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Treatment of the Mentally Disabled: Rethinking the Community-First Idea**

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INTRODUCTION

In the past several decades the treatment, habilitation and education of the mentally disabled has been heavily influenced by what could be called the “community-first” movement. This movement—which encompasses such developments as deinstitutionalization, the least restrictive alternative doctrine, normalization, mainstreaming, and outpatient commitment—is based on the idea that, in caring for the mentally disabled, we should favor placement in the community rather than in institutions segregated from mainstream populations. The community-first idea is not unanimously supported.¹ But Congress, many courts, and countless advocacy groups composed of lawyers, mental health professionals and laypeople have rallied behind the community first standard as a means of providing more effective

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1. See, e.g., *infra* notes 33 & 36.

treatment, habilitation and education with fewer restrictions on liberty and less stigmatization.

The burden of this article is to highlight the challenges to this near consensus. Although the community first notion clearly offers much that is good, we should recognize that in at least some contexts it has had significant adverse consequences. Some community-based approaches are based on flawed premises. Even if these flaws were eradicated, serious implementation problems abound. This article examines some of these conceptual and practical problems. The purpose of canvassing the dark side of the community-first idea is to curtail blind endorsement of it and to suggest, in a broad way, reforms of the reforms.

II. THE LEGAL BASIS OF THE COMMUNITY-FIRST MOVEMENT

Before launching into a criticism of the community-first idea, a brief history of its development is in order. The concept received its first significant impetus in 1963 with the passage of the Community Mental Health Centers Act,² which provided federal financial incentive for the establishment of community-based outpatient treatment for the mentally disabled. Within the past twenty-five years, in large part because of the funding and model provided by this statute, many communities in this country developed some capacity for outpatient treatment of the mentally disabled.

Not long after the CMHC Act was passed, the prolonged reevaluation of the basis for civil commitment of the mentally disabled began. The attempt to narrow the criteria for involuntary confinement by focusing on dangerousness is very familiar to anyone who has studied the law of civil commitment.³ Less well-known, but significantly more important in terms of its effect on the mentally disabled, was the parallel development of the least restrictive alternative doctrine. The doctrine had its genesis in *Lake v. Cameron*.⁴ Judge Bazelon concluded that prior to involuntary institutionalization, the government must bear the burden of demonstrating that no less restrictive alternatives are available. This holding, based on an interpretation of a statute, soon received constitutional status in a number of jurisdictions.⁵ Some courts even went so far as to find that the doctrine required the creation of community services. In *Dixon v. Weinberger*,⁶ for in-

2. 42 U.S.C. § 2689 (1975)(repealed by Mental Health Systems Act of 1980).

3. See generally R. REISNER & C. SLOBOGIN, MENTAL HEALTH LAW: CASES AND MATERIALS ch. 8 (1990).

4. 364 F.2d 657 (D.C. Cir. 1966).

5. See, e.g., Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976); Davis v. Watkins, 384 F. Supp. 1196 (N.D. Ohio 1974).

6. 405 F. Supp. 974 (D.D.C. 1975).

stance, a federal court ordered the District of Columbia and federal governments to spend money on the implementation of new treatment programs and facilities. The court in *Welsch v. Likins*⁷ also ordered development of less restrictive treatments, despite the state's argument that the attendant expenditures would violate the state's constitutional provision requiring a balanced budget.

The Supreme Court's more recent decision in *Youngberg v. Romeo*⁸ has been construed by many to stand for the proposition that there is no federal constitutional right to treatment in the least restrictive environment. In *Youngberg* the Court rejected the lower court's reliance on less intrusive means analysis. Instead, it held that an individual is only entitled to minimally adequate treatment that is reasonable in light of his or her liberty interests in safety and freedom from unreasonable restraints, and emphasized that the treatment decided upon by qualified mental health professionals is presumptively reasonable. Thus, it is plausible to argue that a decision by mental health professionals that institutional treatment is adequate is presumptively constitutional even though less restrictive alternatives have not been explored.

The fact remains that 47 states provide, by statute, that involuntarily committed patients have the right to treatment in the least restrictive available environment.⁹ Indeed, a number of states go further and specifically provide for commitment on an outpatient basis.¹⁰ Moreover, the constitutional arguments survive *Youngberg*. For instance, one federal district court held, post-*Youngberg*, that a constitutional right to the least restrictive method of care or treatment exists if "professional judgment determines that such alternatives would measurably enhance the resident's enjoyment of basic liberty interests."¹¹ Two federal courts of appeal have followed this reasoning in finding a constitutionally-based right to community care for specific individuals.¹² *Youngberg* may have dampened the judicial enthusiasm for the community-first idea as implemented through the least restric-

7. 373 F. Supp. 487 (D. Minn. 1974). For a description of the district court's orders, see 550 F.2d 1122, 1129-34 (1977).

8. 457 U.S. 307 (1982).

9. Keilitz, Conn & Giampetro, *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 ST. LOUIS U.L.J. 691, 709 (1985).

10. As many as 42 states may permit outpatient commitment; however considerable confusion exists as to what constitutes outpatient commitment. Miller, *Commitment to Outpatient Treatment: A National Survey*, 36 HOSP. & COMMUNITY PSYCHIATRY 265 (1985).

11. Association of Retarded Citizens v. Olson, 561 F. Supp. 473, 486 (N.D. 1982), *aff'd*, 713 F.2d 1384 (8th Cir. 1983).

12. Clark v. Cohen, 794 F.2d 79 (3d Cir. 1986); Thomas S. v. Morrow, 781 F.2d 367 (4th Cir. 1986). See generally Costello & Preis, *Beyond Least Restrictive Alternative: A Constitutional Right to Treatment for Mentally Disabled Persons in the Community*, 20 LOY. L.A.L. REV. 1527, 1545-52 (1987).

tive alternative doctrine, but reports of its death are greatly exaggerated.

Parallel to the development of the least restrictive alternative doctrine as a constitutional requirement has been the statutory endorsement of this idea by the federal government. In the 1970's, Congress passed three laws that gave further impetus to the community-first notion. First, the Developmentally Disabled Assistance and Bill of Rights Act ("DD Act"),¹³ was enacted to provide federal assistance to programs for the developmentally disabled. It contains a preamble listing a number of so-called congressional "findings," including a finding that the developmentally disabled "have a right to appropriate treatment, services and habilitation . . . in the setting that is least restrictive of the person's personal liberty." In *Pennhurst State School v. Halderman*,¹⁴ the Supreme Court held that this language did not confer an enforceable right to treatment in the less restrictive environment, primarily on the ground that the wording of the statute was intended to be precatory and not binding on states which accepted federal money. However, *Pennhurst* left open the possibility of a suit under the federal civil rights statute designed to enforce the least restrictive setting provision of the DD Act. And even if there is no cause of action under this language, the DD Act and its legislative history suggest that Congress has at least symbolically jumped on the community-first, deinstitutionalization bandwagon.

A second federal statute, the Education of the Handicapped Act ("Education Act"),¹⁵ makes this abundantly clear in more concrete ways. The Education Act obligates public schools to identify handicapped children and provide them with a "free, appropriate education" in the least restrictive environment commensurate with their other special education needs. The intent behind this requirement is to maximize "mainstreaming," the use of the regular education system as a means of training and educating the handicapped, whether they be deaf, blind, learning disabled, mentally retarded or emotionally disturbed. In *Board of Education v. Rowley*,¹⁶ the Supreme Court, apparently due to financial concerns, held that the Education Act does not require the state to provide education designed to realize the full potential of the handicapped child. However, the Court also held that the Education Act does require the state to provide individualized instruction that will enable the child to benefit educationally. There is no doubt that the Education Act has provided significant impetus toward integrating the education of the handicapped with the non-handicapped. Parents now have an enforcement mechanism to avoid

13. 42 U.S.C. § 6010 (1982).

14. 451 U.S. 1 (1981).

15. 20 U.S.C. §§ 1400-1461 (1976).

16. 458 U.S. 176 (1982).

segregation of their handicapped children and are using it. In California, for instance, during the first year of the Education Act's operation there were 278 hearings concerning the propriety of educating handicapped children within the regular school system, and this number has increased annually.¹⁷

A third federal statute passed in the 1970's, whose potential for bolstering the community-first idea has yet to be tested at the Supreme Court Level, is the Rehabilitation Act of 1973 ("Rehabilitation Act").¹⁸ In section 504 of the Rehabilitation Act, Congress prohibited discrimination against handicapped individuals receiving federal financial assistance. The recently passed Americans with Disabilities Act of 1990 ("ADA") extends this anti-discrimination prohibition to most private employers as well.¹⁹

These statutory bases for making equality-type arguments could become extremely important in light of the Supreme Court's recently demonstrated reluctance, in *City of Cleburne v. Cleburne Living Center*,²⁰ to use constitutional equal protection analysis to vindicate claims by the mentally disabled. *Cleburne* involved the constitutionality of a zoning ordinance which prohibited use of a building as a group home for the mentally retarded in an area zoned to allow nursing homes, dormitories and apartment hotels. The Court eventually concluded that the ordinance was unconstitutional as applied because in this particular case the prohibition of the group home appeared to result from, to use the Court's words, "an irrational prejudice against the mentally retarded."²¹ Nonetheless, the Court refused to hold that statutes which allegedly discriminate on the basis of mental retardation are subject to strict scrutiny under the equal protection class; the mentally retarded, held the Court, are neither a suspect or "quasi-suspect" class. The Court's holding permits lower courts to uphold a statute that discriminates against the mentally retarded so long as a rational basis for the statute can be found (although, given the result in *Cleburne*, the basis may have to be more "rational" than is usually required for this tier of equal protection analysis).²² There is no doubt that the Court would apply the same relatively lenient approach to statutes discriminating against the mentally ill and other handicapped individuals as well.

17. Kirst & Bertken, *Due Process Hearings in Special Education: Some Early Findings in California*, in SPECIAL EDUCATION POLICIES 138 (Chambers & Hartman, eds. 1983).

18. 29 U.S.C. § 794 (Supp. III 1979).

19. P.L. 101-336, 104 Stat. 327 (July 26, 1990). [42 U.S.C. § 1201]

20. 473 U.S. 432 (1985).

21. *Id.* at 450.

22. See, generally, Minow, *When Difference Has Its Home: Group Homes for the Mentally Retarded, Equal Protection and Legal Treatment of Difference*, 22 Harv. C.R.-C.L. L. Rev. 111 (1987).

To the extent constitutional equality arguments are unavailing after *Cleburne*, section 504 and the ADA could become very useful, especially if these statutes, like the analogous federal statutes barring gender and race discrimination, are construed to cover discrimination that the constitution does not reach. For instance, advocates should be able to claim successfully that a zoning ordinance barring a group home automatically violates section 504 if it otherwise allows living arrangements other than single family homes.²³

III. A CRITICAL LOOK AT THE ARGUMENTS IN FAVOR OF THE COMMUNITY-FIRST IDEA

This synopsis sets the stage for a discussion of problems with the community-first idea as implemented through legislative and judicial pronouncements. Congress and most courts seem to accept the idea that we should try to treat or educate as many people in the community as possible. Granted the Supreme Court, for one, seems more concerned about cost than community-first advocates might like, but even *Rowley* and *Cleburne* demonstrate some receptivity to the idea.

Why this emphasis on community treatment, habilitation and education? There are at least five underlying rationales. First, treatment in the community is thought to be less of an infringement on individual liberty than placement in a segregated institution. From the legal perspective, this is the principal impetus of the community-first movement. Second, there is the belief that integrated treatment, habilitation and education within the community (a trilogy which will henceforth be designated as "THE") is at least as effective, if not more so, than institutional, segregated THE. Increased effectiveness is clearly the *clinical* touchstone for the entire community-first movement. Indeed, the remaining justifications are merely spinoffs of this

23. In the housing context, section 504 is probably no longer the best line of attack, however. In 1988, Congress enacted the Fair Housing Amendment Act of 1988 providing that it is "unlawful to discriminate in the sale or rental or otherwise make unavailable or deny a dwelling to any buyer or renter because of a handicap." 42 U.S.C. § 3604.

The Rehabilitation Act could also be useful in other contexts. For instance, although after *Rowley* neither the constitution nor the Education Act will be of much use to plaintiffs in the same position as the Rowleys, one can argue that § 504 is violated whenever the state fails to expend resources for education of the handicapped proportional to the amount of resources expended on the education of the non-handicapped. Thus, if non-handicapped children in the school district receive resources that enable them to realize 90% of their potential, the handicapped should receive funding at a similar level even if, in absolute terms, they take more out of state coffers. Cf. 34 C.F.R. § 104.33(b)(1988)(Section 504 regulations requiring that the needs of the handicapped be met "as adequately as the needs of non-handicapped children"). See generally, Guernsey, *The EAHCA, 42 U.S.C. § 1983, and Section 504: Statutory Interaction Following the Handicapped Children's Protection Act of 1986*, 68 NEB. L. REV. 564, 588-92 (1989).

rationale. Third, is the belief that community THE places the mentally disabled person closer to family and friends and the emotional sustenance these groups can provide. Fourth, community THE is meant to facilitate what I will call "individual integration" into the community by allowing more contacts with potential employers and by giving the mentally disabled person practice at and "role models" for dealing with the rest of the world. Fifth, community THE supposedly facilitates what could be called "group integration" by exposing the mentally disabled to the non-mentally disabled and accelerating the former group's acceptance by the latter. In other words, community THE is meant to overcome stereotyping and false stigmatization.²⁴

It may well be that for many mentally disabled individuals community treatment often achieves these objectives. For instance, the types of mentally retarded individuals involved in the *Cleburne* litigation—relatively well-adapted adults who are not committable and want or at least do not protest the state's efforts to treat them—may benefit from a community approach in most or all of the ways described above. But for other groups, the assumptions about the advantages of the community-first notion must be challenged. In particular, this article will look at two groups: mentally disabled adults meant to benefit from the least restrictive doctrine and handicapped children who are educated through mainstreaming. In the course of discussing community treatment of these two groups, this article will make broad assertions rather than try to criticize specific statutory language. Again, the goal is to provoke a global reassessment of the community-first idea, not redraft its enabling laws.

A. The Least Restrictive Alternative Rationale

Of course, many forms of community treatment are less physically confining than institutional treatment. It does not necessarily follow from this fact that the community first notion is more respectful of individual liberty. First, community THE is *not* always conducted on an outpatient basis. If the individual is merely moved from a ward in an isolated state hospital to a ward in the community, which has often

24. A sixth reason often given for community THE is that it costs less than institutional programs. Some evidence exists that the per patient cost of an institutional program is higher than the per patient cost of a community program for certain types of individuals (*i.e.* those with psychoses). See C. KIESLER & A. SIBULKIN, *MENTAL HOSPITALIZATION* 177 (1987). However, the same research indicates that, for other types of individuals (*i.e.* those with personality disorders) community care costs more. *Id.* Furthermore, no research is available which compares the cost of one hospital to the cost of the many community programs that would have to be developed *in each community* to service patients from that hospital. It is unlikely that such a study would find that alternative care costs less than institutionalization.

been the case in recent times,²⁵ little has been accomplished by way of increasing that person's freedom. Similarly, if the handicapped child is taken from an institution and placed in a separate building on an elementary school campus, again a common occurrence,²⁶ the phrase "less restrictive" is hard to apply.

More significantly, to focus on physical liberty as a sole indicator of individual autonomy is myopic. First, it is important to realize that restrictiveness is in the eye of the "beholdee"; patients may see some forms of non-institutional community treatment as more "restrictive" than institutional therapy.²⁷ Second, even from an objective standpoint, for some types of people segregated care or education may be better, of shorter duration, or less stigmatizing than "less restrictive" care. Indeed, more physical liberty may be useless or even harmful if it detracts from an individual's recovery or makes it difficult to concentrate on the rehabilitative tasks at hand.²⁸ In the end, the liberty issue is inextricably bound up with the issue of effectiveness.

B. Effectiveness

Evaluating effectiveness is very difficult since there is such a wide range of handicaps, each of which has unique needs, even within the two groups focused upon in this article—adults subjected to involuntary commitment and children who are mainstreamed. Moreover, the law's differing approaches to these two groups, particularly in terms of the degree of coercion exerted, may have significant consequences when addressing the effectiveness issue. The ultimate conclusion, however, is the same with respect to both: the community-first idea, as currently conceptualized and implemented, is not particularly efficacious.

25. See Bachrach, *Is the Least Restrictive Alternative Always the Best? Sociological and Thematic Implications*, 31 HOSP. & COMMUNITY PSYCHIATRY 97 (1980).

26. See *infra* note 56.

27. Hospital inmates commonly state a preference for seclusion rather than psychotropic medication, even though use of the latter usually results in less physically restrictive environments. Cf. *Washington v. Harper*, 110 S. Ct. 1028, 1046 (1990) (noting that Harper stated he would rather die than take medication). Analogously, some convicted offenders appear to prefer prison to probation because the latter disposition is of longer duration than the former and imposes numerous restrictions on freedom of movement, etc. *State Inmates Choose Prison Over Probation*, Gainesville Sun, Feb. 19, 1990, p. 7A.

28. In *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 110, 1139-43 (1977), Hoffman and Foust make this eminently clear. For instance, they point out that "[so] desperate may be the need of such patients for less, rather than more stimulation, that some authors question whether the normal hospital environment is sufficiently tranquil." *Id.* n. 119. See also, Goldberg & Rubin, *Recovery of Patients During Periods of Supposed Neglect*, 37 BRIT. J. MED. PSYCHIAT. 265 (1964).

1. *Involuntary Care*

Turning first to the involuntary commitment context, there is no doubt that many of the treatments currently provided in hospitals can also be provided in the community, on an outpatient basis. This fact, combined with the liberty interests meant to be furthered by the least restrictive alternative doctrine, has led a number of states to enact provisions permitting outpatient commitment or some other type of forced care in the community rather than in an isolated state hospital.²⁹ However, there are countless problems with the outpatient commitment concept.

Most fundamentally, a plausible argument can be made from the modern, libertarian perspective, that outpatient commitment is either meaningless or so subversive it should be abandoned. If we are serious about limiting involuntary civil commitment to those who are clearly and convincingly dangerous to self or others, then candidates for outpatient treatment will be rare indeed, because the imminently very dangerous almost always require institutionalization.³⁰ Even if we are willing to expand the committable group to include anyone who is so severely mentally disabled as to be dysfunctional, it is unlikely the outpatient commitment net would catch many more persons, since these people also would find it very difficult to exist outside an institution. Not surprisingly, however, outpatient statutes *are* being utilized. How is this possible? Presumably, civil commitment criteria are being interpreted broadly so as to include those nondangerous people and those competent people who are diagnosable and potentially treatable.³¹ Ironically, outpatient commitment, which is seen by many libertarians as the logical extension of protection against undue deprivations of liberty, could have the opposite effect. It could easily undo the rewards — as minimal as they are — of two decades of legal battles aimed at narrowing the commitment criteria.

Even assuming this significant conceptual problem can be overcome,³² there are several practical obstacles to effective outpatient

29. See *supra* note 10.

30. DeRisi & Vega, *The Impact of Deinstitutionalization in California's State Hospital Population*, 34 HOSP. & COMMUNITY PSYCHIATRY 140, 144 (1983); Sheridan & Teplin, *Recidivism in Difficult Patients: Differences Between Community Mental Health Center and State Hospital Admissions*, 138 AM. J. PSYCHIATRY 688, 689 (1981).

31. Indeed, in some states, the criteria for outpatient commitment are explicitly relaxed. See Stefan, *Preventive Commitment: The Concept and Its Pitfalls*, 11 MENTAL DISABILITY L. REP. 288 (1987).

32. One could argue that outpatient commitment is a lesser deprivation of liberty than hospitalization and therefore does not require the same level of justification. The question then arises as to how to enforce treatment: if a patient committed on an outpatient basis solely on the ground that the patient needs treatment fails to take medication, hospitalization is not possible. At the least, outpatient com-

commitment. First and foremost is the shameful lack of treatment facilities in virtually every community in the country.³³ Until state and local governments are willing to provide money for such facilities, outpatient treatment, even if it makes sense theoretically, will be ineffective for large numbers of persons because appropriate treatment will not be available. Admittedly, there are CMHCs in many communities. However, as one commentator has noted, the ex-hospital patients released through the deinstitutionalization movement are not being served by these centers. As he puts it, "quite apart from the centers' uneven geographical distribution and their current fiscal problems, both their ideology and their most common services are not directed at the needs of those who have traditionally resided in state psychiatric institutions."³⁴ Given this situation, outpatient commitment is unlikely to work well. When deciding upon the disposition of a person who meets the criteria for civil commitment, a judge who must choose between either institutional treatment and nothing, or institutional treatment and a community program designed for other types of individuals, will have little difficulty choosing the former option in both instances.

Even when appropriate facilities exist, as noted earlier,³⁵ the problems of institutionalization are often replicated in the community. Particularly with respect to the chronically mentally ill, deinstitutionalization has often meant reinstitutionalization in nursing homes and other facilities, a situation which, as one commentator has put it, is "replete with its own failings and shortcomings."³⁶ For the non-chronically ill, community placement is supposed to lessen the chance of rehospitalization, but there is at least some evidence of a "revolving door" cycle in the community hospital psychiatric units and emergency rooms reminiscent of the experience at state hospitals.³⁷ It has even been suggested that outpatient treatment can *encourage* sick be-

mitment should be permitted only if the state can show that the person will be harmful to self or others if treatment is not monitored on an outpatient basis. Cf. AMERICAN BAR ASSOCIATION CRIMINAL JUSTICE MENTAL HEALTH STANDARD §§ 7-7.4(d), at 7-382 and accompanying commentary (1984).

33. Brown & Bremer, *Inadequate Means to a Noble End: The Right to Treatment Paradox*, 6 J. PSYCHIATRY & L. 45, 58-59 (1978); Scull, *A New Trade in Lunacy: The Recommodification of the Mental Patient*, 8 AM. BEHAV. SCIENTIST 741, 743-44 (1981).
34. Scull, *supra* note 33, at 724, 743-44 (1981). See also Lamb, *Deinstitutionalization at the Crossroads*, 39 HOSP. & COMMUNITY PSYCHIATRY 941 (1988); E. F. Torrey, *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill* 142-51 (1988).
35. See *supra* note 25 and accompanying text.
36. Goldman, *Deinstitutionalization: The Data Dymythologized*, 34 HOSP. & COMMUNITY PSYCHIATRY 129 (1983). See also Schmidt, *The Mentally Ill in Nursing Homes: New Back Wards in the Community*, 34 ARCHIVES GEN. PSYCHIATRY 687 (1987); Scull, *supra* note 33, at 744-50.
37. DeRisi & Vega, *supra* note 30, at 144.

havior, at least in those charged with criminal offenses who have been found incompetent to stand trial and may otherwise be convicted.³⁸

Schwartz and Costanzo discuss a number of other problems with outpatient commitment that are likely to affect treatment efficacy.³⁹ These include the difficulty of compelling compliance with a treatment regimen when walls and locked doors can no longer be used as an enforcement mechanism, the resistance of community mental health professionals to the coercive nature of outpatient treatment and the greater likelihood of liability, the intrusion of judges into the treatment relationship due to the need to monitor continued adherence to treatment plans, and the likelihood of hostile community reaction to the presence of mentally disabled individuals. Schwartz and Costanzo predict that outpatient commitment will become synonymous with forced medication, with all the constitutional and operational difficulties that approach occasions.

Despite all of these problems, one might still argue that community treatment is better than hospital treatment. Any attempt to suggest the contrary must confront Kiesler's review of research involving institutionalized treatment and alternative care.⁴⁰ Kiesler very carefully examined the entire universe of studies comparing the two types of treatment using randomized assignment. He concluded that "alternative care is more effective and less expensive [and is better at] keep[ing] people out of the hospital."⁴¹

This finding is probably accurate, as far as it goes, but it does not mean that institutional treatment comes in second in all or even most cases in the context at issue here. First, as Kiesler himself admits, there are some flaws in the research. For instance, he points out that the alternative care programs studied, which were generally quite innovative, were compared to traditional, not necessarily the best, hospital programs.⁴² Moreover, he admits, many of these innovative alternative care programs might work just as well (if not better?) in a hospital, yet were not tried there.⁴³ In addition, rehospitalization—the outcome variable most often used in the research reviewed by Kiesler as a means of testing the success or failure of the treatments

38. D. WEXLER, *MENTAL HEALTH LAW* 122 (1981). Note, however, that outpatient commitment makes more sense in the competency to stand trial setting, because *restorability*, not dangerousness, is the issue. *Jackson v. Indiana*, 406 U.S. 715 (1972). In contrast to those who are imminently dangerous to self or others, many of those found incompetent to stand trial can be effectively treated on an outpatient basis.

39. Schwartz & Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 *LOY. L.A.L. REV.* 1329, 1377-97 (1987).

40. C. KIESLER & A. SILBUKIN, *supra* note 24.

41. *Id.* at 179.

42. *Id.* at 173.

43. *Id.* at 176.

studied — is suspect. As Kiesler notes,⁴⁴ the best predictor of whether someone will be hospitalized is whether he or she has been hospitalized in the past. The greater rehospitalization of those treated in hospitals compared to those who were not may merely reflect the preferences of their admitting clinicians or the influence of past decisions by other clinicians.

Even accepting the research on its face, the conclusion that community care might be more effective than institutionalized care in the isolated situations reviewed by Kiesler does not mean that it works better in all situations. It will still probably distort the commitment criteria, fail miserably to the extent society is unwilling to foot the bill, result in its own revolving door problems, and occasion the headaches outlined by Schwartz and Costanzo. Moreover, as Kiesler notes, the research does not prove that every type of individual involved in the studies will do better in alternative care; the possibility remains that some subgroups will receive better treatment in a hospital.⁴⁵ In addition, in all of the studies, the impact of alternative care diminished considerably after one or two years. That is, those treated in the hospital were rarely worse off than those treated in the community at the end of this period.⁴⁶ Finally, and most importantly, although Kiesler states that all the studies involved patients who were "seriously ill,"⁴⁷ it is unlikely that any of the studies involved patients who were considered imminently dangerous to self or others. It is hard to imagine the local judiciary (or most mental health professionals) allowing random assignment of such patients to the hospital or alternative care.⁴⁸ If this assumption is correct, Kiesler's conclusion is close to meaningless in the context with which we are concerned — the treatment of those subjected to involuntary hospitalization.

One might well point out that provision of community services for those who *want* them is not nearly as problematic; if this is the group focused upon, Kiesler's research is likely to be relevant and the problems with coercion identified by Schwartz and Costanzo are non-existent. However, as stated at the outset, this article looks at conceptual and practical problems with the law as it is currently conceived and implemented. To date, no court and no state legislature has been

44. *Id.* at 179.

45. The authors state that their conclusion about the superior quality of community care "may not be true for all disorders, age groups, etc. Insufficient detail is provided in these studies to assess such questions even preliminarily." *Id.* at 177.

46. *Id.* at 175.

47. *Id.* at 173.

48. *Cf. Mills & Cummins, Deinstitutionalization Reconsidered*, 5 INT'L J.L. & PSYCHIATRY 271, 276 (1982)(a review of studies concluding that the studies showing clearly favorable outcomes for community treatment had excluded the most severely disturbed patients, while those that included this group show community treatment was not as successful).

willing to provide a constitutional or statutory right to community mental health treatment services for the general populace. It must be remembered that the least restrictive alternative idea developed as a limitation on the state's attempts to force institutionalized treatment on its citizens; thus, in analyzing the doctrine, involuntary outpatient commitment is the correct focal point. This part of the article has shown that, in terms of effectiveness, the community-first idea in the involuntary commitment context has significant shortcomings.

2. *Voluntary Care*

Even when government is willing to extend an entitlement to community services to an entire population, as Congress has done with the Education Act, serious questions of effectiveness can arise. As in the involuntary commitment context, conceptual and practical problems detract from the effectiveness of mainstreaming the handicapped for educational purposes.

The biggest conceptual problem with the Education Act is that it rests on conflicting premises. The Education Act's most interesting feature is its emphasis on the individual child. Each child who is identified as handicapped is to be educated according to an Individualized Educational Program ("IEP") developed by school authorities in collaboration with the parents of the child.⁴⁹ This aspect of the Education Act is commendable when viewed in isolation. Yet the Education Act also requires that the IEP be implemented, whenever feasible, through the regular educational system.⁵⁰ As many commentators have pointed out,⁵¹ this latter system is based on a premise diametrically opposed to the individualized approach. Children in the regular school system are handled according to categories — that is, grades, tracks or age — rather than as individuals with unique characteristics. Moreover, the types of educational resources they receive are based on their ability to satisfy certain universally applied requirements, not on their need for a particular type of training or education, as is the case with the handicapped. The Education Act thus requires two different educational paradigms to operate at once — the first based on individualized needs, the second based on categorically-defined abilities.

The paradigmatic clash plays itself out in several ways. Under the Education Act, for instance, school authorities and parents are supposed to cooperate in devising the IEP.⁵² This collaborative process is

49. 20 U.S.C. §§ 1401(19), 1414(a)(5)(1988).

50. *Id.* § 1414(a)(1)(C).

51. See, e.g., Bartlett, *The Role of Cost in Educational Decisionmaking for the Handicapped Child*, 48 LAW & CONTEMP. PROBS. 7, 19-26 (1985); Hill, *Legal Conflicts in Special Education: How Competing Paradigms in the Education for All Handicapped Children Act Create Litigation*, 64 DET. C.L. REV. 129, 142-48 (1986).

52. 20 U.S.C. §§ 1414(a)(1)(C)(iii), 1415(b)(1)(D)(1988).

meant to facilitate identification of the child's needs. Yet it has frequently failed to work. School officials, operating under the norms of the traditional system, tend to classify handicapped children according to diagnoses or other relatively general labels, while parents, who are of course very familiar with their child, tend to view them as a composite of unique traits. It is not surprising that studies of the IEP development process contemplated by the Education Act indicate that the schools often ignore parents' input, at least until the parents initiate litigation.⁵³

Even if there is agreement on the child's needs, there is often disagreement over how to meet those needs. School administrators are used to allocating resources on an institution-wide basis, and to the extent they consider individuals or smaller groups at all in making such decisions, they are likely to reward merit. Yet when it comes to handicapped children, the Education Act *requires* them to focus on individual rather than institutional needs; moreover, given the high cost of educating the handicapped (which on average is twice the cost-per-pupil), it asks them to do so in inverse proportion to merit. Administrators find this hard to do. Naturally enough, their definition of "appropriate education," which the Education Act requires be given to every handicapped child, is likely to weigh institutional concerns over the individual concerns of the handicapped. Their emphasis is on what is available institutionally rather than what might be made available on an individual basis.⁵⁴ Needs of the handicapped are dubbed psychological or medical rather than educational (thus avoiding the mandate of the Education Act) when they are not easily handled by the school's current curriculum.⁵⁵ Of those whose needs are considered educational, the vast majority are still segregated from their schoolmates, analogous to the treatment of the civilly committed.⁵⁶

53. Clune & Van Pelt, *A Political Method of Evaluating the Education for All Handicapped Children Act of 1975 and the Several Gaps of Gap Analysis*, 48 LAW & CONTEMP. PROBS. 7, 33 n.159 (1985)(citing Thouvenelle, *Study of Procedures for Determining the Least Restrictive Environment Placement of Handicapped Children: Final Project Report* 3.14-3.22 (1980)). See also, *id.* at 19; Wegner, *Variations on a Theme: The Concept of Equal Educational Opportunity and Programming Decisions Under the Education for All Handicapped Children Act of 1975*, 48 LAW & CONTEMP. PROBS. 169, 174-76 (1985).

54. Miller & Miller, *The Handicapped Child's Civil Right as It Relates to the "Least Restrictive Environment" and Appropriate Mainstreaming*, 54 IND. L.J. 1, 5 (1978); Note, *Board of Education v. Rowley: Handicapped Children Entitled to a Beneficial Education*, 69 IOWA L. REV. 279, 286-87 (1983).

55. See, e.g., *In re Bill D.*, [1980-81 Dec.] Educ. Handicapped L. Rep. (CRR) 502:259 (SEA Conn. Jan. 17, 1981); *In re Carlisle Area School District*, [1982-83 Dec.] Educ. Handicapped L. Rep. (CRR) 504:194 (SEA Pa. Aug. 23, 1982).

56. See, e.g., *St Louis Parents Assn.*, 591 F. Supp. 1416, 1451 n.73 (W.D. Mo. 1984)(85% of handicapped are educated in specially designed buildings); Position Paper, Florida Advocacy Center for Persons with Disabilities (1987)(87.2% of mentally handicapped in Florida are placed in special class or separate schools).

If the handicapped child is mainstreamed, other problems arise, again stemming from tension between the two education paradigms. School authorities would prefer to treat handicapped children like other children as much as possible when it comes to teaching, grading and discipline. But if they do so, they could easily violate the aims of the Education Act. For instance, the Education Act requires that the needs of handicapped children be satisfied in the least restrictive environment. Therefore, expulsion for disciplinary purposes, which results in a return to a special education setting, is impossible unless the school once again meets with the parents to devise a new plan. This obligation to provide special treatment again rubs school officials the wrong way. As one commentator has pointed out:

[T]he school administrator is forced to operate two systems within the same school: one based on rules and structure, the other on standards and flexibility. Faced with administrative schizophrenia, he may attempt to resolve the problem by asserting the norms of the dominant system over those of the subordinate system. When he does, he conflicts with the statute and litigation results.⁵⁷

The paradigm clash re-emerges during litigation, where resistance to individualization results in a triumph of form over substance. In particular, school boards often rely on their attention to the procedures of the Education Act as a defense in suits which allege their failure to individualize education. Judges, who tend to be rule-oriented as well, often find the defense valid.⁵⁸ One finds in much of the litigation a fixation by both bureaucrats and courts on procedural fairness rather than on substantive fairness.

Even if the parents "win" on the substantive issue, one wonders how effective the child's subsequent education will be. In the law of contracts, it is well-accepted doctrine that specific performance of a personal service will rarely be granted; damages is the preferred remedy. If Liz Taylor breaches a contract to perform in *Cleopatra*, the court will require her to pay a multi-million dollar sum, not force her to assume the role. The reasons should be obvious: while one can make a contractor finish a building according to specifications, it is very difficult to monitor the quality of an actress' performance; indeed, it is very possible Liz will do everything in her considerable power to ruin the production in ways that cannot be rectified. Under the Education Act, a financial remedy makes little sense. The only

57. Hill, *supra* note 51, at 153.

58. Clune & Van Pelt, *supra* note 53, at 193; Sindelar, *How and Why the Law Has Failed: A Historical Analysis of Services for the Retarded in North Carolina and a Prescription for Change*, 48 LAW & CONTEMP. PROBS. 125, 126 (1985). Apparently, the Department of Education routinely refuses to investigate substantive aspects of complaints under the Education Act, so long as procedural requirements are met. Tucker, *Section 504 of the Rehabilitation Act After Ten Years of Enforcement: The Cost and the Future*, 1989 ILL. L. REV. 845, 867 (1989).

remedy that parents can seek is performance by the defendant school, performance of a very sophisticated service. Granted, schools may not be as quixotic as Ms. Taylor, but the possibility of subtle sabotage is surely there.

This is not to suggest that school authorities and courts don't care about individual handicapped children. They may care about them as much as they care about any other student in the system. However, the attitudes inculcated by that system make it difficult for them to respond in the ways required by the Education Act. These attitudes are likely to persist on the part of school administrators. Indeed, one could argue that they are a necessary foundation of our regular school system.

Thus, it is worthwhile to question whether, as *currently implemented*, mainstreaming is a good idea if effective institutional programs can also be made available. The facts of *Rowley* provide a perfect example of the dilemma posed. In that case, the Supreme Court was confronted with an extremely intelligent plaintiff who happened to be deaf and thus was able to comprehend less than half of what was said in the classroom unless provided the assistance of a sign language interpreter. The school was unwilling to provide such an interpreter, however, because it burdened institutional resources and because, even without an interpreter, Rowley was able to do well enough to progress from grade to grade. Rowley was not receiving individualized instruction but rather was thrust into the grade appropriate for her age; she was being gauged according to merit rather than need.⁵⁹ Nonetheless, the Court agreed with the school in finding her education appropriate and not in violation of the Education Act. The Court emphasized that the school had followed the procedures mandated by the Education Act and was providing education that was of some benefit to the plaintiff.⁶⁰

Amy Rowley's mainstream education, as sanctioned by the Court, is no better, and is probably worse, than the education she would receive in a school for the deaf where teachers would be able to sign or automatically provided with interpreters. One can certainly argue that the Court's decision is erroneous, but it is not surprising, given the premises of traditional education.⁶¹

59. The District Court found that Amy "is advancing easily from grade to grade" but "understands less of what goes on in class than she could if she were not deaf" and thus "is not learning as much, or performing as well academically, as she would without her handicap." Board of Educ. v. Rowley, 458 U.S. 176, 185 (1982).

60. *Id.* at 209-10.

61. Moreover, a finding in favor of the Rowleys could have had several drawbacks: disgruntled administrators and teachers, disrupted classrooms, and perhaps added pressure on Amy, whose use of an interpreter would likely be conspicuous. See *infra* text accompanying notes 63-67 for further discussion of this point. The tension between the two different educational paradigms is not easily resolved.

This article has tried to demonstrate that the community-first idea, as currently implemented, may not result in more effective treatment, habilitation or education than that provided in a segregated institutional setting. To this point effectiveness has been defined rather narrowly. Yet to be considered are other attributes of community THE that might make it an attractive option, namely the fact that it facilitates contact with loved ones and promotes individual and group integration. The analysis of these supposed advantages of the community-first idea will be even briefer but enough will be said to suggest that these claims are also suspect.

C. Family Contacts

There is no doubt that mainstreaming allows children to be closer to their parents than would be the case if education took place in some far-off institution. Those committed to outpatient treatment will also likely be closer to loved ones. Moreover, regardless of how effective community treatment might otherwise be, this arrangement is probably good in and of itself. However, the claim that THE in the community is beneficial because it keeps persons who are mentally disabled close to home makes sense only if there is a worthwhile home to be close to. Particularly with respect to those subjected to involuntary civil commitment it is frequently the case that no significant others exist, or that those who do exist will only detract from the effectiveness of care. Very often it is a relative, tired of caring for or putting up with the sick or dysfunctional individual, who initiates the institutionalization process in the first place.⁶² One does not need a Freudian background to believe that family dynamics can perpetuate a person's sickness or psychosocial maladjustment. In these circumstances, institutionalization may be preferable to outpatient treatment or local habilitation and education. Yet, current statutes encouraging or mandating community THE make no effort to differentiate between those who can benefit from proximity to certain individuals in the community and those who cannot.

D. Individual Integration

Probably the strongest argument in favor of community THE is that it facilitates integration of the mentally disabled individual into the community. Ensnared in an institution far from the "real world", such an individual, even if his or her primary mental problem is successfully treated, may find it difficult to acquire the psychosocial skills

One possible, but improbable, resolution is to individualize the *entire* educational system.

62. See Dix, *Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 WASH. U.L.Q. 485, 503.

necessary for adequate assimilation in the community once released. Community THE probably makes it easier to acquire these skills and, at the same time, makes it easier to find employment or other conditions in which the skills can be applied.

The only question advanced here is whether integration is ever feasible for any but the most "normal" mentally disabled individuals. If most mentally disabled people do not have sufficient capacity to function in society, then only a few will benefit from community THE. Even if a large number of them have such capacity, it is reasonable to ask whether their potential will be realized given the rest of society's attitude toward them. Ultimately, individual integration is a function of group integration, the fifth justification for community THE.

E. Group Integration

The rationale behind group integration is as follows: only if the mentally disabled become familiar to and interact with the rest of society will they have any chance at successful assimilation into the community. Otherwise, "irrational prejudices," to use the Supreme Court's language in *Cleburne*⁶³, will persist and even those mentally disabled persons who are qualified will be discriminated against in subtle ways that can make it difficult for them to recover fully or function to the best of their ability.

The mentally disabled have often been compared in this regard to minorities. The Supreme Court's decision in *Brown v. Board of Education*⁶⁴ was based, not so much on proof that schools for blacks were inherently unequal in quality to schools for whites, but on the notion that separate education of blacks would symbolize continued diminishment of their status and prevent them from being taken seriously as members of society. Analogously, so the argument goes, the mentally disabled should be educated and treated in the community with the rest of the populace, or prejudices against them will be perpetuated and their position in society will remain precarious.

Unfortunately, when the focus is mentally disabled persons who are committable or who require special educational services, it is easy to harbor doubts about the validity of the thesis that familiarity breeds acceptance. As Professor Minow has argued, discrimination based on perceived differences usually does not depend upon the extent to which those who are different are physically integrated with the rest of the population.⁶⁵ Just as segregation can stigmatize the mentally disabled by marking them as different, incautious integration can stig-

63. *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 450 (1985).

64. 347 U.S. 483 (1954) (separate but equal doctrine found to be unconstitutional).

65. Minow, *Learning to Live With the Dilemma of Difference: Bilingual and Special Education*, 48 LAW & CONTEMP. PROBS. 157 (1985).

matize the disabled by making painfully obvious their difficulties. The deaf child who needs an interpreter, the emotionally disturbed child who receives "counseling," and the mentally retarded child who attends special classes clearly become more conspicuous and very possibly more alien to the rest of society when their needs are met by the public schools instead of a segregated institution. The number of instances in which communities have attempted to remove group homes from their midst suggests that outpatient treatment may produce the same result.

Ultimately, Minow suggests this "dilemma of difference" can be overcome through integration, but only if differences are treated as aspects of the community's identity rather than as evidence of inequality or lower status. For example, rather than singling out the deaf child who has been mainstreamed by providing her an interpreter or requiring her to attend special classes after regular hours, the entire class could be taught sign language. This approach, Minow asserts, would be effective in "making the hearing-impaired child's difference no longer signify stigma or isolation while still responding to that difference as an issue for the entire community."⁶⁶ As another example, Minow suggests that all students, not just those who are handicapped, spend different days or portions of different days in different settings, with different mixes of children and teachers. As she states, "a real mix of special classes could modulate the implicit hierarchy of such extra classes, and diminish the implication that difference resides in the unusual student rather than in all the students."⁶⁷

The problem with Minow's approach is that, as she readily admits,⁶⁸ it can be extremely hard to implement. If we do not create programs that treat the differences of the mentally disabled as one type of difference among many rather than as a special problem area, then we are left with the dilemma that Minow describes. Under such circumstances, the community-first notion may not be better than institutional programs at producing effective assimilation of the mentally disabled.⁶⁹ Separate but equal institutions may make more

66. *Id.* at 208.

67. *Id.* at 209.

68. *Id.* at 208.

69. Most of the research indicates that unless integration of the type described by Minow takes place, mainstreaming is conceptually and practically problematic. Taylor, *Caught in the Continuum: A Critical Analysis of the Principle of the Least Restrictive Environment*, 13 J. A. SEVERELY HANDICAPPED 41 (1988) (arguing that the least restrictive environment idea is outmoded and should be replaced by a policy of integration, meaning the elimination of social, cultural, economic, and administrative barriers to community integration and encouragement of relationships between people with developmental disabilities and nondisabled people). See also Hamre-Nietupski, *Enhancing Integration of Students with Severe Disabilities Through Curricular Infusion: A General/Special Educator Partnership*, in EDUCATION AND TRAINING OF THE MENTALLY RETARDED 78

sense, assuming the institutions are indeed "equal" in quality.

IV. CONCLUSION

Perhaps we should not even try to bring about assimilation of the mentally disabled. We may be morally bound to do so in the case of minorities, whose "condition" can be blamed on the majority. Moreover, we need minorities *in* the community for the community to survive. But why should we attempt to bring into society a class of people, a large number of whom have great difficulty engaging in social dialogue and contributing to the works of the community? Do we really have any *communal* relationship with them?

Professor Burt believes the answer to this latter question is yes:

It is [admittedly] paradoxical that handicapped people must depend on others' assistance in order to achieve their goal of independence from others. But in this paradoxical dependence, handicapped people resemble everyone who, in striving for independent autonomy, is nonetheless constrained by an inescapable economic and social network of interrelated dependencies—everyone, that is, in America today.⁷⁰

In other words, Professor Burt argues, our communal relationship with the mentally disabled, even those who are severely disabled, lies in the fact that *everyone* needs help in becoming a functioning member of the community. We should recognize in their plight the plight of all of us.

Yet accepting this argument, which I do, does not mean that current efforts to bring about a greater sense of community are appropri-

(1989); Hamre-Nietupski & Nietupski, *Integral Involvement of Severely Handicapped Students Within Regular Public Schools*, 6 TASH 30 (1981); Stainback & Stainback, *A Review of Research on Interactions Between Severely Handicapped and Nonhandicapped Students*, 6 J. A. SEVERELY HANDICAPPED 23 (1981); Voeltz, *Effects of Structured Interactions with Severely Handicapped Peers on Children's Attitudes*, 86 AM. J. MENTAL DEFICIENCY 380 (1982); J. GEARHART & A. WEISHAHN, *THE HANDICAPPED STUDENT IN THE REGULAR CLASSROOM* 90 (2d. ed. 1980) (if more than physical integration is not achieved, handicapped students may become "more severely and directly stigmatized, stereotyped, and rejected" than if they had stayed in their segregated classrooms.)

Unfortunately, since *Rowley*, although the lower courts have finetuned mainstreaming analysis, they have paid little attention to these concerns. The emphasis has been on physical integration, to the exclusion of other issues. Indeed, the leading case, *Roncker v. Walter*, 700 F.2d 1058 (6th Cir. 1983), stated that even if a placement is considered better for academic reasons, it may not be the appropriate placement if it fails to mainstream the child. *Id.* at 1063. While this holding is not surprising, given the language of the Act, its emphasis on mainstreaming rather than efficacy is troublesome. See also *Gillette v. Fairland Bd. of Educ.*, 725 F. Supp. 343 (S.D. Ohio 1989); *A.W. v. Northwest R-1 School Dist.*, 813 F.2d 158 (8th Cir. 1987). A more sophisticated approach is provided in *Daniel R.R. v. State Bd. of Educ.*, 874 F.2d 1036 (5th Cir. 1989).

70. Burt, *Constitutional Law and the Teaching of Parables*, 93 YALE L.J. 455, 492-93 (1984).

ate. We should reject reliance on outpatient commitment as currently conceptualized. We should engage in mainstreaming only if we are willing to reorient the learning process in ways that are truly integrated. Otherwise, we could easily be making matters worse.