No. 98-536

In the Supreme Court of the United States

OCTOBER TERM, 1998

TOMMY OLMSTEAD, COMMISSIONER OF THE DEPARTMENT OF HUMAN RESOURCES OF THE STATE OF GEORGIA, ET AL.,
Petitioner,

v.

L.C. AND E.W., EACH BY JONATHAN ZIMRING, AS GUARDIAN AD LITEM AND NEXT FRIEND,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

AMICUS CURIAE BRIEF OF 58 FORMER STATE COMMISSIONERS AND DIRECTORS OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, ET AL. IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

This case raises issues of great importance to the mental health and disability communities in this country. As former state commissioners and directors of mental health and developmental disabilities and the state of Oregon, *amici* are uniquely positioned to speak to many of the policy issues presented by this case, including how public systems of care may operate in a manner that best addresses the needs of people with disabilities and that is cost-effective for the primary providers of care, the fifty states. As a result of their considerable experience not only in serving people with disabilities directly but also in managing state systems of care, *amici* have a breadth of understanding about the broader social implications of this case, such as the mechanisms states use to fund disability services and the long and tortured history that lies behind the states' treatment of people with mental disabilities.

Amici are from thirty-six different states: Alabama, Alaska, Arizona, California, Connecticut, Colorado, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, Washington, Wyoming, and the District of Columbia. Among the *amici* on whose behalf this brief is filed are a former directors of mental health and mental retardation from the state of Georgia and former commissioners or directors from several states that have joined the *amicus* brief on behalf of the petitioners, including Colorado, Hawaii, Indiana**,** Louisiana, Mississippi, South Carolina, Tennessee, Texas, and Wyoming.[2] These former state commissioners and directors of developmental disability and/or mental health have been involved with every aspect

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[1] The parties have consented to the filing of this brief under S. Ct. Rule 37.2 and their letters of consent have been lodged with the Clerk of the Court. Pursuant to S. Ct. Rule 37.6, *amici* state that counsel for a party did not author this brief in whole or in part and that no one other than *amici* or their counsel made a monetary contribution to the preparation or submission of this brief.

[2] Biographies of the 58 former commissioners and directors on whose behalf this brief is filed are attached to the brief as Appendix A.

of their respective state service systems, from making budgetary decisions to overseeing the closing of institutions and the development of new community care alternatives, to tackling challenges posed by local community groups and unions. *Amici* strongly support community services in integrated settings as the best method of treating the majority of people with disabilities.[3] *Amici* believe that the Court of Appeals' decision should be affirmed and that enforcement of the Attorney General's integration regulation will not impose unreasonable financial or administrative burdens on the states. In fact, the position of *amici* is that, in situations in which mental health professionals recommend that individuals receive treatment in the community, such treatment is more appropriate, more effective, and less costly for the states.

SUMMARY OF ARGUMENT

The Eleventh Circuit's decision to enforce the Attorney General's integration regulation will not profoundly change the way states are providing care to their citizens with disabilities.[4] Instead, it will result in more cost-effective and better quality systems of care. The Americans with Disabilities Act ("ADA") prohibits as discriminatory the unnecessary segregation of individuals with disabilities in institutions when, as here, their treating profes-

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[3] Essentially, the term "integrated setting" means a community setting, as opposed to an institutional setting. See 35 C.F.R. Pt. 35, App. A, § 35.130 (ADA regulations define an integrated setting as one "that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible"). This term is well understood in the mental health and developmental disability fields. Community treatment in an integrated setting generally includes residential services like a group or family home, treatment and habilitation services such as assistance with acquiring, retaining and improving daily living, socialization and adaptive skills, and support services like home health aides, self-help groups and family supports. See CONGRESSIONAL RESEARCH SERVICE, SUBCOMMITTEE ON HEALTH AND ENVIRONMENT OF THE COMMITTEE ON ENERGY AND COMMERCE, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 387 (Jan. 1993).

[4] Throughout this brief, the term "with disabilities" refers to both people with developmental disabilities and people with psychiatric disabilities. Where further distinction between the two groups is necessary, such distinction will be made in the text.

sionals have concluded that they may be appropriately served in the community. In 1990, when Congress enacted the ADA, it was well established that providing care to qualified individuals with disabilities in community settings, as required by the integration regulation, would actually save the states money and result in better quality care.

The fact that the states have traditionally provided services to people with disabilities by confining them in large institutions does not make the integration mandate less compelling. The obligation to provide services to qualified individuals with disabilities in the community rather than in institutions will not significantly change the states' disability systems, both because institutions will remain a viable option when needed and, more importantly, because states already provide most of their disability services in the community. Furthermore, because the federal government provides substantial funding to assist states with the cost of community-based treatment and because institutional care is so much more costly than community care, the integration regulation will not impose unreasonable financial burdens on the states.

The ADA was enacted to rectify a long history of discrimination suffered by people with disabilities in this country. However, stereotypes about people with disabilities and local political and economic interests continue to influence how states treat these citizens. Unfortunately, such arbitrary factors, unrelated to issues of treatment or expense, have caused many states to resist the move to more community-based care, even where medically appropriate and economically sound. Because Congress intended the ADA to be a bulwark against disability discrimination, this Court should enforce that mandate by affirming the decision of the Court of Appeals.

ARGUMENT

I. COMMUNITY INTEGRATION DOES NOT IMPOSE UNREASONABLE BURDENS ON THE STATES.

Contrary to the alarmist claims of the petitioners and the *amicus* states, enforcement and implementation of the Attorney General's integration regulation will not result in careless deinstitutionalization or impose unreasonable financial burdens on the states. Rather, the majority of states already use integrated settings to care for their citizens with disabilities and currently provide most of their disability services in the community. Moreover, there is substantial evidence that community-based care is less costly than institutional care, and in any event, federal funding is available to help the states defray costs that might be associated with moving qualified individuals to community care. In short, if this Court affirms the decision of the Court of Appeals, it will not substantially disrupt state mental health and developmental disability systems. Rather, the experience of the *amici*, the professional literature and studies in the field strongly suggest that it will improve the quality of care states provide and result in a more cost-effective method of delivering services to people with disabilities.

A. Community Integration Will Not Result in Improper or Careless Deinstitutionalization.

This case is not about "deinstitutionalization" in the sense of widespread closure of institutions and release of all patients into the community, whether qualified or not, with or without appropriate care. If this Court affirms the Eleventh Circuit's decision, it will not result in vast numbers of individuals with disabilities roaming the streets of the nation's cities, without sufficient care, treatment or residential placement. Although the petitioners and the *amicus* states who support them here seek to portray the case this way, as part of a parade of horribles that will allegedly follow if the Eleventh Circuit's decision is affirmed,[5] the ADA does not require states to undertake "massive deinstitutionalization," see L.C. v. Olmstead, 138 F.3d 893, 901 (11th Cir. 1998), and neither the respondents nor the *amici* urge such a result.

Instead, the respondents and *amici* maintain that, in the context of this case, enforcing the Attorney General's integration regulation simply requires that states provide community services *to institutionalized individuals who are deemed qualified for and appropriate to receive such services by their treating professionals*. The argument of the respondents, already adopted by both the district court and the Eleventh Circuit, as well as by other federal courts to have considered this issue, see, e.g., Cable v. Dept. of Developmental Services of the State of Calif., 973 F. Supp. 937 (C.D. Cal. 1997); Charles Q. v. Houston, 1997 U.S. Dist. Lexis 17305 (M.D. Pa. 1997); Kathleen S. v. Dept. of Public Welfare, 10 F. Supp.2d 476 (E.D. Pa. 1998); Williams v. Wasserman, 937 F. Supp. 524 (D. Md. 1996), is that keeping an individual in an institution once a treating professional has determined that the individual could be treated in an integrated setting constitutes unnecessary segregation in violation of the ADA. The Court of Appeals explicitly adopted this position:

> [O]ur holding does not mandate the deinstitutionalization of individuals with disabilities. Instead we hold that where, as here, a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting – the most integrated setting appropriate to that patient's needs. Where there is no such finding, on the other hand, nothing in the

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[5] See, e.g., Brief for Petitioners at 2 ("This is not the first national effort to impose a one-size-fits-all solution to an intricate medical problem – here, institutionalization versus deinstitutionalization of medical care."); *Amicus Curiae* Brief of the States in Support of Petitioners ("States' Brief") at 2 ("The overall thrust of this litigation is toward massive deinstitutionalization, regardless of the disruption and regardless of the short-term costs.") and at 4 (characterizing the respondents' argument as requiring "an immediate transition…to a community setting for each and every individual for whom it [is] a theoretical possibility").

> ADA requires the deinstitutionalization of that patient.

L.C., 138 F.3d at 901. In light of the clear language of the Court of Appeals, *amici* vigorously dispute the apocalyptic claims of the *amicus* states that enforcing the integration regulation will result in the careless release of large numbers of individuals with disabilities into the community without proper care and support. States' Brief at 4.[6]

B. States Already Provide Most Disability Services in the Community.

More importantly, states are already moving in the direction of using community services as the primary means of treating their citizens with disabilities, and they are experiencing great success with those programs. Therefore, the claim in the States' Brief that placement of qualified individuals in these existing programs would significantly change the states' disability systems is inaccurate. The statutes of many states, including Georgia and several of the *amicus* states, explicitly provide that qualified individuals with disabilities be placed in the community or in the least restrictive setting appropriate to their needs. See Brief of *Amicus Curiae* American Association on Mental Retardation, et. al. Therefore, the petitioners and the *amicus* states cannot complain that this Court's affirmance of the Eleventh Circuit's decision would impose unreasonable burdens on them when the integration regulation simply confirms a policy that many of the states' legislatures have explicitly enacted.

Furthermore, the clear trend throughout the country in the fields of developmental disability and mental health care is toward downsizing or closing institutions and providing care in integrated settings. For example, at least six states (Alaska, New Hampshire, New Mexico, Rhode Island, Vermont, West Virginia) and the Dis-

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[6] As discussed further below, providing community care to qualified individuals with disabilities need not result in the complete elimination of state-run institutions. It will remain economically feasible for states to make institutions available for those individuals who need and choose such care.

trict of Columbia now provide *all* services to people with mental retardation in the community. See DAVID BRADDOCK, THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES (David Braddock, et al. eds., 5th ed. 1998) at 9 ("Braddock"). Since the late 1980s, states have closed or reduced in size more institutions than at any other time in history. Between 1988 and 1995, states closed more than 85 institutions for people with developmental disabilities, over three and one-half times more closures than in the previous twelve years. See K. Charlie Lakin and Robert Prouty, *Trends in Institution Closure*, IMPACT, University of Minnesota, Winter 1995-96 at 4 ("Lakin and Prouty").

There is an equally strong trend toward serving more individuals with mental illnesses in the community, although somewhat fewer state-run psychiatric institutions have been closed. According to a survey of state mental health commissioners, "76% of the States are currently working to reorganize their State Psychiatric Hospital systems. The most common activities are downsizing existing hospitals, closing wards, reorganizing or reconfiguring one or more hospitals, [and] closing State hospitals." Web Site of the National Association of State Mental Health Program Directors (last modified Feb. 17, 1999), <http://www.nasmhpd.org> ("NASMHPD Web Site"). See also REINVESTMENT OF RESOURCES FROM FACILITY DOWNSIZING/CLOSURES TO COMMUNITY SERVICES: A COMPREHENSIVE REVIEW OF REINVESTMENT INITIATIVES (February 2, 1999) at 3 ("REINVESTMENT OF RESOURCES")(most state mental health authorities are actively reducing the size of state hospitals through either closure or downsizing). During the 1990s, states closed 37 state psychiatric hospitals, three times more closures than in the previous two decades combined. Opening Statement of A. Kathryn Power, Director, Rhode Island Department of Mental Health, Retardation and Hospitals, before U.S. Commission on Civil Rights, November 13, 1998, at 1-2 ("Power Statement"). Among the states actively downsizing state psychiatric hospitals are Georgia and several of the *amicus* states (Louisiana, South Carolina, and Wyoming). See Joint Appendix at 201; NASMHPD Web Site.

In addition to closing or downsizing institutions, states currently serve a greater number of individuals with disabilities in the community than at any time in the past. The total number of people with developmental disabilities served in the community in the United States grew from fewer than 5000 in 1960 to more than 250,000 in 1996, while the institutional population decreased by more than 130,000 in the same period. Braddock at 26. In addition, all but two states reduced the number of individuals with developmental disabilities in institutions between 1992 and 1996. Id. Likewise, from 1970 to 1990, the number of beds available in state psychiatric hospitals decreased by nearly 50%. The state hospital population decreased from 186 residents per 100,000 in 1969 to 33 residents per 100,000 in 1992. See NASMHPD Web Site; Aileen B. Rothbard and Eri Kuno, *The Success of Deinsitutionalization: Empirical Findings from Case Studies on State Hospital Closures*, JOURNAL OF INTERNATIONAL LAW AND PSYCHIATRY, January 28, 1999 at 1.

The shift of dollars away from institutions and to community services further demonstrates the states' current commitment to community-based care. From 1992 to 1996, state spending for community services for individuals with developmental disabilities increased at an inflation-adjusted rate of 41%, or 9% per year. This compares to a 7% decline in institutional spending for developmental disabilities. By 1989, the amount of state money spent on community care exceeded the amount of funds allocated for institutions. See Braddock at 32. The same is true for mental health spending. In 1981, 63% of state mental health dollars were spent on institutional care. By 1993, expenditures for community-based services exceeded institutional expenditures. See NASMHPD Web Site (in 1993, states spent $6.92 billion on community care, as compared to $6.89 billion on institutional care). Between 1981 and 1993, state psychiatric hospital spending decreased by 24.5% and spending on community services increased by 44.1%. Id. See also UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH, UNITED STATES, 1996 (Ronald W. Manderscheid and Mary Anne Sonnenschein, eds., 1996) at 100 (the proportionate share of total state mental health expenditures for institutions changed significantly from 1969 to 1992; in 1969, spending on state-run hospitals represented 55% of total state mental health expenditures, as compared to 27% in 1992). The trend in Georgia is consistent with the national trend.

In recent years, the state has redirected dollars from developmental disability institutions to community services to the point where 57% of state funding went toward community services in 1997. Joint Appendix at 200-01.

C. Federal Funding is Available to Assist States in Paying for Community Care.

Because the funding for community-based services does not come from the states alone, full implementation of the Attorney General's integration regulation will not create economic hardship for the states. The federal government has long provided a portion of state funding for mental health and developmental disability services, and the percentage of federal funding has increased substantially with the move to community-based care. See REINVESTMENT OF RESOURCES at 10 ("[m]any studies have noted the shifting of mental health care costs to the [f]ederal government through Medicare and Medicaid"); Braddock at 33 (in 1996, federal funding represented over 43% of all funding for community-based services for people with developmental disabilities); Mental Health, United States, 1996 at 102 (in 1992, federal funding represented 31% of all spending for treatment of the mentally ill, compared to 40% from state funds). The structure of federal funding programs now clearly favors community treatment. See Braddock at 34 (citing the federal Medicaid Home and Community-Based Services waiver program as a central reason federal funding for developmental disability community services increased by more than 18% per year throughout the 1980s); Mental Health, United States, 1996 at 103 (federal legislation promotes community-based services to the exclusion of state hospital services); Aileen B. Rothbard, et al., *Unbundling of State Hospital Services in the Community: The Philadelphia State Hospital Story*, 24 ADMINISTRATION AND POLICY IN MENTAL HEALTH 391, 396 (May 1991) (providing services in the community to individuals previously institutionalized at Philadelphia State Hospital created a 300% increase in federal participation in the care of those individuals because of structure of federal funding programs). By allowing states greater flexibility in how they can use federal funds to pay for mental health and developmental disability care and creating programs that are targeted toward community-based services, the federal government has substantially eased the economic burden of providing care to people with disabilities.

The most important funding mechanism for community care for people with developmental disabilities is the Home and Community-Based Services ("HCBS") waiver program under the Medicaid program, in which all fifty states participate. See Braddock at 10. This program allows states to use Medicaid money to provide services in the community to individuals with developmental disabilities who would otherwise be treated at a higher cost in institutional settings. See 42 U.S.C. § 1396n(c)(1); 44 C.F.R. § 441.300 (the waiver program "permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization"). The HCBS waiver program has enabled states to move institutionalized individuals to less expensive community-based settings.[7]

States have used the HCBS waiver program to move countless individuals with developmental disabilities out of institutions. Indeed, the waiver program is no longer an alternative to institutionalization, it is now the primary means of serving people with developmental disabilities. See GARY A. SMITH AND ROBERT M. GETTINGS, THE HCB WAIVER AND CSLA PROGRAMS: AN UPDATE ON MEDICAID'S ROLE IN SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES IN THE COMMUNITY 14-15 (October 1994); Gary A. Smith, et al., *The HCB Waiver Program: The Fading of Medicaid's "Institutional Bias,"* MENTAL RETARDATION 262 (August 1996) (since 1992, the number of in-

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[7] Under the Medicaid program, nearly all state institutions for people with developmental disabilities are categorized as "intermediate care facilities for individuals with mental retardation" (ICF/MRs). See 42 U.S.C. §§ 1396d(a)(15), 1396d(d); 42 C.F.R. § 440.150. Under Medicaid, the cost of these facilities is shared by the federal government and the states according to a statutory formula. The formula produces, for each state, the specific percentage of the cost that the state will pay and the "federal match," the specific percentage that the federal government will pay. The federal match generally covers from 50 to 75 percent of the cost of ICF/MR services, and state funding is used to finance the remainder of the costs. The federal match is the same for both HCBS waiver services and ICF/MR services.

dividuals served by HCBS waiver programs has been increasing at an annual rate of 29.2%, while the number of individuals served in ICF/MRs declined by 7.2% between 1992 and 1995).[8]

For individuals with mental illness, federal Medicaid money is also available to the states to fund virtually all mental health services in the community, including psychiatric rehabilitative services, outpatient clinic services, case management, prescription drug services, and personal care services. See 42 U.S.C. §§ 1396d(a)(12), (13), (19), (14); 1396n(g); 42 C.F.R. §§ 440.90, 440.130, 440.167.[9] While Medicaid funding is available for community mental health services, state psychiatric hospitals are generally ineligible to receive Medicaid funding. See 42 U.S.C. § 1396d(a)(B). Therefore, it is financially advantageous for states to shift the provision of mental health services from state institutions to integrated settings. In addition, managed care options available under Medicaid give states discretion to implement innovative packages of community mental health services designed to reduce hospitalization. See 42 U.S.C. § 1396n(b).[10] These options make

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[8] States actually save money by providing services in integrated settings to previously institutionalized individuals through the HCBS waiver program. Because the cost of community care is significantly less than the cost of institutional care, and the federal government contributes the same percentage of funding for each, states can provide services to a greater number of individuals with developmental disabilities at a smaller overall cost to the state.

[9] The federal match for these services is the same as the federal match for HCBS waiver services.

[10] Since 1990, when the ADA was enacted, the U.S. Department of Health and Human Services ("HHS") has become increasingly more permissive in granting states flexibility through the use of HCBS waivers and managed care waivers in their Medicaid programs. See, e.g., GARY A. SMITH AND ROBERT M. GETTINGS, THE HCB WAIVER AND CSLA PROGRAMS: AN UPDATE ON MEDICAID'S ROLE IN SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES IN THE COMMUNITY, B4 (October 1994) (describing various Congressional amendments to the waiver program loosening restrictions on obtaining waivers); Gary A. Smith, et al., *The HCB Waiver Program: The Fading of Medicaid's "Institutional Bias,"* MENTAL RETARDATION 262, 262-63 (Aug. 1996) (rapid growth of HCBS waiver programs between 1990 and 1996 a result of, among other things, federal administrative policy changes affording states greater latitude to expand waivers and cover a wider range of services); RESEARCH AND TRAINING CENTER ON COMMUNITY LIVING, INSTITUTE ON COMMUNITY INTEGRATION/UAP, RESIDENTIAL SERVICES

community-based services even more attractive from a fiscal standpoint.[11]

Because considerable federal money is available to help states fund community-based services for both people with developmental disabilities and mental illnesses, any costs associated with the transition to increased community care will not fall primarily on the states. Moreover, even if certain short-term costs were to fall on the states, this would not justify a refusal to provide community care to qualified individuals when such care is recommended by their treating professionals. Congress specifically contemplated imposing certain costs on the states and determined that such costs would not constitute a reason for non-compliance with the Act. The House Report on the ADA stated explicitly that "[t]he fact that it is more convenient, either administratively or fiscally, to provide services in a segregated manner, does not constitute a valid justification for separate or different services under…this title." H.R. REP. NO. 101-485 (III) at 49-50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 472-73. See also 135 CONG. REC. S4986 (daily ed., May 9, 1989) (statement of Senator Harkin)("Costs do not provide the basis for an exemption from the basic principles in a civil rights statute, like the ADA").

Courts have interpreted the ADA in a manner consistent with this legislative history. As a general rule, courts have held that "[i]nadequate state appropriations do not excuse noncompliance" with the ADA. L.C., 138 F.3d at 904, quoting Alabama Nursing Home Ass'n v. Harris, 617 F.2d 388, 396 (5th Cir. 1980). Thus, courts have forced states to fund compliance with the ADA regardless of the budgetary constraints facing those states. See, e.g., Concerned Parents to Save Dreher Park Center v. City of West Palm Beach, 846 F. Supp. 986, 993 (S.D. Fla. 1994) (city must

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FOR PERSONS WITH DEVELOPMENTAL DISABILITIES: STATUS AND TRENDS THROUGH 1997 (Robert Prouty and K. Charlie Lakin eds., 1998) at 67 (cost neutrality requirements have been "considerably relaxed" since 1992).

[11] Other sources of federal funding are also available for community-based mental health services, such as federal block grant money for community mental health centers, see 42 U.S.C. §§ 300x et seq., and federal subsidies for housing and support services. See 42 U.S.C. §§ 8011-8013.

continue to fund recreational programs for the disabled regardless of budgetary constraints; ADA's mandate that local governments provide equal opportunities for the disabled outweighs the public interest in having a balanced budget); Kroll v. St. Charles County, Missouri, 766 F. Supp. 744, 753 (E.D. Mo. 1991) (court justified in ordering an increase in property taxes in order to fund the changes necessary to make county courthouse handicapped accessible). These cases are consistent with the generally-accepted principle that the increased costs of complying with an anti-discrimination mandate do not constitute a valid excuse for failing to comply with that mandate. See, e.g., Int'l Union, United Automobile Workers of America v. Johnson Controls, Inc., 499 U.S. 187, 210 (1991) ("the incremental cost of hiring women cannot justify discriminating against them" under Title VII).

D. Community Care Costs Less than Institutionalization.

Numerous studies comparing the costs and benefits of community care to institutionalization have concluded that community care is the more cost-effective way to provide services to people with disabilities. The annual cost of supporting an individual in the community under an HCBS waiver program is less than one-half the cost of treating that individual in an ICF/MR. See Smith and Gettings at 18. A study conducted for the American Journal of Mental Retardation in 1995 concluded not only that providing care to individuals with mental retardation in the community was more cost-effective than institutionalization, but also that state-owned institutions were the *most* costly mechanism for providing services. Edward M. Campbell and Laird W. Heal, *Government Cost of Providing Services for Individuals with Developmental Disabilities: Prediction of Costs, Rates, and Staffing by Provider and Client Characteristics*, AMERICAN JOURNAL OF MENTAL RETARDATION, July 1995 at 17-35. A study of the costs of treating 321 formerly institutionalized individuals with psychiatric disabilities in the community found that community-based services cost less than one-half as much as institutional care. Aileen B. Rothbard, et al., *Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A Three-Year Follow Up*

Study, AMERICAN JOURNAL OF PSYCHIATRY, December 9, 1998, at 2, 16 (total treatment cost in the community, including the cost of housing, was $60,000 per person per year, compared to $130,000 per person per year for institutional care). See also Herbert Bengelsdorf, et al., *The Cost Effectiveness of Crisis Intervention: Admission Diversion Savings Can Offset the High Cost of Service*, 181 J. NERVOUS & MENTAL DISEASE 757 (1993)(documenting considerable cost savings achieved by community-based services for individuals who otherwise would have been hospitalized).

In addition to being more expensive than community care, the cost of institutional care is rising. "During the 1992-96 period, the national average institutional daily costs [for people with developmental disabilities] advanced from $210 to $258." Adjusted for inflation, this represents a 10% increase over a five-year period. Braddock at 27. See also Lakin and Prouty at 4 (average annual state institution costs in 1980 were approximately $30,000; by 1994, that cost had increased to approximately $82,000). The cost of treating people with mental illnesses in institutions is also increasing. See REINVESTMENT OF RESOURCES at 2 (the rising cost of inpatient care at state psychiatric facilities has caused states to explore alternative community-based treatment).

A major reason that institutional care is so much more expensive than community care is the high cost of overhead. As total care environments, institutions must recreate many of the services that are part of the background of daily life. Thus, the provision of services in institutional settings "requires significant additional expenditures for facility and vehicle maintenance, utilities, and other fixed costs for the operation of separate facilities, as well as compensation for a workforce of cafeteria workers, janitors, and bus drivers." Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 464 (Summer 1991). Moreover, many institutions are aging and require significant capital expenditures to maintain. In the report issued in connection with the closure of a state-run hospital for people with developmental disabilities in Georgia, the state noted that it cost more than $3.3 million each year just to maintain the hospital's buildings. Joint Appendix at 171. Developing community-based services need not and generally does not require construction of new facilities. While large institutional facilities inevitably involve high construction and maintenance costs, developing community-based services is generally accomplished by simply making funding available to service providers to lease houses or other real estate.

Because community services are significantly less expensive than institutional care, states actually save money when they provide greater services in integrated settings. The savings are greatest in the case of individuals with developmental disabilities because of the widespread use of the Medicaid Home and Community-Based Services waiver program. Nationally, "[t]he average annual cost of supporting an individual in the HCB[S] waiver program is $33,444 versus $67,681 in the ICF/MR program." Smith and Gettings at 17-18. See also STATE OF OREGON, DEVELOPMENTAL DISABILITY HCB WAIVER APPLICATION, FY 1999-2004 (Oct. 1998), at App. G-6 (in 1999, the cost to the state of Oregon to serve a developmentally disabled person in the community is projected to be $39,465, while it would cost $99,930 to serve that same person in an institution). When states use HCBS waiver slots to move individuals from institutions to the community, they actually save money and are able to provide services to a greater number of disabled people. See Joint Appendix at 181 (state of Georgia will save money by closing institution for people with developmental disabilities, permitting the state to provide community services not only to all former institutional residents but also individuals on waiting lists for those services).[12]

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[12] While many states are taking advantage of the savings potential of the waiver program, some states, including Georgia, could be realizing even more savings. Under the statutory scheme, states are permitted to determine how many individuals they will serve in their waiver programs, and HHS approves funding for that number of waiver participants. See 42 U.S.C. § 1396n(c). However, there are many states, including Georgia, that are not making full use of the waiver program that HHS has approved for those states. For example, as of 1996, Georgia had used only 700 out of 2100 slots eligible for Medicaid waiver funding. See Joint Appendix at 93. Thus, Georgia could have moved 1400 more people, including the respondents, from institutions to the community and could have saved money in the process. See Joint Appendix at 89.

The experience of individual states is instructive. The record in this case reflects that the average daily cost to treat an individual with a developmental disability in an institution in Georgia is $267, compared to a daily cost of $106 to $181 to treat the person in the community. Joint Appendix at 171. In its current multi-year plan for the provision of services to people with mental retardation, the Commonwealth of Pennsylvania estimates that moving from institutionalization to more community-based care will save the state $105 to $140 million over a five year period. See PLANNING ADVISORY COMMITTEE TO THE OFFICE OF MENTAL RETARDATION, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE, A MULTI-YEAR PLAN FOR PENNSYLVANIA'S MENTAL RETARDATION SERVICE SYSTEM (July 1997) at 11 ("Pennsylvania Multi-Year Plan"). In 1995, the state of Maryland estimated that closing an institution for people with developmental disabilities and placing the 165 residents in integrated settings would save the state $1.2 million in 1996 and $6.1 million in 1997. See DEVELOPMENTAL DISABILITIES ADMINISTRATION, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, OPERATING BUDGET ANALYSIS (Feb. 8, 1995) at 19.

In Massachusetts, a commission appointed by the Governor found that providing care to both people with mental illnesses and developmental disabilities in community-based residential settings is a "highly desirable, highly effective, and less expensive" means of care. GOVERNOR'S SPECIAL COMMISSION ON CONSOLIDATION OF HEALTH AND HUMAN SERVICES INSTITUTIONAL FACILITIES, ACTIONS FOR QUALITY OF CARE (June 1991) at v. The Commission recommended closing and/or downsizing several state-run facilities and expanding community-based care. The Commission determined:

> As a budgetary matter, the Commonwealth will realize substantial savings by placing appropriate consumers in residential settings. The costs for institutional services at mental health and mental retardation facilities can be $100,000 per year per consumer. Community residential care ranges between $30,000 and $70,000, with an average annual per bed cost of $55,000 for the provision of

> residential day services as well as costs associated with real estate.

Id. at 29. The Commission ultimately determined that "[o]nce fully implemented, the net savings to the state are anticipated to be approximately $60 million annually." Id. at vii.

The fact that community-based services are less costly than institutional care is further demonstrated by the factual findings made by the district court in this case. The court found that Georgia could provide services to L.C. and E.W. "at considerably less cost than is required to maintain them in an institution." As the court stated, "[t]he record establishes that, on an annual basis, institutional care for the mentally retarded costs more than twice as much as community care, and the same is true for the mentally ill." L.C. v. Olmstead, 1997 WL 148674, *4 (N.D. Ga., March 26, 1997). See also Helen L. v. DiDario, 46 F.3d 325, 338 (3rd Cir.), cert. denied, 516 U.S. 813 (1995) (court found that moving the plaintiff from institutional to community care would save the state $34,500 per year).

In addition, the cost-saving potential of caring for qualified individuals with disabilities in community settings was well documented when Congress enacted the ADA in 1990. For example, in its 1983 report, from which Congress derived key findings issued in conjunction with the ADA, the U.S. Civil Rights Commission stated, "[v]irtually all the relevant literature documents that segregating handicapped people in large, impersonal institutions is the most expensive means of care. Evidence suggests that alternative living arrangements allowing institutionalized residents to return to the community can save money." UNITED STATES COMMISSION ON CIVIL RIGHTS, ACCOMMODATING THE SPECTRUM (1983) at 78 (footnotes omitted). See also David Braddock, et al., *Synthesis of Research on the Costs of Institutional and Community-Based Care*, JOURNAL OF MENTAL HEALTH ADMINISTRATION 171, 172-74 (Fall 1990) (describing several studies that found community care for people with developmental disabilities to be less costly than institutional care); Laird W. Heal, *Institutions Cost More Than Community Services*, AMERICAN JOURNAL OF MENTAL DEFICIENCY 121, 136 (1987)(1986 per diem institutional cost for a person with developmental disability was $127, compared with

$81 for community-based care). In 1984, Congress itself heard evidence of the cost savings incurred by moving individuals into the community. See *Joint Hearing on Recommendations to Improve Services for Mentally Retarded Citizens before the Subcommittee on the Handicapped of the Senate Committee on Labor and Human Resources and the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the Senate Committee on Appropriations*, 98th Cong. 48 (1984) (statement of Sen. Weicker) (institutional care is "the most expensive care that you can give") and (statement of Ronald Melzer, director of Vermont Community Mental Retardation Programs) (based on experience in Vermont, "we can conclude that on a system-wide basis, community services are less costly than institutional care").

Community-based care is also more cost-effective than institutional care because of the positive benefits for those individuals treated in the community. Because these individuals interact with non-disabled people, learn job skills and learn how to cope in the "real world," they can cease to be an economic drain on society and instead become productive citizens who are more likely to achieve their full potential. Introducing the ADA in the Senate in 1989, Senator Harkin made a similar point:

> [focusing] on the costs of compliance by covered entities totally misses the bigger picture. The economic benefits to society in terms of reductions in the deficit from getting people off of welfare, out of institutions, and on to the tax rolls cannot be ignored. This bill must be part of our overall strategy to get our Nation's economic house in order.

135 CONG. REC. S4986 (daily ed., May 9, 1989). Maintaining potentially productive individuals in institutions not only imposes the costs of care on the states but also imposes the costs of keeping individuals in "unjust, unwanted dependency." Cook, 64 TEMP. L. REV. at 458, citing *Americans with Disabilities Act: Hearing Before the Senate Committee on Labor and Human Resources and the Subcommittee on the Handicapped*, 101st Cong. 66 (1989) (statement of Mr. Dart). See also 135 CONG. REC. S10,798 (daily ed., Sept. 7, 1989) (statement of Senator Simon) ("[T]here is simply no way to put a price tag on the lost dignity and independence

of people who want to be contributing members of their families, their communities, and their country."). Thus, Congress clearly understood that while the ADA might impose short-term costs on the states, the long-range effects of integration would create more productive citizens and benefit society as a whole. See Cook, 64 TEMP. L. REV. at 465.

Making the transition from institutional to community-based care will not impose additional costs on the states because most states have the necessary structures in place to make this transition. For example, all states require periodic evaluations to identify individuals who do not need institutional care and provide appropriate discharge planning for them, both as a matter of professional standards and as a matter of system planning. See, e.g., GA. CODE ANN. §§ 37-3-64, 37-3-91; HAW. REV. STAT. § 333F-6. This information allows states to determine the types of services needed in the community and the approximate cost of those services. With such information, states are able to plan to downsize institutions in a cost-effective manner without admitting new individuals to fill the empty institutional beds. Many states have already transitioned from institutional to community-based care and, therefore, have gained substantial experience with such planning mechanisms. Pennsylvania's five-year plan for reshaping its mental retardation system is a prime example. In that plan, a state commission spelled out the steps necessary for the state to move effectively to more community-based care. The plan includes eight detailed recommendations including how the state can unify its system of funding mental retardation services, convert ICF/MR funding to HCBS waiver funding, and "[s]hift priorities for resource allocation from facility-based programs to services that build on natural supports." See Pennsylvania Multi-Year Plan at 6-12.

Moreover, states that have closed existing institutions as part of the transition to providing more care in the community have found creative ways to recover fixed costs invested in land and buildings. States have been very successful at converting closed institutions to alternative uses such as correctional facilities, juvenile detention centers, and other facilities for public uses. Lakin and Prouty at 5. See also Braddock at 28-29. Vast expanses of public land on which institutions previously stood have been made available for local economic development, private industry, recreation and other local uses. For example, in Kansas City, Missouri, a state institution for the mentally retarded was converted into office space for use by other state government agencies, see Braddock at 29, and in Indiana, a state-run hospital was converted into a special treatment correctional facility. See *State to Close New Castle Center*, THE INDIANAPOLIS STAR, July 24, 1997, at B1. "Of all alternative uses, it seems at present the one of greatest favor is as correctional facilities. Corrections is a major growth industry in the United States, and offers substantial employment opportunities of similar pay and benefits to persons with backgrounds similar to the direct care staff of state institutions." Lakin and Prouty at 5.

Finally, although the move to community-based care may ultimately result in the closing of some state-owned institutions, it will not endanger the quality of care in the institutions that remain open. Instead, moving qualified disabled individuals, who do not need the restrictive care characteristic of institutions, into community care will likely improve the quality of care for those who remain institutionalized. The institution's treating professionals will be better able to provide appropriate care to fewer residents. In addition, although a smaller institutional population could increase the daily cost of an individual's care, the downsizing of the institution has a countervailing effect on its total budget. Thus, even when per capita costs increase, the reduction in total institutional population permits the institution to remain economically viable.

By requiring that individuals receive services in the most integrated setting appropriate to their needs, the Attorney General's integration regulation ensures that all types of care are available to people with disabilities. Because most states have already embraced the policy behind the integration regulation and currently provide most services for people with disabilities in integrated settings, enforcing the integration regulation will neither result in a significant change in state mental health or developmental disability systems, nor will it impose an unreasonable financial burden on the states.

II. RESISTANCE TO COMMUNITY INTEGRATION IS THE RESULT OF HISTORIC DISCRIMINATION AGAINST PEOPLE WITH DISABILITIES, WHICH IS PRECISELY THE SOCIAL ILL THE ADA AND THE INTEGRATION MANDATE WERE MEANT TO CORRECT.

Congress enacted the ADA in 1990 against the backdrop of a long history of discrimination against people with disabilities. Despite the petitioners' attempt to gloss over this unfortunate history, see Petitioners' Brief at 3-6, this Court has recognized that this country has subjected people with disabilities to shameful and humiliating treatment for hundreds of years. See, e.g., City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 461 (1985) (Marshall, J., concurring in part and dissenting in part)("the mentally retarded have been subject to a 'lengthy and tragic history' of segregation and discrimination that can only be called grotesque") (citations omitted). One of the most prevalent forms of discrimination against people with disabilities was, and still is, to segregate them from the rest of society by unnecessarily confining them in state-run institutions. Congress intended the ADA to end this form of discrimination, as well as all forms of discrimination suffered by individuals with disabilities. See 42 U.S.C. § 12101(a)(2) ("historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"); 42 U.S.C. § 12101(b)(1) ("It is the purpose of this chapter to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."). The knee jerk opposition of the *amicus* states to the Eleventh Circuit's decision in the face of substantial evidence of the positive benefits of integration is likely caused by several factors, and is, at least in part, a piece of the legacy of discrimination against people with disabilities.

The overwhelming consensus of mental health professionals, including the *amici*, is that most individuals with developmental disabilities and mental illnesses can be better treated in the community than in institutions. As David Braddock explained in his summary of state services for people with developmental disabilities:

> [t]he efficacy of community living is grounded in research. Positive changes in functional skills or adaptive behaviors have been documented in numerous community integration studies and in the behavior analysis literature. Studies of family attitudes have also indicated that the great majority of parents of formerly institutionalized persons with mental retardation are consistently satisfied with the benefits of their relative's community living experience.

Braddock at 12. A study of the effects of deinstitutionalization on people with mental retardation concluded, based on eighteen studies conducted between 1976 and 1988, that people who move from state institutions to small community settings experience increased development in functional and adaptive skills. Sheryl A. Larson & K. Charlie Lakin, *Deinstitutionalization of Persons with Mental Retardation*: *The Impact on Daily Living*, JOURNAL OF ASSOCIATION OF PERSONS WITH SEVERE HANDICAPS 324 (March 1989). In fact, the state of Georgia has itself acknowledged the benefits of community care for treating people with developmental disabilities. In the written description accompanying the closure of a state-run institution, the Georgia Department of Human Resources noted:

> [m]ore than 50 studies nationwide and our own experience in Georgia show that people with mental retardation who move from institutions to community services make dramatic gains. They learn a variety of daily living skills, have fewer behavior problems, usually have more contact with their families and are more satisfied.

Joint Appendix at 169-70.

The same can be said for treatment of people with mental illnesses. The "growing consensus within the mental health field [is] that, whenever feasible, people with mental illnesses should receive services in a community, rather than institutional, setting." Power Statement at 2. As with individuals with developmental disabilities, those people with mental illnesses who are treated in the community function with "greater independence…[and] express far greater satisfaction with their living situation and overall quality of life." Elizabeth C. McDonel, et al., *Downsizing State Operated Psychiatric Facilities: Three New Research Efforts to Examine the Quality of Community Care for Persons with Severe Mental Illness* (National Association of State Mental Health Program Directors Research Institute, Fourth Annual National Conference Proceedings, Jan. 1994) at 20. See also id. at 22 ("the literature has continued to pile up in favor of community alternatives [for people with mental illnesses]….There is certainly very little evidence suggesting that…long term hospitalization is a good idea, and clear indications that it is actually harmful."); Rothbard and Kuno, JOURNAL OF INTERNATIONAL LAW AND PSYCHIATRY at 3-4 (describing several studies that found considerable improvement in social interaction and overall functioning level of formerly institutionalized people with mental illnesses receiving treatment in the community).

The experience of treating professionals included in the record is consistent with the findings of the national studies. See, e.g., Affidavit of Diane Cobb, Joint Appendix at 132 ("In my experience, persons with mental retardation and mental illness, especially if they have been frequently institutionalized, often have long-standing behavior problems which can be more effectively addressed in the community where the individual can form a consistent relationship with one or two trained staff in a supportive environment."). In sum, there is now a clear consensus among researchers and other professionals that services in community settings produce better results for individuals with disabilities than does institutional care. See Cook, 64 TEMP. L. REV. at 413; Braddock at 12-16.

Notwithstanding the treatment and cost benefits of community care compared to institutional care, the petitioners and the *amicus* states have objected strenuously to the enforcement and implementation of the integration regulation. The available evidence, and the experience of the *amici*, suggests that there are several factors that likely explain the motives behind their objections. One likely contributing cause is historical discrimination against people with disabilities. See Cleburne, 473 U.S. at 461-65. An additional reason is the stigma surrounding mental illness, which has historically generated opposition to community placement in residential neighborhoods for both people with developmental disabilities and those with mental illnesses, further complicating the development of housing and employment opportunities. See Power Statement at 3. Community residents often resist efforts to create group homes for people with disabilities, contending that the disabled residents will engage in "unruly behavior," cause property values to decline, or harm other residents. Marianne Comfort, *Disabled Neighbors Joining in Daily Life*, AKRON BEACON JOURNAL, Feb. 2, 1997, at G3. See also *Finding a Place for the Mentally Ill*, BOSTON GLOBE, Jan. 31, 1996, at 12 ("nearby residents say they are afraid just to walk past the group home" for people with mental illnesses); John Richardson, *A Struggle to Fit In*, MAINE SUNDAY TELEGRAM, Dec. 1, 1996, at 1A (describing a community protest against an existing group home for individuals with mental illnesses in which a protester cut off a sewer line and filled the home with raw sewage, forcing the residents to evacuate).

This "not in my backyard" objection to community-based care was dramatically displayed in the city ordinance challenged in the Cleburne case. The City of Cleburne, Texas required a special zoning permit for a home for people with mental retardation that it did not require for other multiple occupancy dwellings. 473 U.S. at 436. One of the city's reasons for requiring the special permit was the "negative attitude" of the majority of property owners located near the proposed home and the fears of those residents. Id. at 448. This Court properly held that "mere negative attitudes, or fear, unsubstantiated by factors which are properly cognizable in a zoning proceeding, are not permissible bases for treating a home for the mentally retarded differently from apartment houses, multiple dwellings, and the like." Id.

Congress intended the ADA to dispel the fear and stereotypes about people with disabilities by encouraging interaction between disabled and non-disabled persons in daily life. One important means of encouraging this interaction is by permitting qualified people with disabilities to live in community facilities, with appropriate care and support, surrounded by disabled and non-disabled people alike. Greater inclusion of people with disabilities benefits both disabled individuals and society as a whole. See 136 CONG. REC. H2603 (daily ed., May 22, 1990) (statement of Rep. Collins) ("To be segregated is to be misunderstood, even feared. If we have learned any lessons in the last 30 years, it is that only by breaking down barriers between people can we dispel negative attitudes and myths that are the main currency of oppression."); Cook, 64 TEMP. L. REV. at 448-49 ("It is well documented that when peers with and without disabilities receive accurate information about one another and are provided with opportunities to interact with one another on an ongoing basis, social acceptance occurs. The research demonstrates that these types of…interactions lead to greater tolerance for diversity and difference by persons without disabilities.").

Local economic and political interests are an additional reason states continue to overutilize institutions as one method of caring for people with disabilities, even in the face of the overwhelming evidence that community placement is preferred by treating professionals and is less costly. Often, influential state legislators whose constituents' jobs or profits depend on institutions prevent or delay downsizing or closure. See SUSAN STEFAN, DISCRIMINATION AGAINST PEOPLE WITH PSYCHIATRIC DISABILITIES (*forthcoming* 1999) at Ch. 9, n. 55 ("In Montana, the State Legislature resisted the efforts of the State Department of Institutions to close its facility for people with mental retardation openly on the grounds that even if closure would improve the lives of the residents at the institution, people in the surrounding area needed the jobs."). Labor unions have also been a vocal and influential force in keeping institutions open, even in the face of evidence demonstrating that closure might be sound economic and mental health policy. See Mental Health, United States, 1996 at 103 ("Confounding the options of policy makers are economic pressures brought by communities and labor unions to keep the state and county mental hospitals open [and] to increase their size."). Unions like the American Federation of State, County and Municipal Employees ("AFSCME") have often stridently resisted state efforts to move to community care in order to protect its members' jobs. AFSCME has only supported the downsizing or closing of institutions in states where community services were to be provided by the state itself rather than by private providers, thereby protecting the jobs and wages of AFSCME members. See AFSCME PUBLIC POLICY DEPARTMENT, AFSCME AND THE MENTALLY DISABLED: INSTITUTIONS TO COMMUNITY CARE (June 1992) at 9.

While labor unions may have legitimate concerns about the stability of their members' jobs, a civil rights statute like the ADA and its implementing regulations cannot be held hostage to such political or parochial interests. The type of care to be provided to an individual should be determined by the individual's particular needs and his or her civil rights, not the desires of a labor union or any other interest group. The integration regulation, by requiring a state to provide services to an individual in the most integrated setting appropriate for his or her needs, properly implements this principle.

Finally, bureaucratic inertia is the reason for reluctance on the part of some states to embrace fully the mandate of the integration regulation. States have been caring for their citizens with disabilities in large institutions for more than one hundred years, and many institutional administrators have resisted making changes in the status quo. After all, providing services to individuals with disabilities in the community requires more commitment, creativity, and innovation than simply congregating large groups of individuals with vastly different disabilities in a few state-run institutions. The record in this case reflects that the state of Georgia took a long time to find community placements for the respondents largely because of neglect and bureaucratic inertia. See, e.g., Joint Appendix at 118-19 (series of memoranda over the course of four months describing lack of progress in finding treatment for E.W. in the community).[13]

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[13] Another example of such inertia was noted by the court in Helen L., 46 F.3d at 337-38, in which the state offered "administrative convenience" as a reason for not placing the plaintiff in community care.

In sum, the Attorney General's integration regulation is a reasonable construction of the ADA that will not have catastrophic financial implications for states that might have to increase the speed with which they transition to community treatment. Nor will it have dramatic social implications in the form of the careless release of severely ill individuals into the community without proper care and support. Instead, it represents sound civil rights, mental health and fiscal policy, and it reflects the direction in which the majority of state providers of care are already moving. The factors that contribute to the *amicus* states' and the petitioners' opposition to the Eleventh Circuit's decision, such as past discrimination, local political and economic interests and bureaucratic inertia, are unacceptable reasons to keep potentially productive citizens unnecessarily confined to institutions and prevent them from reaching their full potential.

CONCLUSION

The judgment of the Court of Appeals should be affirmed.

Respectfully submitted.

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