonable to read the ADA to permit such court intervention. See *id.* at 613 (Kennedy, J., concurring).

158. *Id.* at 615 (Kennedy, J., concurring).

C. *A Clouded Future: Mentally Disabled Individuals and the Right to Treatment in the "Least Restrictive Environment"*

Due in large part to the passage of statutory mandates such as those contained in Section 504 and Title II of the ADA, the law now provides a direct remedy against discrimination in treatment and health care for people with psychiatric disabilities.¹⁵⁹ Commentators note that the ADA's non-discrimination mandate is increasingly important at a time when all health care and treatment services are rationed, especially for low-income people.¹⁶⁰ The ADA may provide an effective tool for curbing state officials' discretion of singling out disfavored, politically impotent groups, such as those with disabilities for inequitable treatment under state health care plans.¹⁶¹

In deciding *Olmstead*, the Supreme Court had the opportunity to further strengthen the ADA's mandate by removing discretionary treatment power from the domain of the individual states.¹⁶² Instead, the Court elected to place the ability to determine who is eligible for community-based treatment firmly in the hands of the state health care professionals evaluating each psychiatric patient's treatment needs.¹⁶³ States can now refuse to treat the mentally disabled at two separate stages: first, when the State determines whether or not an individual is sufficiently disabled for commitment to a treatment program, and then again, when a committed patient is evaluated for community placement.¹⁶⁴

159. See Rubenstein, *supra* note 65, at 358.

160. See *id.*

161. See *id.*

162. Cf. Helm Mark, *Court Tackles States' Rights In Mental-Care Issue*, THE DES MOINES REGISTER, April 22, 1999, at 7 ("Georgia Senior Assistant Attorney General Patricia Downing told [the Supreme Court] that states should be free to choose between community settings and large state hospitals as long as each institution provides proper care for the patients.").

163. See *supra* note 131 and accompanying text.

164. Cf. Bill Rankin, *Court Wary of Broader Disability Law*, ATLANTA J. & CONST., April 22, 1999, at C1 (discussing the Supreme Court's concerns, as expressed during oral argument, that ruling against the state of Georgia would actually result in more mentally disabled individuals being denied proper treatment); see generally *L.C. v. Olmstead*, 527 U.S. 581, 609-10 (1999) (*Olmstead III*) (Kennedy, J., concurring) (detailing the negative effects of the deinstitutionalization trend of the last fifty years). Under deinstitutionalization, state release of patients from mental institutions led to some mentally disabled individuals receiving no treatment whatsoever—their "least restrictive setting" frequently being a cardboard box, a jail cell, or the confines of their own minds. See *id.* at 609 (Kennedy, J., concurring). Now, in addition to having the power to turn away individuals who seek treatment, state mental health professionals have been given additional power to refuse community-based treatment to otherwise qualified, already institutionalized individuals.

It remains to be seen how a majority of the states will implement the *Olmstead* decision, but the potential for ambiguity, misuse, and further neglect of the mentally disabled most certainly exists.¹⁶⁵ For instance, in *Rodriguez v. City of New York*,¹⁶⁶ the United States Court of Appeals for the Second Circuit relied on the language of the *Olmstead* decision to deny mentally disabled individuals crucial community-based treatment.¹⁶⁷ In *Rodriguez*, a class of patients suffering from various mental disabilities challenged New York's refusal to provide funding for in-home safety monitoring that the patients needed in order to continue living in their homes.¹⁶⁸ The patients argued that they were being discriminated against because such safety monitoring was comparable to New York's other personal-care services that were being provided to other individuals.¹⁶⁹ The district court agreed with the patients and issued a permanent injunction requiring New York to provide funding for in-home safety monitoring.¹⁷⁰

165. See e.g., *ADAPT Confronts Ohio's Poor Record on Community Services*, U.S. Newswire, Oct. 29, 1999, available in WL 22283065 (detailing a national disability rights activist group's efforts to force the Ohio legislature to shift the State's funding from institutional care into community-based treatment). The difficulties that the group's members experienced are a perfect example of the potential for neglect under the current interpretation of the ADA advanced by the Supreme Court. See *id.* The group lobbied the Ohio legislature for a proponent hearing on a bill currently pending before the Ohio General Assembly that would allow disabled Medicaid recipients to purchase home and community-based services. See *id.* Additionally, the group attempted to enforce the Supreme Court's *Olmstead* decision through the filing of several Title II complaints. See *id.* The group, however, was denied seven separate requests for meetings with Governor Taft and was repeatedly stonewalled by the state Medicaid Director, who is personally responsible for implementing the ADA and the rights of the disabled in the State. See *id.*

166. 197 F.3d 611 (2d Cir. 1999).

167. See *id.* at 619 (reversing the district court's permanent injunction requiring the City of New York to provide in-home safety monitoring as a personal-care service under the ADA).

168. *Id.* at 614. The patients, who were granted partial class certification by the district court, were eligible for Medicaid and suffered from various mental disabilities that required them to seek assistance with daily living activities. See *id.* The patients received such assistance but, without the needed safety monitoring, the services provided by the City of New York were inadequate and required them to seek institutional treatment. See *id.*

169. See *id.* The safety monitoring the patients required consisted essentially of a caregiver who would be present in the patient's home to ensure that the patient did not injure himself. See *id.*

170. See *id.* Initially, the district court ordered New York to include safety monitoring as a Medicaid-funded service. See *Rodriguez v. DeBuono*, 177 F.R.D. 143, 166-67 (S.D.N.Y. 1997). The Second Circuit vacated that grant of injunctive relief due to procedural improprieties in the entering of the order. See *Rodriguez v. DeBuono*, 175 F.3d 227, 233-36 (2d Cir. 1999). On remand, the district court found that New York violated the Medicaid Act and its regulations, the Rehabilitation Act, and the ADA. See *Rodri-*

On appeal, the Second Circuit disagreed and reversed the injunction, relying primarily on the language of the Supreme Court in *Olmstead* to support its holding.¹⁷¹ The patients' argument did not convince the court that New York's failure to provide in-home safety monitoring renders community-based treatment ineffective for many disabled individuals who, although otherwise qualified, are unable to enjoy treatment in the community without such services.¹⁷² Noting the patients' reliance on the *Olmstead* decision to support their argument, the Court held that "*Olmstead* does not . . . stand for the proposition that states must provide disabled individuals with the opportunity to remain out of institutions."¹⁷³ Instead, the Court noted that the *Olmstead* decision only holds that "[s]tates must adhere to the ADA's non-discrimination requirement with regard to the services *they in fact provide*."¹⁷⁴ The court noted that the *Olmstead* decision does not require states to provide new benefits.¹⁷⁵

Thus, the *Rodriguez* decision is a perfect example of the fatal flaw of the Supreme Court's holding in *Olmstead*: if a state does not provide a community-based service, it cannot be forced to provide one.¹⁷⁶ In order to avoid increased costs, liability-wary states simply do not provide a service in the first place, or stop providing certain services, in order to prevent courts from requiring provision to mentally disabled individuals seeking access to community-based treatment options.¹⁷⁷

IV. CONCLUSION

Title II of the Americans with Disabilities Act of 1990, along with its implementing regulations, presents courts with the best opportunity to date to eliminate discrimination against the disabled, particularly against individuals with mental disabilities, through the provision of many key services. Although the ADA does not provide an explicit right to dein-

guev v. DeBuono, 44 F. Supp. 2d, 601, 605 (S.D.N.Y. 1999).

171. See *Rodriguez*, 197 F.3d at 619.

172. See *id.* at 618-10.

173. *Id.* at 619. In *Olmstead*, the court contended, the parties only disputed where the state should provide treatment, not whether the state must provide treatment to individuals with disabilities. See *id.*

174. *Rodriguez*, 197 F.3d at 619.

175. See *id.* The court noted that "[u]nder the ADA, it is not our role to determine what Medicaid benefits New York must provide." *Id.* Instead, the court reasoned that it "must determine whether New York discriminates on the basis of a mental disability with regard to the benefits it does provide." *Id.* As a result, because safety monitoring is not a benefit provided separately to anyone, the court held that New York did not violate the ADA by failing to provide this benefit to the patients. See *id.*

176. See *id.*

177. See *id.* at 616 n.3.

stitutionalization, the Act's integration mandate guarantees treatment to qualified individuals in the "least restrictive environment." Some commentators theorize that the right to treatment in the least restrictive environment requires the provision of state-funded community treatment programs. Various circuit courts, however, are unable to agree on the extent to which the costs of providing community-based treatment should factor into a State's placement of disabled individuals. In *Olmstead v. L.C.*, the Supreme Court affirmed the right to community-based treatment for qualified individuals if the individual has been found eligible for such treatment. Unfortunately, however, the Court was unable to arrive at a uniform resolution of the cost issue. Combined with the deference given to the States regarding which individuals are qualified for community-based treatment, the Court's failure to resolve the cost issue may result in fewer mentally disabled individuals receiving proper treatment. Only Congressional clarification of the broad scope of the ADA's integration mandate will resolve the Court's current cost dilemma and ensure that in future years the full range of treatment options will be available to the mentally disabled.