

**State of Wisconsin
Council on Physical Disabilities**

FREEDOM FROM BARRIERS:
A State Plan for People with Physical Disabilities

Adopted April 23, 2004

State Plan for People with Physical Disabilities

Executive Summary

The Wisconsin Council on Physical Disabilities was created by the state legislature in 1989 with the passage of Act 202. Among other duties, the Wisconsin legislature charged the Council to develop, approve and continue modification of a state plan for services to persons with physical disabilities. The Council has chosen to combine this task with its own work plan. Additional information about the Council and its activities can be found at: www.pdcouncil.state.wi.us.

The Council envisions a world where all persons with physical disabilities have access to the same life choices and opportunities as any other Wisconsin citizen. The Council has identified four areas which are critical to people with physical disabilities and has identified goals for each area.

Housing

1. Increased accessibility by people with physical disabilities to/from all buildings in Wisconsin.
2. Choice of integrated, community living for all people with physical disabilities.
3. Choice of home ownership for people with physical disabilities.

Long-Term Support

1. Access to accurate and current information, counseling on eligibility, assistance with application procedures, and advocacy for appeals for public and private benefit programs.
2. Self-directed in all choices about services and supports needed with education provided regarding options available to consumers.
3. No waiting lists for community services.
4. Entitlement to a comprehensive care system (e.g., Family Care) that supports home and community living for people with physical disabilities.
5. Statewide respite care in homes and communities.
6. Statewide access to and funding for assistive technology (services, devices, consumer training and maintenance) as needed for individuals of any age.
7. Work incentives and training for realistic employment opportunities with living wages and health benefits.

Transportation

1. Safe, reliable, cost effective and accessible transportation for people with physical disabilities.
2. Adequate parking for people with physical disabilities and public awareness of the need.
3. Decrease/eliminate the need for transportation (especially to and from work) by using technology (e.g., use of telecommuting to allow people to work at home).

Emergency Preparedness

1. The needs of people with physical disabilities are included in plans for emergencies and disasters.

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* to be developed in 2004

Wisconsin Council on Physical Disabilities

The Wisconsin Council on Physical Disabilities was created by the state legislature in 1989 with the passage of Act 202.

The Council seeks to represent the 6.9 percent of Wisconsin citizens with physical disabilities—approximately 339,000 individuals.

Among other duties, the Wisconsin legislature charged the Council to develop, approve and continue modification of a state plan for services to physically disabled persons. The Council has chosen to combine this task with its own work plan.

Members

The Council is comprised of 14 members appointed by the Governor for staggered three-year terms. One Council position is reserved for the Governor's representative, and the rest are unpaid volunteers. At least six members must be people with physical disabilities and at least one member must be a service provider to people with physical disabilities.

In 2004, members are: JorJan Borlin (Chairperson, Dodgeville), Jeff Fox (Vice Chairperson, Gordon), Joanne Zimmerman (Secretary, Bayside/Milwaukee), Jon Baltmanis (Waupaca), Christine Duranceau (Rothschild), Denise Gilchrist (Altoona/Eau Claire), Marge Liberski-Aznoe (Green Bay), Virginia Lukken (Mount Horeb), John Meissner (Little Chute), Linda Rowley (Mineral Point), Karen Secor (Montreal), Jackie Stenberg (Superior) and Pamela Wilson, M.D. (Madison).

Staff

The Council is administratively attached to the Office for Persons with Physical Disabilities (OPPD) in the Division of Disability and Elder Services (DDES), Department of Health and Family Services (DHFS). In addition to other responsibilities, Dan Johnson, Director of OPPD, and Brian Powers, Information and Program Operations Assistant, provide staff support to the Council.

Website

The Wisconsin Council on Physical Disabilities internet address is: www.pdcouncil.state.wi.us.

Mission

The mission of the Wisconsin Council on Physical Disabilities is to:

- develop a state plan for services to people with physical disabilities;
- request reports from state agencies regarding programs, funding, clients or services to people with physical disabilities;
- advise state agencies on legislation, funding, programs, policies and operations with respect to people with physical disabilities;
- encourage public understanding of the needs and issues concerning people with physical disabilities;
- consider all questions and matters brought to the Council concerning people with physical disabilities; and
- submit an annual report to the state legislature with recommendations on legislation.

Vision

The Council envisions a world where all persons with physical disabilities have access to the same life choices and opportunities as any other Wisconsin citizen.

Philosophy/Beliefs

1. Inclusion and integration benefits the lives of people with physical disabilities.
2. People with physical disabilities must be allowed and encouraged to determine and direct their lives.
3. People with physical disabilities want to participate in the workforce to their maximum capacity.
4. People with physical disabilities want to have choices about where and how they live.
5. People of all ages have physical disabilities.
6. Technology can be used to improve the quality of life for people with physical disabilities.
7. The Americans with Disabilities Act must be upheld.
8. People with physical disabilities are valuable resources for improving and evaluating services.

Strategies/Means to be Used

1. Promote public awareness and understanding of the abilities of and barriers that face people with physical disabilities.
2. Encourage the development and use of programs and policies which benefit people with physical disabilities and/or which prevent physical disabilities.
3. Form committees for the consideration of policies and programs for people with physical disabilities.
4. Write letters and provide testimony regarding legislation, policies, programs and public portrayals which are of concern to people with disabilities.
5. Coordinate with other councils and agencies working to improve the lives of people with disabilities.
6. Research information concerning programs, funding, clients or services as they relate to persons with physical disabilities.
7. Represent people with disabilities on committees and workgroups.
8. Study and understand current state and federal funding for people with physical disabilities.
9. Capture state and federal funding to ensure public support of services for people with physical disabilities.

Priorities

The Council has identified four areas which are critical to people with physical disabilities:

- housing,
- long-term support,
- transportation, and
- emergency preparedness.

The Council is a relatively small group of volunteers who cannot possibly accomplish all that needs to be done, but can encourage others who are working to improve the lives of people with physical disabilities. Therefore, in the objectives which follow, these terms are used:

“Support.....” indicates the Council will provide testimony, letters and/or other expressions of agreement to funding sources, legislators, government staff, etc. to accomplish the objective.

“Collaborate.....” indicates the Council will take a leading role, work on an on-going basis with other people, or be represented on a group seeking to accomplish the objective.

Definitions and Acronyms

ADA = Americans with Disabilities Act

COP = Community Options Program

COP-W = Community Options Program - Medicaid Waiver

CIP II = Community Integration Program - Medicaid Waiver

DHFS = Department of Health and Family Services

OPPD = Office for Persons with Physical Disabilities

SILC = State Independent Living Council

Universal Design = market driven process intended to create environments that are usable and safe for all people.

Visitability or visit-ability = having at least one entrance with no steps, 32” clear passage through all main floor doors and hallways, and a usable bathroom on the main floor.

WCPD = Wisconsin Council on Physical Disabilities

Additional information can be found on the Council’s website: www.pdcouncil.state.wi.us.

Physical Disability

A physical disability means a physical condition, including an anatomical loss or musculo-skeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one of the following major life activities of a person: self-care; walking; mobility, other than walking; breathing; employment; performance of manual tasks unrelated to employment; receptive and expressive language; education; or capacity for independent living.

Housing

Housing Issues

A place to live, a place to call home is needed by everyone. For adults with disabilities who receive federal Supplemental Security Income (SSI) benefits — equal to a monthly income of \$512 in 2000 — this is particularly true. Because of their severe lack of income, people with disabilities are facing a housing crisis — a crisis which is getting worse.

In Priced Out in 2000: The Crisis Continues, a report of the Technical Assistance Collaborative, Inc. (TAC) and the Consortium for Citizens with Disabilities (CCD) Housing Task Force, key findings document that people with disabilities lost more “buying power” in the rental housing market between 1998 and 2000, and were the low-income group with the highest levels of unmet need for housing assistance. Priced Out in 2000 documents that:

- People with disabilities continued to be the poorest people in the nation. As a national average, SSI benefits in 2000 were equal to only 18.5% of the one-person median household income, and fell below 20% of the median income for the first time in over a decade.
- In 2000, people with disabilities receiving SSI benefits needed to pay — on the national average — 98% of their SSI benefits in order to be able to rent a modest one-bedroom unit at Fair Market Rent, published by the U.S. Department of Housing and Urban Development (HUD). (www.hud.gov)
- Cost of living adjustments to SSI benefit levels did not keep pace with the increasing cost of rental housing. Between 1998 and 2000, rental housing costs rose almost twice as much as the income of people with disabilities.
- In 2000, there was not one single housing market in the country where a person with a disability receiving SSI benefits could afford to rent a modest efficiency or one-bedroom unit.
- “Housing wage” data for the National Low-Income Housing Coalition (www.nlihc.org) shows that people with disabilities who received SSI benefits needed to triple their income to be able to afford a decent one-bedroom unit. On average, SSI benefits are equal to an hourly rate of \$3.23 — only one-third of the National Low-Income Housing Coalition’s housing wage and almost \$2 below the minimum wage.

The U.S. Supreme Court Olmstead v. L.C. decision affirmed that, under the Americans with Disabilities Act (ADA), people with disabilities have a basic civil right to live in the most integrated community-based setting appropriate to their needs. While the Olmstead case was not about affordable housing, providing affordable housing opportunities is important to any community-based integration plan. Without accessible housing and housing assistance, the vision of community-based integration cannot be achieved.

Other issues that have contributed to the housing crisis for people with disabilities include:

- the lack of a requirement for all single-family housing to be built with at least one accessible entrance, with a path of travel that would allow access to the first-floor and with an accessible bathroom on the first floor;
- the inability of public housing authorities to apply for and receive all of the Section 8 vouchers available to persons with disabilities;
- the blatant housing discrimination still practiced by owners and managers of subsidized housing; and
- the lack of a coherent and comprehensive federal and state housing policy to address the increasing need for housing among the lowest income people with disabilities — those living on SSI benefits.

Housing Goal 1: Increased accessibility by people with physical disabilities to/from all buildings in Wisconsin.

Objective 1.1: Collaborate with SILC and others to broaden direction of Wisconsin visitability legislation or code by 2007.

Objective 1.2: Support development and distribution of easy to understand information regarding requirements and recommendations for accessibility and/or visitability (including allergy and chemical considerations).

Housing Goal 2: Choice of integrated, community living for all people with physical disabilities.

Objective 2.1: Support using COP, COP-Waiver and CIP funding only in home or apartment-style housing which is integrated in the community and integrated by age, race and sex.

Objective 2.2: Support increased funding for programs to help people with disabilities obtain or remain in their own homes: Housing and Urban Development (HUD) Section 8, Weatherization, Low-Income Energy Assistance Program (LIHEAP), Community Aids, Community Options Program (COP), COP-Waiver and Community Integration Program (CIP).

Objective 2.3: Support provision of information and choices of universal design standards for all new and remodeled housing projects, both private residential and commercial properties.

Housing Goal 3: Choice of home ownership for people with physical disabilities.

Objective 3.1: Support creation of incentives to finance the housing needs of people with disabilities.

Long-Term Support

Long-Term Support Issues

Long-term support includes non-acute health, community living, employment supports, assistive technology services and supports, as well as other services and supports that enable individuals with disabilities of all ages to be independent and productive members of the community.

Wisconsin lacks a comprehensive and flexible long-term support benefit for all 72 counties. The Community Option Program (COP) services all client groups in need of long-term care and is entirely state-funded. The statutes also permit COP funds to be used with the flexibility to expand Medicaid waiver programs. The federal government grants waivers of Medicaid rules to permit states to provide long-term care at home to a population that qualifies for Medicaid coverage of nursing home care. The Community Options Program Waiver (COP-W) is limited to persons who are elderly and/or persons with a physical disability. COP-W also includes the Community Integration Program II (CIP II).

The current COP funding is an allocation to each county, and funding does not follow the person. Access to care varies from county to county. If people are on a waiting list and move, they will likely have to start at the bottom of the list in the new county of residence. As of 2000, almost as many people (2,668) with physical disabilities were on the COP waiting list as were enrolled in the program (3,452). The total waiting list for COP was 10,879. Due to stable caseloads, waiting times are particularly long for people with physical disabilities, over nine years in some counties.

In 2000, the introduction of Family Care (a comprehensive long-term care benefit) began in five counties. Family Care has served 700 people with physical disabilities and there are no waiting lists for services in these Family Care counties. Family Care serves individuals with disabilities who are over age 18. The long-term care system redesign for children with disabilities has not yet begun to provide services. Children with disabilities, when eligible, continue to receive services through the traditional COP, Family Support Program and the Katie Beckett Program.

There is an increasing need for mental health and alcohol and drug treatment services for people with physical disabilities of all ages. Family Care estimates that 25% of individuals with physical disabilities receiving services require access to mental health or alcohol and drug treatment services.

In the course of planning for the redesign of the long-term care system and again in the 2000-2001 WCPD survey, people with physical disabilities have identified the desire to be able to self-direct their personal care. Currently, Medical Assistance does not provide a self-directed care option for individuals requiring personal care. Individuals with physical and other disabilities are dependent on the home health care and personal care provider agencies to recruit, train and reimburse their personal care workers. The 2000-2001 WCPD Survey found many individuals complained that home health agencies or personal care provider agencies cannot find workers,

cannot find workers at the times they are required, and workers are not trained to meet their needs. Workers complain that they are not paid a living wage and do not have access to benefits such as health care and vacation.

Less than 1% of people receiving Social Security Disability Income (SSDI) and/or Supplemental Security Income (SSI) ever return to work. People with physical disabilities in Wisconsin, like individuals with disabilities in other states, have identified the loss of health and long-term care benefits as the single greatest fear about returning to work. In addition, people responding to the 2000-2001 WCPD Survey also identified lack of supports, poor health, can't find work in their field, lack of transportation, accessibility problems, low wages and lack of employable skills.

There are as many as 40 different funding sources providing programs and services that people with physical disabilities depend on for access to appropriate/affordable housing, transportation and health and long-term care. Each of these programs has different eligibility and cost-sharing requirements. These multiple programs often require individuals with disabilities to meet with multiple case managers, vocational specialists, housing providers, county income maintenance workers and others monthly. There is no one to help or advocate for individuals to determine the eligibility for programs and services.

There is no one to coordinate and/or advocate for individuals who are trying to understand the array of benefits or the effects of earned income if they choose to go to work. The 2000-2001 WCPD Survey of individuals with physical disabilities included these comments: need direction for younger families, constant fear of needed services not being covered by either private insurance or Katie Beckett, have decision makers visit homes before taking away services, flexible system to accommodate all, problems with preauthorization of medications, can't afford rehab, lack of resources for advocates, and social workers have too much power.

On the 2000-2001 WCPD Survey, individuals indicated a significant amount of stress in the life of the person with a physical disability and their family/caregiver. Pain, depression, feelings of isolation, segregation, loneliness, a difficult life, lack of recreation and limited activities, lack of role models for children with disabilities, difficulties with timely and proper diagnosis, marriage penalty problems, and a lack of acceptance were included in the comments. Respondents indicated problems with the services system that included: lack of staff to assist, high staff turnover, institutional bias, lack of dentists for disabled people, reductions and elimination of therapy, difficulty keeping equipment running, and services too far away.

Long-Term Support Goal 1: Access to accurate and current information, counseling on eligibility, assistance with application procedures, and advocacy for appeals for public and private benefit programs.

Objective 1.1: Support the statewide disability benefit special program with legal back-up for on-going training, technical assistance, and legal representation.

Long-Term Support Goal 2: Self-directed in all choices about services and supports needed with education provided regarding options available to consumers.

Objective 2.1: Collaborate with the Office for Persons with Physical Disabilities to create the self-directed personal-care pilot program identified in the Governor's budget by 2005.

Objective 2.2: Support adoption of a Medical Assistance fee-for-service, self-directed, personal-care benefit.

Long-Term Support Goal 3: No waiting lists for community services.

Objective 3.1: Support passage of the Medicaid Community Attendant Services and Supports Act (MICASSA) at the federal level.

Objective 3.2: Collaborate with other groups to obtain passage of an entitlement to community-based, long-term support services (e.g., Family Care) at the state level by 2010.

Long-Term Support Goal 4: Entitlement to a comprehensive care system that supports home and community living for people with physical disabilities.

Objective 4.1: Support improved incentives for providing dental services to people with physical disabilities.

Objective 4.2: By 2010, explore alternatives that maximize the individual's potential and replace rehabilitation services traditionally provided in an acute care setting.

Objective 4.3: Support changes in funding that increase access to occupational therapy, physical therapy and speech therapy services to people in their homes.

Objective 4.4: Collaborate with other groups to fully fund Family Care statewide by 2010.

Objective 4.5: Support awareness by the general public about strengths and needs of people with physical disabilities.

Long-Term Support Goal 5: Statewide respite care in homes and communities.

Long-Term Support Goal 6: Statewide access to and funding for assistive technology (services, devices, consumer training and maintenance) as needed for individuals of any age.

Objective 6.1: Support reauthorization of the federal assistive technology act (Title I, II and III).

Objective 6.2: Support training and technical assistance to county case managers for inclusion of assistive technology assessments in all long-term support plans.

Objective 6.3: Support funding for Medical Assistance fee-for-service coverage of

wheelchair lifts, bathroom modifications, elevators, ramps, vehicle modifications and driving aids (hand controls and “joy sticks”).

Objective 6.4: Support funding for consumer training, technical assistance and maintenance of equipment.

Objective 6.5: Support increased funding for housing modifications.

Long-Term Support Goal 7: Work incentives and training for realistic employment opportunities with living wages and health benefits.

Objective 7.1: Support improvements to the Medical Assistance Purchase Plan (MAPP) so more individuals with disabilities can secure or continue employment.

Objective 7.2: Support elimination of disincentives currently in long-term support eligibility and cost-sharing provisions.

Objective 7.3: Support funding for a statewide system of work incentive specialists with on-going legal back-up, training and technical assistance.

Objective 7.4: Support fully funding Vocational Rehabilitation Services (state rehabilitation counseling and client assistance program) so that Wisconsin captures all federally matchable funds.

Objective 7.5: Support passage of the U.S. Disabled Workers Empowerment Act (tax credits for disability-related work expenses).

Transportation

Transportation Issues

Access to transportation is key to the integration of people with disabilities in the community of their choice. The Rehabilitation Act (Section 504) and the Americans with Disabilities Act have required access to public transportation for more than 20 years. In urban areas, mainline buses are or are becoming accessible. Paratransit services offer individuals who cannot use mainline buses important transportation; however, the paratransit services do not offer comparable services. Paratransit services require advanced registration and fares can be higher.

In rural areas, transportation services for individuals who are elderly and/or disabled are usually only available Monday through Friday during the 8 AM to 5 PM business day. The specialized transportation services usually prioritize medical trips, trips for employment and trips for nutrition. This leaves individuals with disabilities limited opportunities to shop, attend religious services or participate in social activities in the evenings and on the weekends.

People with physical disabilities who require wheelchairs for mobility also require automobiles or vans that are specially modified and equipped to meet their driving needs. Some need only modifications to an automobile such as hand controls to operate the accelerator and brake. However, others require modifications to a van including dropping the floor, raising the roof, installing a wheelchair lift, modifying vehicle switches and modifying interiors. These modifications are done by after-market van conversion providers. There is limited financial assistance for the purchase of these modifications from State or county programs that provide long-term support services or vocational rehabilitation services.

Transportation Goal 1: Safe, reliable, cost effective and accessible transportation for people with physical disabilities.

Objective 1.1: Support additional rural transportation options for people with physical disabilities.

Objective 1.2: Support increased availability of affordable evening and weekend transportation (e.g., vouchers for people with physical disabilities).

Objective 1.3: Support safe and appropriate transportation for students to attend school and extra-curricular activities.

Objective 1.4: Support broadening utilization of existing transportation services by increased awareness of their availability.

Objective 1.5: Support existing and new initiatives for drivers and passengers to own or rent wheelchair accessible vehicles.

Objective 1.6: Support a one-stop clearinghouse to contact by persons with physical disability for transportation for any need (work, medical, recreational, shopping etc).

Objective 1.7: Support the concept and implementation of requiring background checks for drivers transporting people with disabilities of all ages.

Transportation Goal 2: Adequate parking for people with physical disabilities and public awareness of the need.

Objective 2.1: Support uniform and significant fines for disability parking violations.

Objective 2.2: Support public awareness of the need for disabled parking.

Transportation Goal 3: Decrease/eliminate the need for transportation (especially to and from work) by using technology.

Objective 3.1: Support development of and access to technologies that allow people to work at home (e.g., use of telecommuting to allow people to work at home).

Emergency Preparedness

Emergency Preparedness Issues

Recent disasters, including September 11th, have disproportionately harmed people with physical disabilities. Even simple emergencies like black-outs can be fatal to people who depend on electrical medical equipment.

Many evacuation plans do not consider special needs. Spending the night in an emergency shelter may not be a viable option for many people with physical disabilities. Emergency instructions to “stay inside at home” precludes personal care workers reaching people who require their assistance to get out of or to go to bed.

Emergency Preparedness Goal 1: The needs of people with physical disabilities are included in plans for emergencies and disasters.

Objective 1.1: Support inclusion of people with physical disabilities in the development of state plans for disasters and emergencies.

Objective 1.2: Support inclusion of emergency preparedness in IPE and COP plans.

Objective 1.3: Support emergency plans which recognize the individual needs of students with disabilities in all schools.

Objective 1.4: Support public awareness of the unique needs of people with disabilities in the event of an emergency or disaster.

Brief History of Policies and Legislation

The disability policy model before the 1970s legally sanctioned segregation and exclusion in separate schools and institutions without options for integration. Most families which included a member with a disability had only two choices: 1) struggle through alone without services, or 2) accept institutional placement. The burden of dealing with the consequences of disability rested on the person. Attempts were made to medically and vocationally rehabilitate, but society assumed no responsibility for removing barriers to equality.

Shift in attitudes, the growth of the disability rights movement and the identification of persons with disabilities as a minority group began to change this model. Now, many policies have been initiated on the federal and state levels to promote the independence, productivity and inclusion of persons with disabilities. The following are the most significant.

Civil Rights Act of 1964 prohibits discrimination in private employment, public accommodations, and programs/activities receiving federal funds. Title VII of this Act is also known as the Equal Employment Opportunity Act. Discrimination is prohibited on the basis of race, color, religion, national origin, and sex; however, discrimination on the basis of disability was not included in this legislation.

Wisconsin Fair Employment Act (WFEA) was passed in 1945. Wisconsin was one of the first three states to prohibit discrimination in employment. In 1965, disability was added as a protected class. This law is often seen as a national model and has a fairly comprehensive set of court interpretations. In 1982, language was specifically added which states that a basis for a discrimination complaint is the employer's refusal to "reasonable accommodate the employee's or prospective employee's disability unless the employer can demonstrate that an accommodation would pose a hardship on the employer's program, enterprise, or business." The WFEA also prohibits discrimination in the fringe benefits of employment.

Architectural Barriers Act of 1968 requires that buildings built or leased by the federal government, or buildings built with the assistance of federal government funds, must comply with accessibility standards.

1968 Fair Housing Act, also referred to as "Title VIII of the Civil Rights Act of 1968," prohibited discrimination in housing on the basis of race, color, religion and national origin; gender was added as a protected class in 1974.

Rehabilitation Act of 1973 went much further than the Civil Rights Act of 1964 and the Architectural Barriers Act of 1968. For the first time, people with disabilities were recognized as belonging to a class, regardless of which disability they have. Discrimination was recognized as a root cause of isolation, segregation and creating a second class citizenship. **Section 502** of the Rehabilitation Act of 1973 established the Architectural and Transportation Barriers Compliance Board to enforce the Architectural Barriers Act of 1968. **Section 503** requires all employers who have contracts in excess of \$2,500 with the federal government to use affirmative action when hiring and advancing persons with disabilities. **Section 504** prohibits discrimination against people with disabilities in any activity that receives federal funding for programs and

services, including transportation, hospitals, schools, and housing. The law also requires that the building in which the program or service is located must permit easy entrance for, and use by, people with disabilities. However, this law does not require major, fundamental, or substantial changes to programs that receive federal funding. **Technology-related assistance** for individuals with disabilities was addressed as a part of the 1988 amendments to the 1973 Rehabilitation Act. By passing these amendments, Congress recognized that proper technology can make certain tasks faster and easier to perform for all people, disabled or not. Among people with disabilities, provision for assistive technology enables some individuals to have greater control over their own lives, interact with greater effectiveness with their non-disabled peers, and to participate more fully at home, in school, at work and in their community.

Education for All Handicapped Children Act of 1975, renamed the Individuals With Disabilities Act (IDEA) mandates a free, appropriate public education for every child with a disability that affects learning ability in the least restrictive environment appropriate for the child.

Uniform Federal Accessibility Standards (UFAS) were adopted in 1984 to present uniform standards for the design, construction, and alterations of buildings so that persons with disabilities would have access to, and use of, buildings in accordance with the Architectural Barriers Act of 1968. To ensure compliance with the standards, Congress established the Architectural and Transportation Barriers Compliance Board (ATBCB) in **Section 502** of the Rehabilitation Act of 1973.

Voting Accessibility for the Elderly and Handicapped Act of 1984 improves access for elders and individuals with disabilities to registration facilities and polling places in federal elections. State and local election officials are responsible for implementing this Act's guidelines.

Air Carriers Access Act of 1986 prohibits discrimination against persons with disabilities in air travel by private airlines. This federal Act requires that new aircraft be designed for access by persons with disabilities including a larger accessible lavatory, onboard wheelchair to be used during flight, and aisle seats with movable armrests.

Handicapped Children's Protection Act of 1986 provides attorney's fees for lawyers representing children with disabilities in enforcement actions under IDEA, giving children with disabilities equal protection.

Federal Fair Housing (FFH) Law, also referred to as the Fair Housing Amendments Act, was enacted in March 1988. This Act made significant changes in the way the Fair Housing Act is enforced and administered. In addition, the Act added new types of discrimination prohibited under the Fair Housing Act. Any new multifamily building receiving a permit or permit extension after January 13, 1991, and having first occupancy after March 12, 1991, is required to comply with the accessibility guidelines developed by the U.S. Department of Housing and Urban Development. This Act prohibits discrimination against people with disabilities in selling and renting of public and private housing; requires landlords to permit tenants to make accessibility modifications at their own expense; and makes discriminatory zoning practices illegal.

Civil Rights Restoration Act of 1988 reinstated federal protections against discrimination on the grounds of race, sex, or physical disability to an institutional-wide basis. Any state or local government, university or educational system, private organization, or any other institution that receives federal funding must provide broad-based anti-discriminatory protections. This Act overturned a Supreme Court decision that limited the scope of coverage of Section 504 and other civil rights laws.

Americans with Disabilities Act (ADA), the world's first comprehensive civil rights law for people with disabilities, was signed by President Bush in front of 3,000 people on the White House lawn on July 26, 1990. The ADA established a clear and comprehensive prohibition of discrimination on the basis of disability. ADA bars discrimination in the areas of employment, public services, places of public accommodation, and telecommunications. Unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to indemnify such discrimination. What the ADA does, in essence, is: (1) to codify many regulatory concepts and guidelines from Section 504 and other predecessor laws, and (2) to extend the Section 504 prohibition against discrimination to the private sector. The net result is that persons with disabilities now enjoy a degree of anti-discrimination protection afforded others in today's society.

Civil Rights Act of 1991 amended the 1964 Act and overturned 1989 Supreme Court decisions that eroded the rights of people experiencing discrimination. This law allows people with disabilities who feel they have been discriminated against to request a jury trial and, in the private sector, to receive punitive damages.

Wisconsin Fair Housing Amendments Act was signed into law on April 30, 1992, and became effective on September 1, 1992. New protections under this Act added people with disabilities, familial status, and housing for elderly persons as protected classes in housing transactions. This law incorporates the federal standards to make housing accessible to persons with disabilities and increases penalties and damages awarded to victims of housing discrimination.

Demographics

The Numbers

According to the 2000 census, Wisconsin's population includes 338,728 people with a physical disability. Although this number seems large, it is most likely an under-representation of people with physical disabilities.

According to the 1990 census, the number of persons with physical disabilities in Wisconsin (ages 16 and over) include: 27,134 who use a wheelchair for mobility; 67,209 who have difficulty with self-care; 71,830 who use a cane, crutch or walker; and 140,237 who are unable to use stairs.

One category of physical disability — spinal cord injury — has been analyzed by the Wisconsin Department of Health and Family Services. The data shows that between January 1, 1990, and December 31, 1997, a total of 1,502 Wisconsin residents were hospitalized for a spinal cord injury.

- 74% of the injured individuals were male and 26% were female.
- Their ages ranged from 2 years old to 96 years old.
- 35% of the injuries occurred to people between the ages of 16 and 30.
- The average age at time of injury was 41.7 and the most frequent age at time of injury was 21.
- The leading cause was accidental falls (29%) while motor vehicle crashes caused 27% of the injuries.
- 50% occurred on the weekend and few occurred on Tuesday or Wednesday.
- The majority occurred in warmer months with July and September having high numbers and December the lowest number of occurrences.

Abuse

Studies have shown that people with disabilities are more likely to be victims of domestic violence (Sobsey, 1994) and are twice as likely to be sexually abused as their counterparts without disabilities (Young, Nosek, Howland, Chanpong and Rintala, 1997).

Long-Term Support Services

Community Option Program (COP) data from 2000 shows:

- 3,452 people with physical disabilities are being served by COP, COP-W or CIP II; while
- 2,668 people with physical disabilities are on waiting lists for those services.

Statute Creating the Council on Physical Disabilities

15.197 (4) COUNCIL ON PHYSICAL DISABILITIES

(a) *Definitions.* In this subsection:

1. “Major life activity” means any of the following:
 - a. Self-care.
 - b. Performance of manual tasks unrelated to gainful employment.
 - c. Walking.
 - d. Receptive and expressive language.
 - e. Breathing.
 - f. Working.
 - g. Participating in educational programs.
 - h. Mobility, other than walking.
 - i. Capacity for independent living.
2. “Physical disability” means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person.
3. “Physically disabled person” means an individual having a physical disability.

(b) *Creation and membership.* There is created a council on physical disabilities, attached to the department of health and family services under s. 15.03. The council shall consist of all of the following:

1. The governor, or his or her designee.
3. Thirteen members, appointed for 3-year terms, under the following criteria:
 - a. The members shall be appointed from residents of this state who have a demonstrated professional or personal interest in problems of physical disability and shall be selected so as to include a reasonably equitable representation of those communities located in the state’s urban and rural areas and with regard to sex and race.
 - b. At least 6 members shall be physically disabled persons. Two members may be parents, guardians or relatives of physically disabled persons.
 - c. At least one member shall be a provider of services to physically disabled persons.

(c) The Council has the functions specified in s. 46.29.

(4) COUNCIL ON PHYSICAL DISABILITIES. (a) *Definitions.* In this subsection:

1. "Major life activity" means any of the following:
 - a. Self-care.
 - b. Performance of manual tasks unrelated to gainful employment.
 - c. Walking.
 - d. Receptive and expressive language.
 - e. Breathing.
 - f. Working.
 - g. Participating in educational programs.
 - h. Mobility, other than walking.
 - i. Capacity for independent living.

2. "Physical disability" means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person.

3. "Physically disabled person" means an individual having a physical disability.

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 - b. At least 6 members shall be physically disabled persons. Two members may be parents, guardians or relatives of physically disabled persons.
 - c. At least one member shall be a provider of services to physically disabled persons.
- (c) The council has the functions specified in s. 46.29.

entity represented:

a. The entity in this state that is designated by the federal department of health and human services as a university center for excellence in developmental disabilities education, research, and services.

b. The state protection and advocacy system under s. 51.62, designated by the director of the state protection and advocacy agency under s. 51.62 (2).

c. Each of the local governmental agencies, nongovernmental agencies, and private nonprofit groups that are concerned with services for individuals with developmental disabilities.

(bm) A member specified in par. (am) 1. or 3. shall recuse himself or herself from any discussion by the council of grants or contracts for which the member's department, agency, program, or group is a grantee, contractor, or applicant and may not vote on a matter that would provide direct financial benefit to the member or otherwise give the appearance of a conflict of interest.

(cm) 1. At least 60% of the membership of the council shall be individuals specified under par. (am) 2. who are not managing employees, as defined under 42 USC 1320a-5 (b), of an entity, or employees of a state agency, that receives federal funds for the developmentally disabled or uses the funds to provide services to persons with developmental disabilities. Of those individuals, one-third shall be individuals specified under par. (am) 2. a., one-third shall be individuals specified under par. (am) 2. b. or c., and one-third shall be individuals specified under par. (am) 2. a., b., or c.

2. At least one of the individuals described under subd. 1. shall be an individual with a developmental disability who resides in or previously resided in an institution, including a state center for the developmentally disabled, or the immediate relative or guardian of such an individual. The requirement under this subdivision does not apply if such an individual does not reside in this state.

(12) COUNCIL ON BIRTH DEFECT PREVENTION AND SURVEILLANCE. There is created in the department of health and family services a council on birth defect prevention and surveillance. The council shall consist of the following members appointed for a 4-year term by the secretary of health and family services:

- (a) A representative of the University of Wisconsin Medical School who has technical expertise in birth defects epidemiology.

OLMSTEAD V. L. C. (98-536) 527 U.S. 581 (1999)
138 F.3d 893, affirmed in part, vacated in part, and remanded.

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U.S. 321, 337.

SUPREME COURT OF THE UNITED STATES

**OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES,
et al. v. L. C., by Zimring, guardian ad litem and next friend, et al.**

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

No. 98—536. Argued April 21, 1999—Decided June 22, 1999

In the Americans with Disabilities Act of 1990 (ADA), Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. 42 U.S.C. § 12101(a)(2), (5). Title II of the ADA, which proscribes discrimination in the provision of public services, specifies, *inter alia*, that no qualified individual with a disability shall, “by reason of such disability,” be excluded from participation in, or be denied the benefits of, a public entity’s services, programs, or activities. §12132. Congress instructed the Attorney General to issue regulations implementing Title II’s discrimination proscription. See §12134(a). One such regulation, known as the “integration regulation,” requires a “public entity [to] administer ... programs ... in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 CFR § 35.130(d). A further prescription, here called the “reasonable-modifications regulation,” requires public entities to “make reasonable modifications” to avoid “discrimination on the basis of disability,” but does not require measures that would “fundamentally alter” the nature of the entity’s programs. §35.130(b)(7).

Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women were voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where they were confined for treatment in a psychiatric unit. Although their treatment professionals eventually concluded that each of the women could be cared for appropriately in a community-based program, the women remained institutionalized at GRH. Seeking placement in community care, L. C. filed this suit against petitioner state officials (collectively, the State) under 42 U.S.C. § 1983 and Title II. She alleged that the State violated Title II in failing to place her in a community-based program once her treating professionals determined that such placement was appropriate. E. W. intervened, stating an identical claim. The District Court granted partial summary judgment for the women, ordering their placement in an appropriate community-based treatment program. The court rejected the

State’s argument that inadequate funding, not discrimination against L. C. and E. W. “by reason of [their] disabilit[ies],” accounted for their retention at GRH. Under Title II, the court concluded, unnecessary institutional segregation constitutes discrimination *per se*, which cannot be justified by a lack of funding. The court also rejected the State’s defense that requiring immediate transfers in such cases would “fundamentally alter” the State’s programs. The Eleventh Circuit affirmed the District Court’s judgment, but remanded for reassessment of the State’s cost-based defense. The District Court had left virtually no room for such a defense. The appeals court read the statute and regulations to allow the defense, but only in tightly limited circumstances. Accordingly, the Eleventh Circuit instructed the District Court to consider, as a key factor, whether the additional cost for treatment of L. C. and E. W. in community-based care would be unreasonable given the demands of the State’s mental health budget.

Held: The judgment is affirmed in part and vacated in part, and the case is remanded. 138 F.3d 893, affirmed in part, vacated in part, and remanded.

Justice Ginsburg delivered the opinion of the Court with respect to Parts I, II, and III—A, concluding that, under Title II of the ADA, States are required to place persons with mental disabilities in community settings rather than in institutions when the State’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Pp. 11—18.

(a) The integration and reasonable-modifications regulations issued by the Attorney General rest on two key determinations: (1) Unjustified placement or retention of persons in institutions severely limits their exposure to the outside community, and therefore constitutes a form of discrimination based on disability prohibited by Title II, and (2) qualifying their obligation to avoid unjustified isolation of individuals with disabilities, States can resist modifications that would fundamentally alter the nature of their services and programs. The Eleventh Circuit essentially upheld the Attorney General’s construction of the ADA. This Court affirms the Court of Appeals decision in substantial part. Pp. 11—12.

(b) Undue institutionalization qualifies as discrimination “by reason of . . . disability.” The Department of Justice has consistently advocated that it does. Because the Department is the agency directed by Congress to issue Title II regulations, its views warrant respect. This Court need not inquire whether the degree of deference described in *Chevron U.S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844, is in order; the well-reasoned views of the agencies implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. *E.g.*, *Bragdon v. Abbott*, 524 U.S. 624, 642. According to the State, L. C. and E. W. encountered no discrimination “by reason of” their disabilities because they were not denied community placement on account of those disabilities, nor were they subjected to “discrimination,” for they identified no comparison class of similarly situated individuals given preferential treatment. In rejecting these positions, the Court recognizes that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA. The ADA stepped up earlier efforts in the Developmentally Disabled Assistance and Bill of Rights Act and the Rehabilitation Act of 1973 to secure opportunities for

people with developmental disabilities to enjoy the benefits of community living. The ADA both requires all public entities to refrain from discrimination, see §12132, and specifically identifies unjustified “segregation” of persons with disabilities as a “for[m] of discrimination,” see §§12101(a)(2), 12101(a)(5). The identification of unjustified segregation as discrimination reflects two evident judgments: Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, cf., e.g., *Allen v. Wright*, 468 U.S. 737, 755; and institutional confinement severely diminishes individuals’ everyday life activities. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. The State correctly uses the past tense to frame its argument that, despite Congress’ ADA findings, the Medicaid statute “reflected” a congressional policy preference for institutional treatment over treatment in the community. Since 1981, Medicaid has in fact provided funding for state-run home and community-based care through a waiver program. This Court emphasizes that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. In this case, however, it is not genuinely disputed that L. C. and E. W. are individuals “qualified” for noninstitutional care: The State’s own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. Pp. 12—18.

Justice Ginsburg, joined by Justice O’Connor, Justice Souter, and Justice Breyer, concluded in Part III—B that the State’s responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of “reasonable modifications” to avoid discrimination, and allows States to resist modifications that entail a “fundamenta[l] alter[ation]” of the States’ services and programs. If, as the Eleventh Circuit indicated, the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State’s entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. 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 ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA’s mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State proposed, then retracted, for E. W. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time to stabilize acute psychiatric symptoms. For others, no placement outside the institution may ever be appropriate. To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list

that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions. The case is remanded for further consideration of the appropriate relief, given the range of the State's facilities for the care of persons with diverse mental disabilities, and its obligation to administer services with an even hand. Pp. 18—22.

Justice Stevens would affirm the judgment of the Court of Appeals, but because there are not five votes for that disposition, joined Justice Ginsburg's judgment and Parts I, II, and III—A of her opinion. Pp. 1—2.

Justice Kennedy concluded that the case must be remanded for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U.S.C. § 12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed. On the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. Thus, respondents could demonstrate discrimination by showing 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). This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. Thus far, respondents have identified no class of similarly situated individuals, let alone shown them to have been given preferential treatment. Without additional information, the Court cannot address the issue in the way the statute demands. As a consequence, the partial summary judgment granted respondents ought not to be sustained. In addition, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. 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. The lower courts should determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested. Pp. 1—10.

Ginsburg, J., announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III—A, in which Stevens, O'Connor, Souter, and Breyer, JJ., joined, and an opinion with respect to Part III—B, in which O'Connor, Souter, and Breyer, JJ., joined. Stevens, J., filed an opinion concurring in part and concurring in the judgment. Kennedy, J., filed an opinion concurring in the judgment, in which Breyer, J., joined as to Part I. Thomas, J., filed a dissenting opinion, in which Rehnquist, C. J., and Scalia, J., joined.