

In the Supreme Court of the United States

October Term, 1998

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Tommy Olmstead, Commissioner, Georgia  
Department of Human Resources, et al., petitioners,

v.

L.C., by Jonathan Zimring,  
Guardian Ad Litem and Next Friend, et al.

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

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**BRIEF FOR AMICI CURIAE AMERICAN  
ASSOCIATION ON MENTAL RETARDATION, ET AL.,  
IN SUPPORT OF RESPONDENTS**

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**BRIEF FOR AMICI CURIAE AMERICAN**



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**IN SUPPORT OF RESPONDENTS**

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**INTERESTS OF THE AMICI CURIAE<sup>(1)</sup>**

The AIDS Legal Referral Panel provides legal advocacy for people with HIV/AIDS regarding healthcare, housing, autonomy and freedom from discrimination.

The American Association of Retired Persons is a not-for-profit organization serving over 32 million persons aged fifty and older, dedicated to promoting the independence and dignity of individuals as they grow older.

The American Association on Mental Retardation is the nation's oldest and largest interdisciplinary organization of professional and other persons who work exclusively in the field of mental retardation. AAMR promotes progressive policies, sound research, effective practices, and human rights for people with intellectual disabilities.

The American Network of Community Options and Resources is a nationwide association of over 650 private agencies that provide support and services to more than 150,000 people with mental retardation and other disabilities.

The American Orthopsychiatric Association is a multidisciplinary organization that advocates for sound mental health research, practice and policy.

The American Psychiatric Nurses Association provides leadership to advance the psychiatric mental health nursing profession, and works to shape health policy for the delivery of mental health services. Its constituency knows first-hand what it means to provide services to individuals in institutional and community settings.

The American Psychological Association is the major association of psychologists in the United States. Its membership includes the vast majority of psychologists holding doctoral degrees from accredited universities.

The Americans with Disabilities Association, Inc. works on developing Georgia laws that protect the rights of persons with disabilities and encourage integration of persons with disabilities.

The Arc of the United States, through its more than 1,000 state and local chapters, is the largest national voluntary organization devoted solely to the welfare of people with mental retardation and their families. The Arc has vigorously challenged attitudes and public policy, based on false stereotypes, that have encouraged the segregation of people with mental retardation.

The Autism Society of America, with over 24,000 members and 240 chapters, is the nation's leading source of information and referral services on autism.

The Brain Injury Association, Inc., is a national, non-profit organization dedicated to brain injury prevention, research, education, and advocacy on behalf of persons with brain injuries. It serves persons with brain injury, their families and caregivers in all 50 states.

Catholic Charities, USA, is a national association of 1,400 local independent social service organizations that annually provide social services to 90,000 people with disabilities, among others. Our staff and volunteers believe, based on years of experience in provision of services, that community-based services are typically superior to institutional care for persons with disabilities in both quality of care and dignity of the individual.

Disability Rights Education and Defense Fund, Inc. is a national disability civil rights law and policy organization on behalf of Americans with disabilities.

The Epilepsy Foundation of America advances the interests of Americans with epilepsy and seizure disorders. Since its inception, the Foundation has stood against the stigma and estrangement associated with seizures.

The Georgia Advocacy Office has been designated by the state to provide protection and advocacy for people with developmental disabilities, mental illness, and other disabilities.

The Georgia Rural Urban Summit is a statewide advocacy group that promotes cooperation among diverse constituencies, including disabled persons, their families and communities.

The International Association of Psychosocial Rehabilitation Services is dedicated to the promotion, protection, and improvement of services that facilitate the adjustment of persons with psychiatric disabilities into communities. Its members include agencies, mental health practitioners, policy makers, family groups, and consumer organizations.

The International Brain Injury Association provides international leadership for individuals and organizations concerned with advancing opportunities for persons with brain injury.

The Joseph P. Kennedy, Jr. Foundation is the only major, private foundation that has dedicated its resources over the past 50 years to improving the lives of persons with mental retardation.

The Mental Health Association of Georgia is dedicated to improving the lives of people with mental illness.

The National Association for Rights Protection and Advocacy includes recipients of mental health and developmental disabilities services; lay, professional and self-advocates; family members; service providers; disability rights attorneys; and teachers at schools of law, social work and public policy. It is dedicated to promoting the preferred options of people who have been labeled mentally disabled.

The National Association of Protection and Advocacy Systems is a membership organization of state protection and advocacy agencies created by federal law to provide representation for all

persons with disabilities. NAPAS advocates for the inclusion of persons with disabilities in all areas of life.

The National Association of Social Workers is a professional membership organization with more than 155,000 members. NASW believes that persons with disabilities are entitled to live in environments that maximize independence and self-determination.

The National Association of the Deaf, whose members are deaf and hard-of-hearing adults, parents of deaf and hard-of-hearing children, and professionals, works to safeguard the civil rights of deaf and hard-of-hearing Americans.

The National Catholic Office for Persons with Disabilities was established in 1982 as the voice of the Catholic Church in promoting the membership of people with disabilities in the church and society.

The National Council for Community Behavioral Healthcare is the nation's largest membership organization dedicated to ensuring appropriate and affordable community mental health and addiction services. Its membership includes providers of inpatient, outpatient, and residential care; partial hospitalization programs; psychiatric rehabilitation services; state and local policy advocates; and managers of state and county systems of care.

The National Down Syndrome Congress, a national organization of parents, professionals, and persons with Down syndrome, seeks to advance the rights of persons with Down syndrome and to promote their participation in all aspects of community life.

NISH (formerly National Industries for the Severely Handicapped) maximizes employment opportunities for people with severe disabilities. NISH supports civil rights for persons with disabilities in all areas to promote independent living opportunities and full integration into society.

The National Depressive and Manic-Depressive Association is dedicated to educating consumers, families, professionals and the public about depressive and manic-depressive illnesses; fostering self-help for consumers and families; eliminating discrimination and stigma; and advocating for research toward the elimination of these illnesses.

The National Mental Health Association is a national organization with over 330 affiliates dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness, as well as respect, dignity and opportunities for persons with disabilities.

The National Senior Citizens Law Center advocates for the independence and well-being of low-income, elderly individuals, as well as persons with disabilities.

North Georgia Wheelers sponsors a free literacy program for members of the disability community in Georgia, including children and youth in nursing homes and institutions.

The Rehabilitation Engineering and Assistive Technology Society of North America is an interdisciplinary association, the purpose of which is to improve the potential of people with disabilities to live and work in the community.

Shepherd Center is a Georgia specialty hospital serving persons who have experienced catastrophic illness such as multiple sclerosis and other neuromuscular disorders. Our mission is to assist these individuals in returning to the community.

The Statewide Independent Living Council of Georgia promotes the equal participation of people with disabilities within their communities. The Council is run by and for people with disabilities.

Volunteers of America is one of the nation's largest and most comprehensive human service organizations. It currently operates 43 programs providing services to over 2,400 people with developmental disabilities, including independent living training, supported and assisted living, and residential care.

United Cerebral Palsy Associations, Inc., with 150 affiliates in 43 states, seeks to advance independence, productivity and community participation of persons with cerebral palsy and other severe disabilities.

### **SUMMARY OF ARGUMENT**

Like other forms of discrimination, segregation based on mental disability injures both those whose disability subjects them to discriminatory treatment and the broader interests of the public. In interpreting the Americans with Disabilities Act ("ADA") and the Integration Regulation (28 C.F.R. § 35.130(d) (1998)) to bar such segregation where not necessary, the court of appeals effectuated both legislative intent and widely accepted professional standards. Persons who are served in a community-integrated setting make qualitatively greater progress in such a setting than when confined in an institution. For these individuals, including the respondents in this case, institutionalization is a formula for stagnation or decay, preventing participation in mainstream interactions that non-disabled persons take for granted. Furthermore, such substandard results come at a high cost, not only for the individual's well-being, but for the public treasury—the available data convincingly demonstrate that community placement represents a lower-cost solution than institutionalization. Thus, two mutually reinforcing rationales undergird the legislative determination to discourage needless institutionalization: community assistance is both more effective and less costly.

I. Undersigned *amici* believe that an appreciation of the historical context in which this dispute has arisen strongly counsels affirmance of the judgment below. In decades past, individuals with mental disabilities suffered under a dehumanizing regime of forced institutionalization. The needless segregation of individuals with disabilities, often achieved by shuttering them behind the walls of stultifying and abusive state institutions, represented an invidious legacy that Congress plainly intended to reverse in the ADA. The legislative purpose is supported by a vast body of literature recognizing that treating persons with mental disabilities in an integrated community setting yields demonstrably superior results.

II. The mandate for integration found in the ADA—a landmark statute enacted with near-unanimous support from both parties in Congress, championed and signed by a Republican President—becomes all the clearer when considered alongside previous federal civil rights statutes. For more than three decades, the course of federal legislation has pointed in a single direction—away from unnecessary segregation and isolation of persons with disabilities, and toward their full integration into ordinary community life. The ADA's express declaration that unnecessary segregation is a prohibited form of discrimination against persons with disabilities represents the culmination of decades of legislative advancement toward the long-term goal of integrating Americans with disabilities into the community.

III. Affirmance of the judgment below will manifest fidelity to Congress' policy decisions and is consistent with the proper implementation of state programs for persons with disabilities. The majority of states already have committed themselves, by statute, regulation, or funding policy, to serving persons with disabilities in integrated community settings. Indeed, Petitioners' home state of Georgia has itself undertaken "to provide community-based alternatives to total institutional care so that mentally retarded individuals can continue to live in their home communities." Ga. Code Ann. § 37-5-2 (1982). Accordingly, applying the ADA's mandate for community integration is fully harmonious with, not in conflict with, the declared policies of the states. Nor does the decision below threaten an explosion in state expenses for treating persons with disabilities. As Congress was aware when it enacted the ADA, and as numerous studies have shown, treatment or habilitation of persons with disabilities in an integrated community environment is *less* costly to the states on average than institutionalization.

## ARGUMENT

### I.

#### CONGRESS DETERMINED THAT UNNECESSARY SEGREGATION IN INSTITUTIONS IS A PROHIBITED FORM OF DISCRIMINATION

##### A. The Movement Away From Needless Institutionalization

The unnecessary confinement of persons with disabilities is a tragic historical fact that Congress has in recent decades sought to ameliorate. To appreciate the significance of the ADA and its mandate for integration, a historical overview is critical. Viewed from the perspective history provides, the ADA represents a decisive rejection by Congress of needless institutionalization.

The discrimination against, and segregation of, individuals with mental illness, mental retardation, and developmental disabilities<sup>(2)</sup> was widely justified in the late 19th and early 20th centuries by a body of pseudoscientific literature that proclaimed such persons to be subhuman. As Justice Marshall recounted it, during this period,

social views of the retarded underwent a radical transformation. Fueled by the rising tide of Social Darwinism, the "science" of eugenics, and the extreme xenophobia of those years, leading medical authorities and others began to portray the "feeble minded" as a "menace to society and civilization . . . responsible for many, if not all, of our social problems."

*City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 461-462 (1985) (Marshall, J., concurring in part and dissenting in part) (footnotes omitted). These same authorities advised segregating persons with disabilities from the rest of society--not only to minimize the "menace" they posed, but ostensibly because they themselves would benefit from segregation. See, e.g., Yoakum, *Care of the Feebleminded in Texas*, in *Bulletin of the Univ. of Tex.* 83 (Nov. 5, 1914) (segregating persons with disabilities described as "consistent with a deep and abiding charity [that] . . . permits all to live under those circumstances best suited to make each useful and happy").

States heeded the call to segregate persons with disabilities from their communities. One author recounted

the nearly universal state segregation of persons with disabilities which existed throughout this country. That policy of segregation, implemented through official state action, legislatively deemed persons with disabilities to be "unfit for citizenship." In virtually every state, in inexorable fashion, people with disabilities--especially children and youth--were declared by state lawmaking bodies to be "unfitted for companionship with other children," a "blight on mankind" whose very presence in the community was "detrimental to normal" children, and whose "mingling . . . with society" was "a most baneful evil."

Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 *Temple L. Rev.* 393, 400-401 (1991) (footnotes omitted). Another author concluded that to these impositions the states "added some disgraceful refinements: compulsory eugenic sterilization laws, wholesale exclusion from schooling; and a total restriction on rights amounting to a virtual civil death." Stanley S. Herr, *Rights and Advocacy for Retarded People* 28 (1983). As a result, Justice Marshall noted,

[a] regime of state-mandated segregation and degradation soon emerged that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow. Massive custodial institutions were built to warehouse the retarded for life; the aim was to halt reproduction of the retarded and "nearly extinguish their race."

*City of Cleburne*, 473 U.S. at 462 (Marshall, J., concurring in part and dissenting in part) (citations omitted).

Justice Marshall did not exaggerate the parallel between racial segregation and discrimination against citizens with mental retardation, for the justifications offered for the latter mimicked those of the former. Cf., e.g., *Plessy v. Ferguson*, 163 U.S. 537, 551-552 (1896). Isolation of persons with mental illness or mental retardation was justified on the basis that they were not worthy to interact with society at large, but were by nature inferior--and segregation in any event was said to have its good points. The edifice of racial segregation began to crumble with *Brown v. Board of Education*, 347 U.S. 483 (1954), however, and over the decades that followed, professionals and policymakers alike began to recognize that the segregation and institutionalization of persons with disabilities also offended fundamental notions of decency. See, e.g., Arlene S. Kanter, *A Home of One's Own: The Fair Housing Amendments Act of 1988 and Housing Discrimination Against People with Mental Disabilities*, 43 *Am. U. L. Rev.* 925,

929 (1994); American Ass'n on Mental Retardation, *Position Statement on Least Restrictive Alternatives in Living Arrangements* (June 1977).

As the professional community and governmental bodies turned away from the practice of segregation, an emerging body of literature began to support a policy of "normalization." The normalization principle holds that persons with disabilities do better when they live among, rather than apart from, the rest of society. Literature began to recognize the injuries that resulted from the unnecessary isolation of persons with disabilities from "the normal rhythm of daily routines of occupation, leisure, and personal life." Bengt Nirje, *The Normalization Principle and its Human Management Implications*, in President's Comm. on Mental Retardation, *Changing Patterns in Residential Services for the Mentally Retarded* 179, 186-187 (R. Kugel & W. Wolfensberger eds., 1969).

Congress was acutely aware of this history of official segregation of persons with disabilities and the ensuing turn towards the principle of normalization. Indeed, Congress expressly described the ADA as an attempt to eliminate the lingering effects of this historical legacy of segregation, which had persisted despite previous remedial efforts:

[H]istorically, 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(a)(2). This historical background illuminated the ADA's finding that "discrimination against individuals with disabilities persists in . . . institutionalization," among other areas. *Id.* § 12101(a)(3). Congress also found that "individuals with disabilities continually encounter various forms of discrimination, including . . . segregation" as a consequence of their disability. *Id.* § 12101(a)(5). It declared that "the Nation's proper goals regarding individuals with disabilities" included "assur[ing] . . . independent living . . . for such individuals." *Id.* § 12101(a)(8).

Although resort to legislative history might be deemed unnecessary in the face of such clear statutory text, it bears noting that the legislative record powerfully confirms Congress' awareness of the legacy of segregation of individuals with disabilities and the legislative intention to end the practice. For example, the ADA's finding that discrimination persists in institutionalization comes directly from a 1983 report by the United States Commission on Civil Rights entitled *Accommodating the Spectrum of Individual Abilities*, on which the Senate report accompanying the ADA heavily relied. <sup>(3)</sup> See United States Comm'n on Civil Rights, Clearinghouse Pub. No. 81, *Accommodating the Spectrum of Individual Abilities* (Sept. 1983) ("*Accommodating the Spectrum*").

The *Accommodating the Spectrum* report on which Congress relied emphasized that forced institutionalization was a form of discrimination against persons with disabilities. In a section captioned "Forms of Discrimination," the report explained that "[s]egregation singles out handicapped people and separates them from the rest of society, frequently as a condition for receiving some service or benefit." *Accommodating the Spectrum* 41. After summarizing several respects in which persons with disabilities are segregated, the report notes that "[m]ental health

and mental retardation institutions that house residents in almost complete isolation from the non-handicapped community are perhaps archetypal examples of segregation." *Id.* The evidence on which Congress expressly relied in passing the ADA thus made clear that the segregation of persons with disabilities from the broader community, including through needless institutionalization, was a form of discrimination the ADA was meant to address.

By pursuing policies that essentially called for institutionalization as the treatment option of first resort, even for persons with minor disabilities, states swelled the ranks of individuals unnecessarily segregated and isolated from their families and communities. By restricting per capita expenditures on state institutions, more residents could be admitted on a limited state budget which, as the Civil Rights Commission's report noted, "fostered large, understaffed institutions often providing minimal custodial services to residents." *Accommodating the Spectrum* 20 (footnote omitted). As discussed in the next section, however, the "minimal custodial services" offered by overcrowded state institutions did little to alleviate, and much to exacerbate, the developmental and other problems of those whom the institutions ostensibly existed to serve.

### **B. Community Living Benefits Persons Who Have Mental Disabilities; Unnecessary Institutionalization Harms Them**

Congress' requirement that states place persons with disabilities into the most integrated setting appropriate in which they could interact with nondisabled persons was soundly based in the professional literature. The experience of *amici* and a substantial supporting body of professional literature strongly show that persons such as the plaintiffs below<sup>(4)</sup> benefit far more from placement in community-living arrangements than from being forced to remain in an institution. Congress was well aware at the time it enacted the ADA that persons with disabilities can be far more effectively served in a community environment.

Persons with disabilities derive proven benefits from community living. Among these are increased independence and a sense of competence; improved relationships with family members and friends; and increased respect, dignity, and feelings of being a part of community life. See Barbara Wright & Martha P. King, National Conference of State Legislatures, *Americans with Developmental Disabilities: Policy Directions for the States* 21 (Feb. 1991). Individuals with disabilities who are placed in community settings can develop fuller, more enjoyable lives in ways non-disabled persons take for granted, but which are essentially impossible to achieve in an institution--they attend movies, go shopping, enjoy parks and recreation, and visit friends. See Cook, *supra*, at 450 n.385 and authorities cited. Justice Marshall noted just such concerns in writing that isolating persons with mental retardation from the community "deprives [them] of much of what makes for human freedom and fulfillment--the ability to form bonds and take part in the life of the community." *City of Cleburne*, 473 U.S. at 461 & n.5 (Marshall, J., concurring in part and dissenting in part).

The professional literature overwhelmingly confirms that people with mental disabilities who reside in a variety of community settings experience improved adaptive behavior, improved social participation, improved independence, improved control over decision making, and improved perceived quality of life.<sup>(5)</sup> For example, a survey of eighteen studies conducted



between 1976 and 1988 found that every one reported positive gains in the development of functional skills and adaptive behavior for persons moving from an institutional to a community setting. Sheryl Larson & Charlie Lakin, University of Minnesota Institute on Community Integration, *Deinstitutionalization of Persons with Mental Retardation: The Impact on Daily Living Skills* (Mar. 1989). Studies also overwhelmingly show that community-based treatment is more effective than hospital-based care in helping people with mental illness become employed, re-enter the community, and reduce the use of medication. See Paul J. Carling, *Major Mental Illness, Housing, and Supports*, 45 Am. Psych. 969, 971 (Aug. 1990) and authorities cited. Evidence also suggests that institutional settings adversely affect residents' motor-learning skills, communications skills, and general social competency.<sup>(6)</sup>

In deploying the ADA against "institutionalization" and "segregation" and in favor of "independent living," 42 U.S.C. § 12101(a)(3), (5), (8), Congress has recognized the substantial benefits of community living, whether measured by scientific surveys or by simple expressions of happiness. Although needs may differ from one individual to another, the core concept of establishing a home in a neighborhood where residents can live what society perceives as a "normal" everyday life, has proved successful time and again.

## II.

### **THE ADA REPRESENTS THE CULMINATION OF FEDERAL POLICY FOSTERING COMMUNITY-BASED SERVICES FOR PERSONS WITH DISABILITIES**

The enactment of the ADA and the promulgation of the Integration Regulation<sup>(7)</sup> represented a significant reinforcement of federal rights for the community integration of persons with disabilities. Congress previously enacted measures that embraced the policy of normalization and recognized the need to end the lingering harms caused by continued segregation of persons with disabilities from their communities. The ADA's mandate for integration represents the culmination of Congress' efforts to secure the opportunity and benefits of community living for people with disabilities.

Congress took an early step in promoting integration with the Mental Retardation Facilities and Community Mental Health Centers Construction Act ("Construction Act"), Pub. L. No. 88-164, 77 Stat. 282 (1963), <sup>(8)</sup> which provided federal funding for mental disability services in the community.

In the Developmental Disabilities Assistance and Bill of Rights Act, Congress specifically declared that "[t]he treatment services, and habilitation for a person with developmental disabilities should be . . . provided in the setting that is least restrictive of the person's personal liberty." Pub. L. No. 94-103, 89 Stat. 486, 502 (1975). The accompanying House Report declared that "for the vast majority of individuals institutional care is inappropriate and inhumane." H.R. Rep. No. 94-58, at 15, reprinted in 1975 U.S.C.C.A.N. 919, 933. Congress later amended the Act to assert even more forcefully the "national interest" of promoting the right and opportunity for people with developmental disabilities to be part of the community, "to make decisions for themselves and *to live in typical homes and communities* where they can exercise their full rights and responsibilities as citizens." 42 U.S.C. § 6000(a)(4), (9) (emphasis added).

Congress also stressed its goal "to promote the inclusion of all persons with developmental disabilities, including persons with the most severe disabilities, in community life." 42 U.S.C. § 6000(b)(5).

Congress did not stop with efforts to provide community treatment options for persons with disabilities. It took additional steps to ensure that communities did not, by virtue of entrenched negative stereotypes of persons with disabilities, undermine opportunities for community living. The first such effort was the Rehabilitation Act of 1973, 29 U.S.C. §§ 701-797b. The Act aimed to "develop and implement . . . comprehensive and coordinated programs of vocational rehabilitation and independent living, for individuals with handicaps in order to maximize their . . . integration into the workplace and the community." 29 U.S.C. § 701. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, outlawed discrimination against persons with disabilities by any recipient of federal assistance.<sup>(9)</sup> This Court has previously passed on the meaning and importance of section 504. See *Alexander v. Choate*, 469 U.S. 287, 297 (1985) (section 504 outlaws both intentional and unintentional discrimination); *School Board v. Arline*, 480 U.S. 273, 279 (1987) (in enacting section 504 Congress was concerned with "protecting the handicapped against discrimination stemming not only from simple prejudice, but also from 'archaic attitudes and laws' and from 'the fact that the American people are simply unfamiliar with and insensitive to the difficulties confront[ing] individuals with handicaps.'" (citation omitted).

In the ADA, Congress took strong steps to clarify and extend the application of section 504 of the Rehabilitation Act, including making a specific set of findings and standards for interpretation in 42 U.S.C. § 12101. Congress stated--not in legislative history, but directly in the text of the statute itself--its intention "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities" including "segregation." 42 U.S.C. § 12101(b)(1), (a)(5).

Support for the ADA was overwhelming, transcending party affiliation, regional differences, and intergovernmental rivalries. The measure's sponsors forged a near-unanimous consensus behind the fundamental objective of integrating persons with disabilities into mainstream American life. The legislation passed both Houses of Congress by vast margins.<sup>(10)</sup> The Senate on the legislation that became the ADA, lamented that "[f]ifteen years have gone by since the Rehabilitation Act took effect. Nonetheless, persons with disabilities are still too often shut out of the economic and social mainstream of American life." *Americans With Disabilities Act of 1989: Hearings on S. 933 Before the Senate Comm. on Labor and Human Resources and the Subcomm. on the Handicapped*, 101st Cong., 1st Sess. 195 (1989). In signing the ADA, President Bush remarked with sadness on the historical legacy the Act was intended to overcome, noting that despite previous civil rights legislation, "the stark fact remained that people with disabilities were still victims of segregation and discrimination, and this was intolerable." *Remarks on Signing the Americans with Disabilities Act of 1990*, 1990 Pub. Papers 1067, 1068 (July 26, 1990). The ADA, President Bush explained, would "ensure that people with disabilities are given the basic guarantees . . . [of] independence, freedom of choice, control of their lives, the opportunity to blend fully and equally into the rich mosaic of the American mainstream." *Ibid.* In a forceful declaration of the ADA's purpose to end needless segregation, President Bush concluded with a

clear statement of federal policy: "Let the shameful wall of exclusion finally come tumbling down." *Id.* at 1070.

Doubtless due in part to the lingering force of what Justice Marshall identified as "[a] regime of state-mandated segregation and degradation" of persons with mental disabilities, the ADA expressly extended to all state and local governments the non-discrimination principles of section 504 of the Rehabilitation Act. See 42 U.S.C. §§ 12131(1), 12132. Although the statutory text of section 504 had been silent on the question whether segregation of persons with disabilities was permissible,<sup>(11)</sup> Congress in the ADA spoke with singular clarity, repeatedly expressing in statutory findings that needless segregation of persons with disabilities is a "form[] of discrimination" Congress wished to eliminate. 42 U.S.C. § 12101(a)(5); see also 42 U.S.C. § 12101(a)(2), (3).

The common thread linking the anti-discrimination statutes from the Construction Act, through the Rehabilitation Act, to the Americans with Disabilities Act, has been ever-increasing antipathy for the legacy of segregation and discrimination borne by persons with disabilities, matched by ever-stronger legislation in favor of integration of such individuals into the community. The decision of the court of appeals represents the only interpretation of the ADA consistent with its statutory history. Petitioners and their *amici* are fundamentally attacking the federal policy favoring integration over segregation. But Congress, not the court of appeals, is the author of that policy—and Congress is the body to which Petitioners' arguments should be directed.

### III.

#### **AFFIRMING THE JUDGMENT BELOW POSES NO RISK OF DISRUPTING STATE PROGRAMS OR BUDGETS**

Petitioners and their supporting *amici* raise a specter of mass disruption of state programs they contend will arise if the court of appeals' judgment stands. Undersigned *amici* submit that this supposed risk is more speculative than real. The current policy commitment of the states to community services for persons with disabilities undercuts Petitioners' argument that integrated community treatment will disrupt state programs, and the demonstrable cost savings resulting from community services suggest that Petitioners' fears of budget overruns are ill-founded.

#### **A. Most States Have Already Committed Themselves to an Official Policy of Community Treatment and Habilitation**

The official policies established by state mental health and mental retardation agencies establish a strong state preference to serve individuals with disabilities in community, rather than institutional, settings. Thus, for example, as Petitioners concede (Pet. Br. 5), most states have taken the official position that persons with mental disabilities must be treated in the "least restrictive" environment appropriate to their needs. See, *e.g.*, Ga. Comp. R. & Regs. r. 290-4-9-.02(1)(a).<sup>(12)</sup>

Petitioners' home state of Georgia has officially undertaken "to provide community-based alternatives to total institutional care so that mentally retarded individuals can continue to live in their home communities." Ga. Code Ann. § 37-5-2 (1982); see also Ga. Code Ann. § 37-2-1 (Supp. 1994). Indeed, many other states have endorsed community-based care in express terms--including several of the states whose *amicus curiae* brief incorrectly argues that such treatment would work a fundamental alteration in their programs. Significantly, many of the states that originally supported the petition for certiorari have since abandoned Petitioners' cause, reflecting the recognition that reversal of the judgment below poses a far greater threat to settled state policy than does affirmance. Twelve states--Alabama, California, Delaware, Florida, Maryland, Michigan,<sup>(13)</sup> Nebraska, New Hampshire, Pennsylvania, South Dakota, Utah, and West Virginia—and also the Territory of Guam, did not join the states' *amicus curiae* brief on the merits stage of this proceeding after having joined the amicus brief in support of the petition for certiorari. Furthermore, several additional states—Minnesota, Louisiana,<sup>(14)</sup> Massachusetts,<sup>(15)</sup> and Washington--have taken the highly revealing step of disavowing the states' amicus brief on the merits, which they had originally joined at the time of filing.

The small minority of states that continue to support the Petitioners do so even though many of their own state statutes take a contrary position. A few examples are instructive. The State of Montana, a signatory to the states' amicus brief in support of Petitioners, has a statutory directive requiring the state to "make every attempt to move residents" of state institutions "from . . . segregated from the community to integrated into the community living." Mont. Code Ann. § 53-20-148(2)(e) (1998). Hawaii, another signatory, contradicts its own policy that favors "alternatives to institutional care . . . based on principles of residential, community-based treatment," and which guarantees persons with disabilities the rights to "[i]nteract with persons without disabilities in a nontreatment, nonservice-oriented setting," to "[l]ive with, or in close proximity to, persons without disabilities," and to "[l]ive in a setting which closely approximates those conditions available to persons without disabilities of the same age." Haw. Rev. Stat. §§ 333F-8(a)(3), 334-101 (1998). South Carolina joined the states' amicus brief even though its own laws establish a policy of "providing services to enable [persons with mental retardation and related disabilities] to participate as valued members of their communities to the maximum extent practical and to live with their families or in family settings in the community[.]" S.C. Code Ann. § 44-20-20 (1998). Many other states that do not support the Petitioners have legislation furthering the policies articulated by the Respondents in this case.<sup>(16)</sup> Indeed, although sounding a cautionary note about rising demand, the governor of New York recently trumpeted his state's "overwhelming success in changing from an institutionally-based system, . . . to a community-based system that now serves nearly 31,000 citizens in the community[.]"<sup>(17)</sup>

The states' broad policy agreement in favor of community care for persons with mental disabilities reflects the virtually unanimous consensus of expert opinion described in the preceding section. Indeed, as Professor David Braddock and his colleagues conclude, the movement "toward family support and community living, and away from the segregated institutional model of the 19th century" is now the dominant trend. David Braddock et al., Am. Ass'n on Mental Retardation, *The State of the States in Developmental Disabilities* 16 (5th ed. 1998). Unnecessary institutionalization is already a derogation of established state policies and the settled expectations of treating professionals. Affirmance of the court of appeals' decision would represent fidelity to, not the upsetting of, the philosophies that have long since come to

govern state programs for persons with mental disabilities. Indeed, reversal would undermine the broad-based state policies supporting community-based care.

The states have compiled mixed records, however, in effectuating the principles of community integration. The resulting gap between rhetoric and performance makes judicial enforcement of the ADA and the Integration Regulation all the more appropriate. For instance, although Petitioners' home state of Georgia has committed itself, at least on paper, to a regime of community-based care for persons with mental retardation and other mental disabilities,<sup>(18)</sup> its performance in this regard has significantly trailed that of other states.

Nationally, Georgia ranks among the states with the worst records of segregating persons with mental disabilities. Despite the federal and state policies in favor of community treatment, the state of Georgia trails badly in implementing these principles. See Braddock et al., *supra*, at 173 (Georgia in 1996 ranked 50th out of the 50 states plus the District of Columbia in the number of people served in community residential settings on a per capita basis, and had "the ninth highest percentage of total residential placements in congregate facilities"); Robert Prouty & K. Charlie Lakin, Univ. of Minn. College of Educ., *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1995*, at 51, 53 (May 1996) (Georgia ranked next-to-last in the nation in average rate of placement for persons with mental retardation and related disabilities in residential settings with 15 or fewer residents).

In 1992, Georgia applied to the federal government for a Medicaid waiver (under 42 U.S.C. § 1396n(c)) to provide home- and community-based services to persons with mental retardation. Describing its application as "a major initiative to decrease the use of institutions and to increase the likelihood of individuals with intense needs remaining at home or in other community settings," the state declared that:

Over the next five years, the Department is committed to downsizing the ICF/MR [Intermediate Care Facility for the Mentally Retarded] population to less than half its current size. . . . To achieve this goal, 200 individuals per year will be placed in community services rather than continuing in ICF/MR services.

Georgia Department of Medical Assistance, *Request to Provide Home and Community-Based Services Under Section 1915(c) of the Social Security Act for the Purpose of Serving Persons with Mental Retardation* ii-iii (Apr. 1992-Mar. 1997). Although committing itself in its waiver application to a goal of placing 1,000 individuals in community-based settings over a five-year period, a November 1996 report on the state's Brook Run institution noted that the state's performance had fallen far short of the mark:

An obligation to reduce institutional beds by 1,000 by 1997 was established in the 1992 Renewal of the Home and Community Based Services Waiver for Mental Retardation. As of September 1996, only 147 of the proposed 1,000 bed reduction has been realized. The limited success has been due primarily to not having identified a concentrated closure of a large enough number of institutional beds needed to generate the necessary savings.

*Evaluation of Brook Run, A State Mental Retardation Institution: A Report Prepared by a Special Task Force Appointed by the Privatization Commission* 8 (Nov. 1996) ("*Evaluation of Brook Run*").

## **B. Community Care Costs Less Than Institutionalization**

Petitioners and their supporting *amici* also raise the specter of ballooning expenditures if the judgment of the court of appeals is affirmed.<sup>(19)</sup> A closer look, however, reveals this argument to be a red herring. The evidence suggests that providing services in a community setting is less costly per capita than similar treatment provided in a state institution. (See Pet. App. 39a & n.4). It is the perpetuation of the legacy of over-institutionalization, not the modern trend toward community treatment, that poses the greater threat to state mental health budgets. Upholding the decision of the court of appeals, far from representing an undue interference in state spending decisions, will merely reaffirm the sensible principle that states ought not choose the most expensive alternative—institutionalization—where the cheaper option of community treatment will be as or more effective.

Data from the State of Georgia itself show the greater public expense involved in forcing persons like plaintiffs L.C. and E.W. to undergo treatment in costly state institutions. The figures for the Georgia Regional Hospital-Atlanta ("GRH-A"), the state psychiatric hospital where both L.C. and E.W. were once housed, are illuminating. The per diem, per capita cost of institutional care at the special unit for persons with mental retardation at GRH-A was \$283 in fiscal 1996, for an annual cost of \$103,295. (JA 93). For all adult psychiatric services at GRH-A, the cost per person ranges from \$219 to \$505 per diem, or an annual total of \$79,935 to \$184,325. (*Ibid.*). In contrast, under Georgia's Medicaid waiver program, the per diem cost for community services per person is approximately \$118 to \$124, for an annual total cost of \$43,070 to \$45,260. (*Ibid.*).<sup>(20)</sup>

For fiscal year 1997, a recent study found that "[t]he average annual Medicaid expenditures for ICF-MR [Intermediate Care Facilities for Persons with Mental Retardation] services were \$78,899 per person as compared to \$26,729 for each HCBS [Medicaid Home and Community Based Services] recipient." R.W. Prouty & K.C. Lakin, Institute on Community Integration/Research and Training Center on Community Living, University of Minnesota College of Education and Human Development, Report No. 51, *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1997*, at xiii (May 1998).<sup>(21)</sup>

In *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995), another court of appeals assessed the evidence regarding the relative costs of treating individuals with disabilities in a publicly funded institution (there, a nursing home) versus treatment in the individual's own home (through a state-funded attendant care program). The court gave the following summary of the evidence:

DPW's average cost of caring for a person in a nursing home is \$45,000 per year. The Commonwealth pays 44% of this amount (\$19,800) and the difference (\$24,200) is paid by the federal government. DPW's average cost of caring for a person in the attendant care program is \$10,500 per year. That amount is totally borne by the Commonwealth.

*Id.* at 329. Idell S., one of the plaintiffs and the appellant in the *Helen L.* case, had been determined to be eligible to receive attendant care services in her own home, but was nevertheless not provided with such services, allegedly due to a lack of state funding. "Consequently," the court of appeals noted,

the Commonwealth continues to spend approximately \$45,000 a year to keep Idell S. confined in a nursing home rather than spend considerably less to provide her with appropriate care in her own home.

*Ibid.* The court of appeals found it ironic that the state "assert[ed] a justification of administrative convenience to resist an accommodation which would save an average of \$34,500 per year[.]" *Id.* at 338. It concluded, harmoniously with the decision of both courts below in this case, that such costly and medically unnecessary institutionalization of an individual eligible for community-based care could not withstand the ADA's directive to provide services in the most integrated setting.

Congress was well aware at the time it passed the ADA of the cost issues implicated by unnecessary institutionalization of persons with disabilities.<sup>(22)</sup> As a report repeatedly cited in the Senate report on the ADA legislation stated:

Virtually 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. As a Federal court has noted, "Comparable facilities in the community are generally less expensive than large isolated state institutions."

*Accommodating the Spectrum, supra*, at 78-79 (footnotes omitted).

In short, the judgment below threatens neither material disruption of state programs nor any precipitous increase in state budgets for the treatment of persons with mental disabilities, notwithstanding the submissions of Petitioners and their supporting *amici*. Rather, affirmance of the judgment below will carry out the clear legislative purpose of the ADA to eliminate the legacy of segregation and integrate individuals with disabilities into the mainstream of American life.

## CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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## NOTES

1. The parties have consented to the filing of this brief under S. Ct. R. 37.2, and their letters of consent have been lodged with the Clerk of the Court. Pursuant to S. Ct. R. 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*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief. [Back to text.](#)
2. Individuals with mental illness and individuals with mental retardation comprise two distinct, although sometimes overlapping, populations that share comparable histories of segregation in institutions and social stigmatization. The meaning and importance of the ADA is substantially identical for both groups, and the mention of one form or another of mental disability throughout this brief should not be taken as a substantive limitation of the argument to that particular disability. [Back to text.](#)
3. The Senate report noted that "[h]istorically, individuals with disabilities have been isolated and subjected to discrimination and such isolation and discrimination is still pervasive in our society." S. Rep. No. 116, 101st Cong., 1st Sess. 6 (Aug. 30, 1989) (quoting *Accommodating the Spectrum* 159). It found that "[d]espite some improvements, . . . [discrimination] persists in such critical areas as . . . institutionalization[.]" S. Rep. No. 116, at 8 (quoting *Accommodating the Spectrum* 159). [Back to text.](#)
4. It is undisputed that for the plaintiffs below, L.C. and E.W., the most appropriate placement was in the community. This case concerns only the state's claimed entitlement to institutionalize *unnecessarily* persons for whom such confinement is not required. The courts below did not hold that the ADA requires states to serve in the community particular individuals for whom such an environment would be inappropriate. (See Pet. App. 21a). [Back to text.](#)



5. See, e.g., James W. Conroy, *Results of Deinstitutionalization in Connecticut*, in *Deinstitutionalization and Community Living* (Jim Mansell & Kent Ericsson eds., 1996); James W. Conroy, *The Hissom Outcomes Study: A Report of Six Years of Movement to Supported Living* (Dec. 1995) (persons with mental retardation and developmental disabilities who had been deinstitutionalized and placed in small community settings showed significant increases in adaptive behavior, productivity, employment, family contact, and overall quality of life); Teh-wei Hu & Jaclyn W. Hausman, Institute for Mental Health Services Research Working Paper No. 4-94, *Cost-Effectiveness of Community Based Care for Individuals with Mental Health Problems* 26 (July 1994) (community treatment credited with "reduced long-term inpatient hospitalization and readmission rates"; individuals with psychiatric disabilities in "the community based program had higher self-report[ed] satisfaction of life, and improvement of quality of life"); James W. Conroy, et al., Connecticut Dep't of Mental Retardation Report No. 10, *1990 Results of the CARC v. Thorne Longitudinal Study* 40-43, 55, 66 (Jan. 1991) (persons moving from large congregate setting to small community setting showed increase in adaptive behavior, social interaction, valued employment, quality of life, and family satisfaction); John Lord & Alison Pedlar, *Life in the Community: Four Years After the Closure of an Institution*, 29 *Mental Retardation* 213, 219 (1991) (four years after eighteen people were moved from institutional setting to community integrated group home, virtually all had progressed in skills development, and family members reported that their relative was generally happier and responding positively to the stimulation of community living); Paul J. Carling, *Major Mental Illness, Housing, and Supports*, 45 *Am. Psychologist* 969, 971 (Aug. 1990) (citing Charles A. Kiesler, *Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients*, 37 *Am. Psychologist* 349, 349-360 (1982); Peter Braun et al., *Overview: Deinstitutionalization of Psychiatric Patients—A Critical Review of Outcome Studies*, 138 *Am. J. Psychiatry* 736, 736-749 (1981); Donald J. Dellario & William A. Anthony, *On the Relative Effectiveness of Institutional and Alternative Placements of the Psychiatrically Disabled*, 37 *J. Soc. Issues* 21, 21-33 (1981)); Francine Cournos, *The Impact of Environmental Factors on Outcome in Residential Programs*, 38 *Hosp. & Comm. Psych.* 848, 849 (Aug. 1987) (community living provides a critical alternative to hospital-based care, and even to family care by relatives, especially for persons with severe mental disabilities who require assisted living); James W. Conroy & Valerie J. Bradley, Temple University Developmental Disabilities Center, Philadelphia & Human Services Research Institute, Boston, *The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis* (Mar. 1985) (persons with severe mental retardation placed from an institution into small community living arrangements showed significant increase in adaptive behavior, marked decrease in dependency, and significant increase in happiness in most aspects of their lives); James Conroy, Joelle Efthimiou, and James Lemanowicz, *A Matched Comparison of the Developmental Growth of Institutionalized and Deinstitutionalized Mentally Retarded Clients*, 86 *Am. J. Mental Deficiency* 581 (1982) (individuals who left state institution for community placement showed significantly improved functioning and adaptive behavior after two years in the community); B.K. Hill & R.H. Bruininks, University of Minnesota Center for Residential and Community Services, *Family Leisure and Social Activities of Mentally Retarded People in Residential Facilities* (1981) (for persons with all levels of mental retardation, moving to a community setting results in improved adaptive behavior and increased social participation). See also Cook, *supra*, at 455-456 nn.408-416 and authorities cited. [Back to text.](#)

6. See, e.g., Daniel Lauber, *Report on Houston's Interim Regulatory and Zoning Ordinance Proposals for Group Homes, Halfway Houses, Hospices, Emergency Shelters, and Social Service Facilities* 6 (Aug. 18, 1992) (citing Jerri L. Phillips & Earl E. Balthazar, *Some Correlates of Language Deterioration in Severely and Profoundly Retarded Long-Term Institutionalized Residents*, 83 *Am. J. Mental Deficiency* 402-408 (1979)). [Back to text.](#)

7. The Department of Justice's regulations setting forth the prohibited forms of discrimination have been found to be "entitled to substantial deference" by the courts. *Helen L. v. DiDario*, 46 F.3d 325, 331-332 (3d Cir. 1995). [Back to text.](#)

8. This statute was repealed and superseded in 1981 by a provision of the Omnibus Budget Reconciliation Act, Pub. L. No. 97-35, § 902(e)(2)(B), 95 Stat. 357, 560 (1981). The 1981 Act amended the federal Medicaid program to allow States to apply for a waiver of certain Medicaid requirements in order to offer home- and community-based services, in lieu of institutionalization, for people with mental disabilities. See Pub. L. No. 97-35, §§ 2176, 2177(a), 95 Stat. at 812-813 (codified at 42 U.S.C. § 1396n(c)); see also 42 U.S.C. § 1397(4) (creating federal block grants aimed in part at "preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care"). [Back to text.](#)

9. The pertinent portions of Section 504 then provided that:

No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, 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[.]

29 U.S.C. § 794. [Back to text.](#)

10. The final conference report on the ADA was adopted by a vote of 377-28 in the House and 91-6 in the Senate. The original bills passed in the House by 403-20 and in the Senate by 76-8. See 1990 Cong. Qtrly. Almanac 447. [Back to text.](#)

11. The regulations implementing Section 504, though, defined segregation of persons with disabilities as unlawful when services were not provided "in the most integrated setting appropriate to the person's needs." 45 C.F.R. § 84.4(b)(2). Although the statutory text did not explicitly so state, the consistent position of the Department of Justice during the Carter and Reagan Administrations was that unnecessary segregation was a prima facie violation of Section 504. See Brief for the United States at 39-45, *Halderman v. Pennhurst State Sch. & Hosp.*, 612 F.2d 84 (3d Cir. 1979) (Nos. 78-1490 et al.); Supplemental Brief for the United States at 2-10, *Halderman v. Pennhurst State Sch. & Hosp.*, 612 F.2d 84 (3d Cir. 1979) (Nos. 78-1490 et al.); Brief for the United States at 27, *Halderman v. Pennhurst State Sch. & Hosp.*, 673 F.2d 647 (3d Cir. 1982) (Nos. 78-1490 et al.). See generally the Brief of Amicus Curiae Dick Thornburgh and the National Organization on Disability in Support of Respondents, submitted in this case. [Back to text.](#)

12. See also Alaska Stat. § 47.30.655(2) (1998); Cal. Welf. & Inst. Code § 5325.1(a) (1999); Colo. Rev. Stat. §§ 27-10-101, 27-10-116(1)(a) (1997); Conn. Gen. Stat. § 17a-274(a) (1997); D.C. Code Ann. §§ 6-1901(a)(2), 6-1963 (1998); Haw. Rev. Stat. §§ 333F-8(a)(1), (2), 334-104 (1998); Ill. Ann. Stat. ch. 405, para. 5/2-102(a) (Smith-Hurd 1997); Iowa Code § 225C.28A(5) (1997); Kan. Stat. Ann. § 39-1603(g), (i) (1997); La. Rev. Stat. Ann. §§ 28:50(2), 28:390(B) (1998); Me. Rev. Stat. Ann. tit. 34-B, § 3003(2)(A) (1997); Md. Code Ann., Health-Gen. § 7-502(c) (1998); Mich. Comp. Laws § 330.1521 (1998); Minn. Stat. § 245.467(1)(3) (1998); Mo. Rev. Stat. § 630.115(1)(11) (1997); Mont. Code Ann. § 53-20-148(2) (1998); Neb. Rev. Stat. § 71-5053 (1998); N.H. Rev. Stat. Ann. §§ 126-A:19, 135-C:1(II)(b) (1998); N.J. Rev. Stat. § 30:4-24.2(e)(2) (1998); N.M. Stat. Ann. § 43-1-9(C)(2) (1998); N.Y. Comp. Codes R. & Regs. tit. 14, § 586.1(b) (1998); N.C. Gen. Stat. § 122C-2 (1997); N.D. Cent. Code § 21-01.2-02 (1998); Ohio Rev. Code Ann. §§ 340.011(A)(2), 5119.47 (1998); Okla. Stat. tit. 43A, § 1-104 (1998); Or. Rev. Stat. § 410.720(1) (1997); R.I. Gen. Laws §§ 40.1-5.4-6(2), 40.1-8.5-1(a) (1998); S.C. Code Ann. § 44-20-20 (1998); Wash. Rev. Code Ann. § 71.24.015 (1998); cf. Ark. Code Ann. § 20-47-201(b)(2) (1997) (care of persons with mental illness should be "[l]east restrictive of the person's freedom of movement and ability to function normally in society"). [Back to text.](#)

13. In a telling repudiation of Petitioners' position, the State of Michigan explained its withdrawal by saying that, after taking "a fresh look at the arguments Georgia is making," it had concluded that "Georgia's arguments are not consistent with the State of Michigan's position as a leader in community-based mental health care, so we will not join the amicus brief." Letter from

Thomas L. Casey, Solicitor General of Michigan, to Elmer L. Cerano, Executive Director, United Cerebral Palsy Association of Metropolitan Detroit, Inc., Feb. 3, 1999, at 1. [Back to text.](#)

14. See Letter from Laura Bracklin, Executive Director, Office of Disability Affairs, Office of the Governor of Louisiana, to Ira Burnim, Bazelon Center for Mental Health Law, Mar. 11, 1999, at 1. [Back to text.](#)

15. The Attorney General of Massachusetts explained that its earlier participation in the amicus brief "has been wrongly interpreted as a retreat by the Commonwealth from its long-standing support of disability rights in general and deinstitutionalization in particular." Letter from Tom Reilly, Attorney General of Massachusetts, to William D. O'Leary, Secretary of the Massachusetts Executive Office of Health and Human Services, Mar. 5, 1999, at 1. [Back to text.](#)

16. See, e.g., Cal. Welf. & Inst. Code § 5325.1(g) (1999) (guaranteeing persons with disabilities "[a] right to social interaction and participation in community activities"); D.C. Code § 6-1901(a)(5) (1998) (establishing legislative objective to "[m]aximize the assimilation of mentally retarded persons into the ordinary life of the community in which they live"), (b)(2) ("[t]he use of institutionalization shall be abated to the greatest extent possible"), (4) ("[i]ndividuals placed in institutions shall be transferred to community or home environments wherever possible, consistent with professional diagnoses and recommendations"); Kan. Stat. Ann. § 39-1603(f) (1997) (declaring state policy to be "to assist in the provision of services for persons who are mentally ill in local communities whenever possible"); N.H. Rev. Stat. Ann. §§ 126-A:19 (1998) (state policy is to establish "community living facilities for persons with developmental disabilities or mental illness"), 135-C:1(II)(a) (state policy is to provide "persons who are severely mentally disabled adequate and humane care . . . [w]ithin each person's own community"); Ohio Rev. Code Ann. § 340.011(A)(2), (5) (1998) (state policy to "[e]stablish a community support system" providing "comprehensive community mental health services"); Or. Rev. Stat. § 427.007 (1997) (state aims "to facilitate the development of appropriate community-based services"); R.I. Gen. Laws § 40.1-5.4-5(1) (state policy is to "provide persons with serious mental illness adequate and humane care . . . [w]ithin each person's own community . . ."); Wash. Rev. Code Ann. § 71.05.010(6) (state's policy is "whenever appropriate, that services [to persons with mental disabilities] be provided *within the community*") (emphasis added).

Even apart from the applicable statutory provisions, many state agencies have publicly declared their objectives to be to maximize the treatment of individuals with disabilities in community, rather than institutional, settings. For example, the Mission Statement of the Colorado Mental Health System declares that "[a]ll persons with mental illnesses . . . should receive treatment in community-based, community-integrated programs delivered in the least restrictive environment possible." Colorado Department of Human Services, *Mental Health Services: Mission Statement and Values* (last modified Dec. 2, 1998) <<http://www.cdhs.state.co.us/ohr/mhs/mission.html>>. See also New Jersey Department of Human Services, Division of Mental Health Services, *Mission Statement* (visited Feb. 12, 1999) <<http://www.state.nj.us/humanservices/MHSDiv.html#Mission>> ("The mission of the mental health system in New Jersey is to promote opportunities for persons with serious mental illness to maximize their ability to live, work, socialize, and learn in communities of their choice"). [Back to text.](#)

17. New York State Office of Mental Retardation and Developmental Disabilities, *Governor Announces 'NYS-Cares' to Reduce Housing Waiting List* (last modified Aug. 19, 1998) <<http://www.omr.state.ny.us/nycares.htm>>. [Back to text.](#)

18. See, e.g., Ga. Code Ann. §§ 37-2-1, 37-5-2 (1998). [Back to text.](#)

19. Petitioners have raised the issue of cost as an argument for rejecting the statutory interpretation adopted by the courts below. Although their view is wrong on the merits, it is not strictly necessary for this Court to address the issue of costs in any event. Where Congress has not made cost a relevant consideration in the statutory scheme, as in the ADA, the courts should ordinarily show great reluctance to graft a cost-based inquiry onto the statutory structure. See *Cedar Rapids Comm. Sch. Dist. v. Garret F.*, -- U.S. --, 1999 WL 104410, at \*6 (U.S. Mar. 3, 1999) ("Given that § 1401(a)(17) [of the Individuals with Disabilities Education Act (IDEA)] does not employ cost in its definition of 'related services' or excluded 'medical services,' accepting the District's cost-based standard as the sole test for determining the scope of the provision would require us to engage in judicial lawmaking without any guidance from Congress. It would also create some tension with the purposes of the IDEA."). [Back to text.](#)

20. The State of Georgia expected significant cost savings to result from the closure of its Brook Run institution--savings sufficient to "provide community services to 532 individuals," a figure greater than "the current 326 residents of Brook Run[.]" *Evaluation of Brook Run, supra*, at 17. [Back to text.](#)

21. These are average national statistics. For the State of Georgia, the corresponding figures for fiscal 1997 are as follows. Medicaid ICF-MR expenditures per end of year resident: \$71,923; Medicaid HCBS expenditures per end of year recipient, \$27,071. See *id.* at 81, 87 tbls. 3.4, 3.7. An ICF-MR is a state institution that provides care for persons with mental retardation. [Back to text.](#)

22. As the then-U.S. Senate Majority Leader, Bob Dole, had recognized, Congress needed to redirect expenditures away from "costly institutions" and toward "home and community-based long-term care services." Bob Dole, *Foreword*, in David Braddock, *Federal Policy Toward Mental Retardation and Developmental Disabilities xv.* (1987). [Back to text.](#)