The Americans with Disabilities Act and Deinstitutionalization of the Chronically Mentally Ill

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The Americans with Disabilities Act (ADA),[1] enacted by Congress in 1990, is a body of legislation that, broadly speaking, is aimed at protecting persons with disabilities, physical or mental, from discrimination by providers of public services or public accommodations, "by reason of such disability."[2]

As often occurs in the wake of major legislation, specific applications of the ADA have repeatedly unmasked innocent but vital ambiguities, as well as unresolved fundamental policy divisions, lurking behind the deceptively straightforward legislative language. The ADA has consequently turned out to be a spawning ground for litigation[3] and scholarly discussion, including many previous articles in this journal,[4] and it remains quite unclear, nearly 10 years after enactment, what the ADA means or will mean, particularly for the mentally disabled.

The United States Supreme Court grappled with the ADA as it applies to mental health care in *Olmstead v. L.C.*,[5] a case that addresses, basically, whether Georgia committed unlawful discrimination when it failed to provide community placement for voluntary psychiatric inpatients who had become sufficiently stable in the judgment of their treaters to be ready for discharge to outpatient care.

The ruling, on June 22, 1999, was widely reported as a "6–3 decision," or a "6–3 majority opinion," construing the law against the state on this issue,[6] which is quite misleading and essentially misses the point, collectively, of the Court's four separate opinions in the case. It is true, superficially, that six Justices voted to remand the case for further proceedings and that the other three voted to reject the claim. However, of the six in the so-called "majority," two explicitly distanced themselves from the other four on the pivotal issue, namely, what manner of defense a state is permitted to assert under

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the ADA. One of the Justices, Kennedy, staked out a position that, in practical application, may align him more with the three dissenters; the other, Stevens, pointedly took no position at all.

The "6–3 decision" thus turns out to be closer to a 4–4 tie, leaving the law little clearer and exemplifying the perils of relying uncritically on simplified reporting of complex processes.

Discussion

The Law In the opening provisions of the ADA, Congress stated its findings that "historically, society has tended to isolate and segregate individuals with disabilities," that this "continue[s] to be a serious and pervasive social problem," and that "discrimination against individuals with disabilities persists in such critical areas as... institutionalization." Against this backdrop, the ADA provides that: "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[7]

The ADA defines disability, in part, as a "mental impairment that substantially limits one or more of the major life activities of such individual"[8] and defines a "qualified individual with a disability" as "an individual with a disability who, with or without reasonable modifications to rules, policies, or practices,... meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity."[9]

Congress instructed the Attorney General to issue regulations implementing provisions of the ADA. One of the regulations, the "integration regulation," directs that: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[10] Another, the "reasonable-modifications regulation," provides that: "A public entity shall make reasonable modifications to policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."[11]

The Facts "L.C." and "E.W." are mildly mentally retarded women; in addition, L.C. has been diagnosed with schizophrenia and E.W. with a personality disorder. Both have a history of treatment in institutional settings and both were "voluntarily admitted to Georgia Regional Hospital."[12]* Their treaters eventually concluded that they could be

* There is no mention in the various opinions of the Justices of the plaintiffs' subsequent patient status, whether still voluntary or under court commitment, at the time they filed suit. However, involuntary hospitalization generally requires a court finding of dangerousness (to oneself or others) or incapacity to care for oneself, typically on petition of the treatment team, whereas the Court explicitly conditions a right to outpatient placement on, among other things, a determination by the treatment team that community placement is appropriate. Therefore, as a practical matter, *Olmstead* would appear to extend only to patients whom the state has no grounds to confine involuntarily. (However, the possibility of an "incapacity" commitment, where there is no evidence of dangerousness and the patient concedes that he lacks capacity to care for himself independently but offers evidence that outpatient placement would afford sufficient support, leaves matters a little untidy and perhaps invites further appellate litigation.)

treated appropriately in a community-based setting, but the two nonetheless remained institutionalized. They filed suit alleging, among other things, that the state's failure to place them in a community-based program, once their treaters determined that such placement was appropriate, violated the ADA.

Procedural History The U.S. District Court for the Northern District of Georgia granted partial summary judgment for the plaintiffs. The district court held that the state's failure to place L.C. and E.W. in an appropriate community-based treatment program violated the ADA. In so ruling, the court rejected the state's arguments: (1) that the plaintiffs had not shown discrimination, because their continued institutionalization resulted from inadequate funding, not discrimination by reason of their disabilities; and (2) that requiring immediate transfers in cases of this order would fundamentally alter the state's activity. In rejecting the state's "fundamental alteration" defense, the district court held that existing state programs provided the kind of community-based treatment sought by the plaintiffs and that the state could provide such services at less cost than institutionalization. The state appealed. The Court of Appeals for the Eleventh Circuit affirmed the district court's judgment but remanded for reassessment of the state's cost-based defense. Because the district court had apparently entirely ruled out a cost-based defense, the Court of Appeals remanded for consideration of "whether the additional expenditures necessary to treat L.C. and E.W. in community-based care would be unreasonable given the demands of the State's mental health budget."[13] The state viewed this standard as affording it no real defense at all, and petitioned for *certiorari*, which was granted. (Indeed, after the U.S. Supreme Court granted *certiorari*, the district court issued a decision on remand from the Eleventh Circuit, predictably rejecting the state's "fundamental alteration" defense under the appellate court's standard.[14] At the time of the Supreme Court's ruling, the district court's second ruling was on appeal before the Court of Appeals. It is unexplained why the lower courts continued to adjudicate a case under Supreme Court review.)

The U.S. Supreme Court Opinions, in Overview The factual and procedural matrix of the case presented the Supreme Court with two pivotal issues: (1) whether the plaintiffs' continued institutionalization constituted discrimination; and (2) if so, the nature and extent of the state's "fundamental alteration" defense to the relief sought.

All nine Justices addressed the first issue. A bare majority of five (Ginsburg, O'Connor, Souter, Breyer, and, in a separate opinion, Stevens) sided with the plaintiffs, holding that the allegation of continued inpatient care beyond the point at which discharge to outpatient care was deemed appropriate, if proven, would qualify as discrimination under the ADA. This was the only "holding" (i.e., precedent) by the "Court" (i.e., a majority of Justices). Of the other four Justices, three (Thomas, Rehnquist, and Scalia) dissented on the ground that the plaintiffs had not alleged a case of discrimination, reading the ADA as simply not addressing states' choices on inpatient-outpatient

resource allocation, and voted to dismiss the claim. Finally, Kennedy too rejected the plaintiffs' particular claim of discrimination but voted with the majority to remand so that the plaintiffs would have an opportunity to change their claim and try to establish discrimination under a very different test he set forth, a stringent one that would seem to give the plaintiffs little realistic hope. Hence, a six-to-three vote to remand but only a five-to-four "holding" or vote on the merits in favor of the plaintiffs.

Only eight Justices addressed the second issue. A plurality (not majority) opinion on this issue by Ginsburg embraced a somewhat delphic standard whereby a state can defeat a discrimination claim by establishing that, "[t]o maintain a range of facilities and to administer services with an even hand," the outpatient placement of a particular inpatient suing for discrimination cannot be "reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."[15] Kennedy, writing separately, seemed willing to be at least as generous with states defending such claims:

> The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. We must be cautious when we seek to infer specific rules limiting States' choices when Congress has used only general language in the controlling statute.[16]

Of course, the three dissenting Justices did not address the second issue, the question of defense to a claim of discrimination, because in their view there was no valid claim of discrimination in a situation such as this. Thus there was no majority, and therefore no "holding," on this issue at all.

The Opinion for the Court Ginsburg wrote the Court's opinion, answering with a qualified yes the question of whether the proscription of discrimination in the ADA required placement of persons with mental disabilities in community settings rather than in institutions. The statute mandates such action, she wrote, when the state's treatment professionals have determined that (a) community placement is appropriate, (b) the transfer to community placement is not opposed by the individual, and (c) the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities. The Court remanded the case for further consideration of the appropriate relief, given the range of facilities the state maintains for the care of persons with diverse mental disabilities and its obligation to administer services "with an even hand." In the portion of her opinion joined by O'Connor, Souter, Breyer, and Stevens (centered on the first issue), Ginsburg addressed whether undue institutionalization qualifies as discrimination "by reason of. . . disability" under the ADA. She noted that the Department of Justice, the agency directed by Congress to issue regulations implementing the ADA, had consistently advocated that it did, and that its views warranted respect. Ginsburg wrote that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA than that posited by

the state. She reviewed the history of Congressional efforts to secure opportunities for the disabled to enjoy the benefits of community living.

Ginsburg stated that recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments: (1) that unnecessary institutionalization perpetuates unwarranted assumptions that the persons so isolated are incapable of participating in community life, which results in stigmatization, one of the most serious consequences of discriminatory action; and (2) that institutionalization severely diminishes the everyday life activities of individuals. She concluded that dissimilar treatment existed in the key respect that to receive necessary medical services, persons with mental disabilities must relinquish participation in community life, whereas persons without such disabilities could receive necessary medical services without similar sacrifice.

Ginsburg emphasized that the ADA did not condone termination of institutionalization for persons unable to handle or benefit from community settings ("dumping"). Furthermore, the state may rely on reasonable assessments of its treating professionals to determine eligibility for community-based care, and it would be inappropriate to remove a patient from an institution absent a professional determination of eligibility for community-based care. Moreover, there was no requirement that community-based care be imposed on patients who do not desire it.

In the remainder of her opinion, joined only by O'Connor, Souter, and Breyer, Ginsburg addressed the nature of the defense available to the state under the "reasonable-modifications" and "fundamental alteration" regulations. The Court of Appeals had construed these standards to permit only a limited cost-based defense, essentially whether the additional expenditures necessary to treat the two plaintiffs in community-based care would be unreasonable in proportion to the state's overall mental health budget. The Supreme Court held that this construction was unacceptable for it would leave the state "virtually defenseless"; if the expense entailed to place two people in community-based treatment were measured against the state's entire mental health budget, the state could never prevail. Moreover, the district court's simple comparison of the cost of institutionalization versus that of community-based care was inadequate; obviously, a state may experience increased expenses by funding community placements without any accompanying reduction in costs because the state would nonetheless continue to incur expenses in running partially full institutions. The ADA does not require elimination of institutions or moving of patients into inappropriately supervised settings. Institutions will still be necessary for many mentally ill patients and must remain available. Thus, states must have "more leeway" to maintain a range of facilities and administer services "with an even hand." "If, for example," Ginsburg observed, "the State. . . had a comprehensive. . . plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its insti-

tutions fully populated, the reasonable-modifications standard would be met."[17] She held that, sensibly construed, the "fundamental alteration" component of the "reasonable-modifications" regulation would allow the state to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the state has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.

The Separate Opinion of Stevens Stevens, in his separate opinion "concurring in part and concurring in the judgment," made it clear that he voted with the Court's majority on the first issue, discrimination, only so that it would *be* a majority by virtue of his vote, and that he took no position on the second issue, the state's defense. Noting that the district court had already issued its second decision before the Supreme Court had time to rule on the district court's first decision (a strange procedural twist), he believed it was premature for the Supreme Court to short circuit the process and send the case back down again when it was already on its way back up again:

> If the District Court was wrong in concluding [on remand] that costs unrelated to the treatment of L.C. and E.W. do not support [a defense of "fundamental alteration"] in this case, that arguable error should be corrected either by the Court of Appeals or by this Court in review of that decision. In my opinion, therefore, we should simply affirm the judgment of the Court of Appeals. But *because there are not five votes for that disposition*, I join Justice GINSBURG's judgment and Parts I, II, and III-A of her opinion [dealing with the first but not the second issue, which was addressed in Part III-B].[18]

The Separate Opinion of Kennedy In Part I of his two-part separate opinion, Kennedy noted the past and possible future hazards of *hubris* in taking blanket or oversimplified approaches to treatment of the mentally ill. He observed:

> Beginning in the 1950's, many victims of severe mental illness were moved out of state-run hospitals, often with benign objectives. . . . This was not without benefit or justification. . . . Nevertheless, the depopulation of state mental hospitals has its dark side. According to one expert: "For a substantial minority. . . deinstitutionalization has been a psychiatric Titanic. Their lives are virtually devoid of 'dignity' or 'integrity of body, mind, and spirit.' 'Self-determination' often means merely that the person has a choice of soup kitchens. The 'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies' [E. Torrey, *Out of the Shadows*, 1997, p 11]."[19]

As such, Kennedy concluded, "if the principle of liability announced by the Court is not applied with caution and circumspection, States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition. . . . It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers."[20] Political pundits call this "spin." Breyer joined this part of Kennedy's opinion.

In Part II, writing for only himself, Kennedy addressed the two actual issues. As to issue 1, what constitutes discrimination, he sharply distanced himself from

the Justices with whom he voted and instead aligned himself, potentially, with the dissent. *Discrimination*, he unambiguously declared, cannot exist without reference to *groups*: a disabled person treated differently *because he is disabled* (*"by reason of* [*his*] *disability*," in the words of the ADA), i.e., *treated differently with respect to a particular service than a non-disabled person*, clearly not what the plaintiffs claimed. Where Kennedy differed with the dissent is that, reluctant to slam the door on the plaintiffs entirely, he managed to posit a scenario that *would* involve traditional, *intergroup* discrimination:

> In terms... specific to this case, if [the plaintiffs] could show that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities), I believe it would demonstrate discrimination on the basis of mental disability.[21]

With remarkable understatement, Kennedy acknowledged that "[t]his inquiry would not be simple." For starters, under prong (i), what would be a "medical problem of comparable seriousness" to both plaintiffs' mental retardation (congestive heart failure, perhaps?), to L.C.'s schizophrenia (scleroderma?), and to E.W.'s "personality disorder" (lupus?)? There are over 300 separate diagnostic categories in the nearly 900-page DSM-IV. A glance at Kennedy's prongs (ii) and (iii) reveals that they would be little easier than prong (i) to pin down and administer in trial. Kennedy thus has offered a theory of liability under the ADA that surely is unworkable and therefore would impose no liability at all. On issue 1, then, this would ally him as a practical matter with the dissent, whereas with the majority only formally. On issue 2, the state's defense, even if a *prima facie* claim could be made under Kennedy's formulation, he appears to be at least as generous to the state as is Ginsburg for the plurality and probably a good deal more so:

> No State has unlimited resources and each must make hard decisions on how much to allocate to treatment of diseases and disabilities. If, for example, funds for care and treatment of the mentally ill, including the severely mentally ill, are reduced to support programs directed to the treatment and care of other disabilities, the decision may be unfortunate. The judgment, however, is a political one and not within the reach of the statute. Grave constitutional concerns are raised when a federal court is given the authority to review the State's choices in basic matters such as establishing or declining to establish new programs. It is not reasonable to read the ADA to permit court intervention in these decisions. . . . Discrimination, of course, tends to be an expansive concept, and, as a legal category, it must be applied with care and prudence.[22]

The Dissent Thomas, writing also for Rehnquist and Scalia, viewed the matter quite simply: "discrimination" has traditionally meant treatment of an individual by the government differently "by reason of" his or her membership in *a disfavored group*, blacks, for example, or the elderly, or indeed the disabled, compared with those in some *other* (similarly situated) group. Further, under his view of the legislative history, Congress intended to *retain*, not change, this definition for the relevant portions of the ADA. Thomas

stated that the plaintiffs made no allegation of discrimination as traditionally understood; they (reasonably) wanted more funding for the mentally disabled, so that more of *that group* could obtain more appropriate services, sooner. But they did not claim that they were denied *such services* "by reason of" their disability. "[C]ommunity placement," Thomas noted, "simply is not available to those *without* disabilities. Continued institutional treatment [of the plaintiffs after they were ready for community placement]... establishes no more than the fact that [governments] have limited resources."[23]

Conclusion

In complex ways and for many reasons, the judiciary in America, and the Supreme Court in particular, is a fundamentally different institution than it was prior to the "cultural wars" that exploded in the 1960s and continue to flare. Pre-1960,[†] Supreme Court votes were typically nine-to-zero, eight-to-one, or seven-to-two, almost invariably with a single opinion for the majority (and a single opinion, if any, for the dissent).[24] The law promulgated was, for the most part, lucid, grounded in legal principles, and addressed to broad, fundamental issues. In contrast, modern Supreme Court decisions are often, as here, bare majority (five-to-four) or plurality votes, with multiple opinions absorbed in policy quarrels,[25] frequently leaving legal scholars (let alone the public) in confusion or disagreement as to what, if anything, has been decided. Consequently, some perceive a steep and troubling decline in the quality of the law the courts produce (and commensurately in the stature and authority of the judiciary itself).[26] No topic has been discussed more often nor more heatedly in legal scholarship over the past three decades—indeed, many books are devoted exclusively to it[27]—and it is the sacred turf over which acrimonious ideological wars nowadays predictably are waged with each significant judicial nomination.

Olmstead reflects this change and represents the modern, more fractious, and more uninhibitedly political Supreme Court. Ginsburg's reasoning for the formal majority appears to be a calculated middle course, a compromise between the extremes of essentially imposing automatic liability on states, which would be the practical result of the Eleventh Circuit's view, as she acknowledges,[28] and the dissent's position that there is no pertinent protection at all under the ADA. Compromise is central to legislation (a quintessentially *political* function); it is seldom beneficial in adjudication (which, for its legitimacy, must strive to *transcend* politics)—hence the legal adage, "hard cases make bad law." However, increasingly, political compromise seems to constitute the essence of the Supreme Court's output.

Trial courts must now implement Ginsburg's conception (writing for only four Justices) of the state's permissible defense: there is no discrimination if "the

[†] It is, of course, somewhat arbitrary to designate a specific year as the moment that a complex 200-year-old institution fundamentally changed. The eminent Supreme Court scholar Louis Lusky has argued that the change began around the late 1940s and was complete by the early 1970s (*see* Ref. 24); he assigns 1962 as the "watershed" year (*id.* at p. 23).

[outpatient] placement can[not] be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."[29] "[T]he [trial court] must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides to others with mental disabilities, and the State's obligation to mete out those services equitably."[30] Perhaps the Court envisions some blend, put before the jury, of fiscal, actuarial, demographic, policy, and systems evidence, but it is difficult to see how any such evidence could coherently guide a judicial fact-finding of what is "equitable" (as opposed to a legislative judgment, which would be easy—whatever a majority decides).[‡]

The practical implications of *Olmstead* for mental health professionals would appear to be at least three-fold. First, as a vague decision and one that that failed to muster even a majority of the Court on the pivotal issues, little has been settled as to the legal rights of individuals and the programmatic and fiscal responsibilities of states in the mental health field. That is, those working with the mentally ill are left little enlightened as to what to do under the ADA.

Second, as a weak and fractured holding, *Olmstead*, whatever it may mean or augur about the Court's views on mental health or the ADA, is, like so much of the modern Court's work, hardly more stable than the next Presidential election (and ensuing judicial appointments). Thus, one cannot be sanguine about the Court as a redoubt or sanctuary against challenges to the needs of patients or the prerogatives of those who would advocate for them.

Obviously, on this issue as on so many in mental health care, the stakes are high[31] and the judgments subtle and sometimes agonizing that must be made on behalf of those often ill-equipped to speak for themselves. It is of little comfort to have shifting pluralities of remote jurists weighing in with well intended mandates that clearly will alter clinical decision-making in unpredictable ways.[§] Dr. Howard V. Zonana, Director of the Law and Psychiatry Division at Yale University and abundantly experienced in "the-desirable-versus-the-possible" in community mental health care as a long-time attending psychiatrist (and presently Medical Director) at the Connecticut Mental Health Center, has observed, in connection with *Olmstead*: "There are places where you need more outpatient support than currently exists. There is a real worry that [patients] could wind up on the street."[32] Much of Kennedy's opinion recited such concerns:

‡ The complexities involved in the practical application of the Court's ruling are illustrated by the regulation that the Court cites for guidance, from an analogous context, which directs "a case-by-case analysis weighing factors that include: (1) [t]he overall size of the recipient's program with respect to number of employees, number and type of facilities, and size of budget; (2) [t]he type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3) [t]he nature and cost of the accommodation needed." 119 S. Ct. at 2190, n. 16.

§ Both Ginsburg and Kennedy flatly declare, for example, that a homeless shelter is "an inappropriate setting" for a psychiatric patient, when front-line mental health professionals all across the country know that discharges to shelters are routine daily occurrences, as often the only option in our current system of inadequate and shrinking resources (let alone what may obtain under the potentially more-straitened post-*Olmstead* regime).

> It would be. . . tragic. . . were the ADA. . . to be interpreted so that States had some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision. . . . [¶] if the principle of liability announced by the Court is not applied with caution and circumspection, States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition.[33]

And Thomas charged in dissent that:

> . . . the type of claim approved of by the majority does not concern a prohibition against. . . discrimination. . . , but rather imposition of a standard of care. . . . [¶] Continued institutional treatment of persons who, though now deemed treatable in a community placement, must wait their turn for placement, does not establish that the denial of community placement occurred "by reason of" their disability. Rather, it establishes no more than the fact that [governments] have limited resources.[34]

Third, and finally, *Olmstead* illustrates the utility of some measure of skepticism in imagining what legislatures can do and in reading about what courts purportedly have done.

References

1. 104 Stat. 337, 42 U.S.C. §§ 12101 *et seq.* (1994)
2. *Id.* at § 12132
3. *E.g.*, the Supreme Court issued three other ADA cases the same day as *Olmstead*, all dealing with employment discrimination, not mental health issues: Sutton v. United Airlines, Inc., 119 S. Ct. 2139 (1999); Murphy v. United Parcel Service, Inc., 119 S. Ct. 2133 (1999); Albertson, Inc. v. Kirkinburg, 119 S. Ct. 2400 (1999)
4. *E.g.*, Metzner JL: Pennsylvania Department of Corrections, *et al.* v. Ronald R. Yeskey: prisons and the Americans with Disabilities Act of 1990. J Am Acad Psychiatry Law 26: 665–8, 1998; Wall BW: Disability discrimination and *Parker v. Metropolitan Life*: separate, but equal? J Am Acad Psychiatry Law 26:117–21, 1998
5. 119 S. Ct. 2176 (1999)
6. *E.g.*, Greenhouse L: States limited on institutionalization. New York Times, June 23, 1996, p A16 (the "6-to-3 decision. . . was a substantial victory for the disabilities rights movement. . . . "); Zwillich T: High court affirms right to community care for mentally ill. Clin Psychiatry News 27:1, 1999 ("the 6–3 majority opinion"); Diamond EA: Institutionalization may constitute discrimination, Court says. Psychiatr Times 16:40, 1999 ("the U.S. Supreme Court ruled in a 6–3 vote that keeping psychiatric patients in hospitals instead of community homes. . .is. . .outlawed under the ADA.")
7. 42 U.S.C. § 12132 (1994)
8. 42 U.S.C. § 12102 (1994)
9. 42 U.S.C. § 12131 (1994)
10. 28 C.F.R. § 35.130(d) (1998)
11. 28 C.F.R. § 35.130(b)(7) (1998)
12. 119 S. Ct. at 2183
13. 119 S. Ct. at 2188
14. 119 S. Ct. at 2185, n. 7
15. 119 S. Ct. at 2189–90
16. 119 S. Ct. at 2194
17. 119 S. Ct. at 2189
18. 119 S. Ct. at 2190 (emphasis added)
19. 119 S. Ct. at 2191
20. 119 S. Ct. at 2192
21. 119 S. Ct. at 2192–3
22. 119 S. Ct. at 2193
23. 119 S. Ct. at 2199 (emphasis added)
24. Lusky L: Fragmentation of the Court and the loss of simplicity, in Our Nine Tribunes: The Supreme Court in Modern America. Westport, CT: Praeger Publishers, Inc., 1993, pp 29–36
25. *Id.* at 22–3, 29 (". . . the Justices no longer hesitate to deliver dissenting and specially concurring opinions, even at the cost of publication of an 'opinion of the Court,' that is, an opinion agreed to by a majority. . . the present. . . practice strongly suggests that the nine Justices are no longer interpreting rules made by others, but rather are advancing their own individual views of what is best for society.")
26. *Id.* at 36 ("Fragmentation of the Court is particularly disturbing because it symptomatizes a deep-seated, insidious, and deadly affliction: hubris.")
27. *E.g.*, Clayton CW, Gillman H (editors): Supreme Court Decision-making: New Institutionalist Approaches. Chicago: The University of Chicago Press, 1999; Sunstein CR: One Case at a Time: Judicial Minimalism on the Supreme Court. Boston: Harvard Univer-

sity Press, 1999; Spaeth JH, Segal JA: Majority Rule or Minority Will: Adherence to Precedent on the U.S. Supreme Court. New York: Cambridge University Press, 1999 (These comprise a small sample of the scholarly books published this year alone.)
28. 119 S. Ct. at 2188 ("The Court of Appeals' construction... is unacceptable for it would leave the State virtually defenseless once it is shown that the plaintiff is qualified for the service or program she seeks." Why is this "unacceptable"? Is this not a legitimate political position, a question of resource allocation?)
29. 119 S. Ct. at 2190
30. 119 S. Ct. at 2185
31. *op cit., supra* n. 6, Diamond ("The case was originally accompanied by friend-of-the-Court briefs from over 20 states [22 actually, plus Guam]. However, following protests from advocacy groups for the disabled, most of them [15] were rescinded [the other seven supported the plaintiffs' position]. Currently, there are an estimated 75,000 patients in state facilities for the disabled.")
32. *op cit., supra* n. 6, Zwillich
33. 119 S. Ct. at 2191–2
34. 119 S. Ct. at 2198–9