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Mental Disability Law at a Glance

The past year held the promise of being a landmark for the rights of people with mental disabilities. Drafters of health care reform legislation were impressed with arguments for nondiscriminatory coverage of mental health care and substance-abuse treatment; the children's SSI program was reaching more low-income families than advocates had expected; and the courts were receptive to claims of people with mental disabilities under the Americans with Disabilities Act (ADA).

Ultimately, however, although progress was made on some fronts, the results of the year's advocacy overall are sobering.

- Although major gains in mental health coverage for low-income children and adults with mental health needs were made, the comprehensive health care reform effort collapsed.

- Congress enacted punitive disability benefits legislation affecting people with substance-abuse problems and entertained proposals to curtail or eliminate the children's SSI program.

- Plaintiffs made gains in litigation under the Fair Housing Act and the ADA and through systems-change cases.

In 1995, low-income adults and children with mental disabilities will face further attempts at retrenchment. Among the most likely are efforts to cut Medicaid and Medicare in the name of deficit reduction, to replace children's SSI with service vouchers, to limit the fair housing rights of people with disabilities, and to exclude children with disabilities from schools. At the same time, however, new opportunities to bring adults and children with mental health problems into mainstream health care coverage are likely.

Mental Disability Law in 1994

By the Judge David L. Bazelon Center for Mental Health Law

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I. Health Care Reform

Despite Congress' failure to enact federal health care reform legislation, the effort transformed the discussion of national mental health policy and may yield benefits in years to come. Encouraged by data on the cost effectiveness of a range of community-based services for both children and adults -- many funded by Medicaid /1/ -- the Clinton Administration proposed to cover services well beyond hospitalization, psychotherapy, and medication management. The new coverage was to include intensive community-based services such as psychiatric rehabilitation, day treatment programs, intensive in-home services for children, behavioral aide services, crisis residential programs, therapeutic foster care, and therapeutic group homes.

These services are especially important for low-income individuals and families, who seek access to rehabilitative services that focus on recovery and improving functioning in the community. Historically, these approaches have been available only through the underfunded public mental health care and substance-abuse treatment systems. Making them an integral part of the health care system for all Americans would have been a major achievement.

Although the Clinton plan, as finally introduced in November 1993, added convoluted limits and tradeoffs to the benefit package, /2/ congressional committees were able to restructure the limits and create a mental health and substance-abuse benefit that was both broad in the array of services covered and deep in providing coverage without severe limits.

Another innovation in Congress was the development of proposals for states to merge public money (Medicaid, state and local general revenue, and other federal funds) with resources generated from health care premiums to create a fully comprehensive benefit with no arbitrary limits at all, at least for high-priority populations of adults and children with serious disorders who have low incomes. /3/

By the summer of 1994, the movement for comprehensive reform had stalled. But even the insurance reform bills discussed at the end of the session directed a proposed benefit-setting board to give priority to granting "parity" for mental health and substance abuse, defined in the two leading pieces of reform legislation (Senator George Mitchell's /4/ bill and the "mainstream" bill) as having no limits on benefits and no cost-sharing requirements different from those imposed on other health care. The Mitchell bill also mandated "coverage of all medically necessary or appropriate mental illness and substance-abuse services in inpatient, outpatient, residential and

intensive non-residential settings." The only exceptions to parity were for inpatient hospital care (which could be limited to 30 days a year) and psychotherapy (for which there could be a 50 percent copayment).

Thus, for the first time, the needs of individuals with mental illness and substance abuse were given equal weight with other health care needs in a major national health policy debate. The important gains made in the process of this debate will surely have an impact on future federal health policy discussion; they can also be adapted in state advocacy efforts.

II. Social Security Disability and SSI Benefits

A. Benefit Cuts for People with Substance Addictions

The Social Security Independence and Program Improvements Act of 1994, /5/ which had as its main purpose conversion of the Social Security Administration (SSA) into an independent agency, also restricts payments of SSI and disability insurance (DI) benefits to people classified as substance abusers. /6/ This provision was a product of unproven but politically potent allegations of fraud and abuse. It whipped through Congress; little consideration was given to the potential impact of the provision on people struggling with substance addictions, particularly those who also have psychiatric disabilities. /7/ The Senate never even held hearings.

1. Time Limit on SSI and DI Benefits

Under the Act, if alcoholism or drug addiction is a "contributing factor material to the individual's disability," /8/ benefits end after 36 months. /9/ The new time limit applies to both SSI recipients and DI beneficiaries but is computed differently for each group.

For DI beneficiaries, the 36-month limit begins in the month after SSA notifies the individual that appropriate treatment is available. Months in which treatment is not available or benefits are suspended are not charged against the limit. SSA will notify DI beneficiaries whose drug addiction or alcoholism it claims is a contributing factor material to their disability of the new benefit limitation. The beneficiary may appeal that decision.

For SSI recipients, the 36-month period begins "with the first month for which such benefits . . . are payable. . . ." /10/ whether or not treatment is available. This generally means the month of application, not the date when benefits are first received, so new beneficiaries will have fewer than three years of benefits. Each current recipient classified as a drug addict or alcoholic will be notified of the 36-month limit on their benefits, but SSA does not believe the reclassification notice is appealable. /11/

Advocates have urged SSA to treat concurrent beneficiaries under the more liberal DI rules, but, as of this writing, SSA had made no decision. /12/

Implementation of these amendments will have devastating consequences for the many people with psychiatric or other disabilities who also have substance-abuse problems. The likely result of the amendments is that advocates will make extra efforts to establish that claimants have a disabling condition independent of a substance-abuse problem.

2. Continuation of Health Benefits

Medicaid benefits for SSI recipients and Medicare benefits for DI beneficiaries continue during any period of benefit suspension and beyond the 36-month period so long as the individual continues to be disabled. /13/

3. Treatment Requirements and Benefit Suspensions

The legislation also calls for more rigorous implementation of the existing rule requiring people who receive benefits on the basis of a substance-addiction disorder to participate in a treatment program. SSA must define "appropriate treatment program," /14/ establish guidelines to evaluate compliance with a treatment program, and follow new standards in determining when to reinstate and when to terminate benefits after suspension for failing to comply with treatment.

Suspension is required when the recipient fails to undergo or comply with appropriate substance-abuse treatment. /15/ To qualify for reinstatement after suspension, a recipient must demonstrate compliance with treatment for two months after the first suspension, for three months after the second suspension, and for six months after the third suspension. Benefits will be terminated when the individual has been suspended for 12 consecutive months.

Individuals whose benefits are terminated may reapply if they have not exhausted their 36 months of eligibility or if they claim a disabling condition other than drug addiction or alcoholism. /16/

To help implement the new treatment regulations, the Act requires SSA to establish a referral and monitoring agency for each state. Each such agency would identify appropriate treatment programs for SSI and DI beneficiaries, refer them for treatment, monitor compliance, and report failures to SSA. /17/

4. Representative Payees

The Act extends requirements for representative payees to DI beneficiaries with substance-abuse problems. /18/ In designating representative payees, SSA must give preference to community-based, nonprofit social services agencies. The Act also increases the fees that organizational representative payees can charge to 10 percent of the monthly benefit or $50, whichever is less.

5. Other Provisions

The Act requires SSA to prorate retroactive lump-sum benefits to SSI and DI beneficiaries with substance-abuse problems and to pay monthly an amount no greater than 200 percent of the normal benefit amount. /19/ It also codifies Social Security Ruling 94-1c counting earnings derived from illegal activities. /20/ Finally, dependents of DI beneficiaries will continue to receive dependent benefits and Medicare (if eligible) as long as the worker on whose record benefits are paid continues to be disabled, whether the worker has been suspended from benefits or terminated as a result of the 36-month limit. /21/

B. Children's SSI

The number of children receiving SSI disability benefits has more than doubled in the last four years /22/ to more than 780,000. /23/ The largest single group of children under 18 receiving SSI are children diagnosed with mental impairment (55 percent), of whom two-thirds have mental retardation. Approximately two-thirds of the recipients receive the maximum federal benefit of $446. /24/

Even when claims for benefits are denied, many children's SSI cases are won on appeal. /25/ By encouraging and assisting in appeals, legal services advocates can play an especially important role in helping families obtain these important benefits. /26/ Medical personnel are usually unfamiliar with SSA's listed impairment criteria, and families are often unaware of the activities SSA considers as part of a child's individualized functional assessment. As a result, many denials are based on inadequate or incomplete documentation. Providing the appropriate information to doctors and parents can greatly increase the likelihood of accurate decisions by the disability examiners.

Advocates should not wait until a hearing is requested to get involved. Advocacy at the reconsideration level, often requiring only additional documentation and a memorandum summarizing the evidence and issues, has proved very successful in children's cases. This can save families many additional months of financial hardship and personal frustration. /27/

The dramatic growth of the children's SSI program has attracted intense scrutiny. Criticism has taken the form of anonymous stories about families who "coach" their children to fake disabilities by telling them to do poorly on tests or "act crazy" in school. Most allegations involve children with mental or emotional disorders.

In response, the General Accounting Office (GAO) and SSA's Office of Disability investigated new awards. GAO found that 70 percent of all awards went to children whose impairments were severe enough to qualify on the basis of SSA's medical standards (listings) without the need for a functional assessment. /28/ In a separate report, SSA's Office of Disability found no evidence of widespread coaching or "malingering" and that, in general, the rules and guidelines were being applied appropriately and correct decisions were reached in all but 8.6 percent of the allowances. /29/

As a result of the allegations, however, Congress added two provisions to the Act. The Secretary of HHS is directed to appoint a Commission on the Evaluation of Disability in Children to study the effects of the current definition of disability, its appropriateness, and the advantages and

disadvantages of using alternative definitions to determine SSI eligibility. /30/ The commission will examine, inter alia, whether families can meet the high medical care costs for their children with serious impairments through expanded federal health assistance programs; the feasibility of providing benefits through noncash means, including vouchers, debit cards, and electronic transfers; whether SSA can involve private organizations to increase social services, education, and vocational instruction to promote independence; and alternative ways to provide retroactive SSI benefits, including conservation of some portion to promote a child's long-term well-being. The study is due to Congress by November 30, 1995.

The Act also requires SSA to redetermine a child SSI recipient's eligibility, under adult criteria, upon the recipient's 18th birthday. /31/ The provision expires on October 1, 1998, when a report is due to Congress.

C. Plans for Achieving Self-Support

The Act also requires SSA to promulgate regulations establishing guidelines for criteria that consider the length of time individuals need to achieve their employment goals through a Plan for Achieving Self-Support (PASS). /32/ The conferees requested that GAO study various aspects of the PASS program, including the extent to which individuals have become economically independent and whether improvements should be made.

III. Amendments to the Individuals with Disabilities Education Act

In approving legislation to reauthorize programs under the Elementary and Secondary Education Act, Congress also amended the Individuals with Disabilities Education Act (IDEA) /33/ to allow students with disabilities to be moved to alternative education placements without a hearing. The issue arose in the context of school violence -- in particular, how to handle students with disabilities who bring guns to school -- in part because of the Supreme Court's 1988 decision in Honig v. Doe /34/ requiring that students with disabilities remain (or "stay put") in the current educational setting unless the parents agree to a change or unless a hearing is held. The stay-put provision is widely perceived by teachers and administrators as a barrier to action against students with disabilities who break school rules. However, schools have the authority to seek the aid of a court to remove a child immediately when circumstances warrant. In fact, such hearings have often occurred within minutes of the precipitating incident.

The legislation amending the IDEA allows students with disabilities who bring guns to school to be moved to alternative educational placements determined by the child's Individualized Education Plan team for up to 45 days without a hearing. /35/ If the child's parent or guardian requests a due process hearing, the child must remain in the alternative education setting during the pendancy of those proceedings, unless the parents and the local educational agency agree otherwise. /36/

The final compromise leaves most of the IDEA intact. It also directs the Secretary of Education to disseminate widely any current policy on the stay-put provision and to gather data by January 1995 on the incidence of students with disabilities engaging in life-threatening behavior or bringing

weapons to school. The amendment sunsets on the date of enactment of reauthorization of the IDEA, scheduled to occur next year.

IV. Civil Rights

A. Americans with Disabilities Act

1. Employment

On July 26, 1994, the Americans with Disabilities Act (ADA) /37/ became applicable to employers with 15 or more employees. Courts have begun to interpret some of the key terms used in the ADA and to clarify who may be regarded as a person with a disability and the definitions of "major life activities" and "essential job functions." /38/ Psychiatric disorders and their accompanying limitations have been recognized as disabilities, /39/ but courts have varied in their interpretation of the "regarded as" prong of the definition of qualified individual. Some require plaintiffs who claim that they are regarded as having a disability to establish that they have a substantial impairment. /40/

At least two courts have questioned whether someone who takes medication and functions effectively can be classified as an "individual with a disability," despite EEOC's position that such individuals are covered under the ADA. /41/

Attendance has been found an essential function of a job, so that employers are not required to accommodate absenteeism on the basis of disability. /42/ Other courts have held that handling a minimum number of phone calls is essential for a customer service representative /43/ and that a waitress must be able to communicate information about menu changes to customers. /44/

"Undue burden" has also been scrutinized. One court refused to dismiss an ADA claim because the employer had failed to establish that it would be an undue burden to allow an employee to use his vacation days for medical absences. /45/

EEOC, which is responsible for enforcing the private employment provisions of the ADA, issued enforcement guidance entitled "Preemployment Disability-Related Inquiries and Medical Examinations Under the Americans with Disabilities Act of 1990." /46/ EEOC takes the position that employers may not ask applicants whether they require reasonable accommodations to perform the job because such questions are tantamount to asking about disability.

2. Public Services

The Justice Department has vigorously interpreted Title II of the ADA, which prohibits discrimination by state and local governments, particularly its regulation that public entities "administer services, programs, and activities in the most integrated setting appropriate to the needs" of persons with disabilities. /47/ It filed an amicus brief detailing its interpretation of the integration mandate /48/ in a case involving Pennsylvania's failure to provide community-based

attendant care services to a woman with physical disabilities because she remained on a waiting list, thereby forcing her to reside in a nursing home. The Department argues that the ADA mandates an end to the segregation of persons with disabilities and requires that plaintiff be served by the existing attendant care program in the community.

In ADA cases the Department of Justice has also filed briefs arguing that questions about mental health treatment in professional licensing applications violate the ADA. Its view was adopted in a medical licensing case; /49/ more recently, in cases against the Florida and Virginia bar examiners the Department filed amicus briefs challenging mental health inquiries. /50/

Courts have begun to address challenges to the exclusion of persons with mental disabilities, or a subgroup of such persons, from public programs. Unfortunately, the Third Circuit, reversing the district court, recently ruled that Pennsylvania's policy of excluding persons who are not "mentally alert" from services under the state's attendant care services program did not violate the ADA. It held that the ability to supervise and control the attendant was essential to the operation of the program. /51/ A state court in Washington, however, held that the state's refusal to provide personal care services to persons with psychiatric disabilities, although persons with physical disabilities received the service, violated the ADA. /52/ In Florida, a federal district court enjoined the City of West Palm Beach from implementing budget cuts that would have eliminated recreational programs for adults and children with disabilities, effectively denying the plaintiffs the benefits of the city's leisure services programs. /53/

Finally, courts have wrestled with the question of whether the ADA prohibits government from denying people with more severe disabilities participation in community-based programs. /54/

The ADA is also beginning to have an impact on the small but significant denials and indignities that affect the everyday lives of people with mental disabilities. One court directed that a local agency providing community services for persons with mental disabilities must change its early morning board meetings to a later hour to make the meetings accessible to persons who take medications that make it difficult to attend early meetings. /55/ Another court ruled that mental health counselors aided by interpreters do not provide services to persons with deafness equivalent to those otherwise provided to the public by the state department of health and rehabilitative services. /56/ The state was ordered to make mental health counselors with sign-language ability available. Finally, a district court in Kansas denied summary judgment to a city because the city had not established that it conducted an adequate evaluation of the accessibility of its programs. /57/

B. The Fair Housing Act

1. HUD Occupancy Task Force

On April 7, 1994, the HUD Occupancy Task Force delivered its final report and recommendations to HUD and to Congress /58/ for bringing consistency to HUD's program and civil rights regulations. The report also suggested ways in which public and assisted-housing providers can fulfill their programmatic and civil rights responsibilities simultaneously. For example, the task

force recommended that, before housing providers reject applicants with disabilities who do not meet admission requirements, the provider should ask whether the applicant would qualify for admission if a reasonable accommodation were made available to the applicant. HUD will rely on the task force to issue, in early 1995, revised regulations for public and assisted housing.

2. Housing for the Elderly and for People with Disabilities

HUD issued regulations establishing mechanisms for public housing authorities and subsidized private housing providers to create "elderly-only" and "disabled-only" housing. /59/ The public housing regulations require public participation in the development of "designation plans" and include measures aimed at requiring public housing authorities to address the housing needs of those whose apartments will be designated "elderly-only." The assisted-housing rules include no such provisions and give housing providers nearly unreviewable discretion to decide whether they will discontinue housing nonelderly people with disabilities.

3. Fair Housing Enforcement and the First Amendment

On September 2, 1994, following controversy concerning the First Amendment implications of some of its investigations, HUD's Office of Fair Housing and Equal Opportunity issued guidelines that describe how HUD will address fair housing complaints that might run afoul of the First Amendment. /60/ The controversy erupted when HUD inappropriately sought membership lists from organizations opposing housing for people with disabilities and expanded its investigation to focus on forms of harassment of people with disabilities. The controversy led HUD to place greater restrictions on its investigations than the First Amendment requires, for example, restricting investigations of harassment to instances where there are allegations of force or physical harm or of the threat of force or physical harm.

4. Land-Use Cases Under the Fair Housing Act

The body of Fair Housing Act law applicable to people with disabilities continues to grow and, with it, the breadth of issues that the courts consider. The Third Circuit extended the Fair Housing Act requirement that municipalities "reasonably accommodate" residences for people with disabilities to a 48-unit, single-room-occupancy apartment building. /61/ The city had refused to waive a rear-yard requirement, in spite of a large side yard, that was required by the zoning code for a building to be converted from commercial to residential use. The court found that the Fair Housing Act imposed an obligation to make reasonable accommodations for the proposed tenants with mental disabilities and addiction histories by not enforcing the rear-yard requirement.

The Ninth Circuit reversed a district court decision that had held that the Fair Housing Act permitted municipalities to impose limits on the number of unrelated people with disabilities who could live together in a residential neighborhood. /62/ In so ruling, the Ninth Circuit rejected the opposite conclusion of the Eleventh Circuit in a similar case. /63/ The court held that the Fair Housing Act gave municipalities discretion to establish occupancy standards that furthered public-

health standards for everyone by dictating the minimum number of square feet in the unit or the sleeping unit. On October 31, 1994, the Supreme Court granted the City of Edmonds's petition for certiorari. Since the state had invalidated the city's occupancy ordinance while the appeal was pending, Supreme Court watchers were surprised. The case will be the first involving community residences to be heard by the Court since City of Cleburne v. Cleburne Living Center, /64/ and it is likely to have a significant impact on group home litigation for at least the next decade.

V. Systems Reform Litigation

Decisions in institutional reform litigation cases in the early 1980s left the courts' role in compelling state and local governments to develop alternatives to institutions in considerable doubt. Yet litigation has continued to create opportunities for people with mental disabilities to gain access to services in communities. In the past year, advocates have secured several sweeping consent decrees to obtain community-based services for their clients. Coffelt v. Department of Developmental Disabilities /65/ requires the development of quality community-living arrangements for 2,000 people with mental retardation living in four institutions and 300 people inadequately housed in the community in northern California. The consent decree in Joan S. v. Gudeman /66/ requires development of 500 new community support program slots for a class including individuals discharged from a psychiatric hospital without housing and follow-up services. Plaintiffs include persons who have been living in long-term psychiatric units for lack of community-based programs and people who have developmental disabilities who spend long periods of time on acute psychiatric units.

Further, the Department of Justice revived its role in litigation under the Civil Rights of Institutionalized Persons Act. /67/ During the past decade, the Department refused to argue for placement in high-quality community services as a remedy for violations of the rights of institutionalized people; indeed, it filed briefs opposing that view. In the past year, the Department reversed its position. For example, in reentering Wyatt v. King /68/ as amicus curiae, /69/ the Department advised the court that it sought to raise the issues of "the benefits of community placement as well as the harm that has resulted to class members from Alabama's continuing failure to fully integrate class members in community facilities and programs." /70/

Meanwhile, courts continue vigorous oversight of two long-standing benchmark cases. In Halderman v. Pennhurst School and Hospital, /71/ a special master was appointed by the court to assure compliance with obligations to develop habilitation plans for class members and see to their implementation. And in Dixon v. Kelly /72/ the special master was renewed for a second year to put into place mental health services essential to the operation of the District of Columbia's mental health system.

Footnotes

/1/ Bazelon Center for Mental Health Law, Making Medicaid Work to Fund Intensive Community Services for Children with Serious Emotional Disturbance (1994).

/2/ For an analysis of the Clinton plan's mental health benefits, see Bazelon Center for Mental Health Law, Limited Access (1993).

/3/ See, e.g., Health Security Act, H.R. 3600, 103d Cong., 2d Sess. (1994); H.R. Rep. No. 601, pts. 1 -- 2, 103d Cong., 2d Sess. (1994); S. Rep. No. 317, 103d Cong., 2d Sess. (1994). Similar language was included in the House Democratic leadership amendments offered by Representative Richard Gephardt and in the Senate leadership bill, S. 2351.

/4/ S. 2351, 103d Cong. 2d Sess. (1994).

/5/ Social Security Independence and Program Improvements Act of 1994, Pub. L. No. 103-296, 108 Stat. 1464 (1994).

/6/ The new provisions take effect on February 10, 1995, 180 days after enactment. The provision sunsets on September 30, 2004. Pub. L. No. 103-296, Secs. 201(a)(3)(C), (b)(3)(C).

/7/ In August 1994, the Social Security Administration (SSA) counted 72,962 SSI recipients with a drug addiction and/or alcoholism (DA&A) indicator, about 2.5 percent of the total SSI disabled rolls. Another 30,641 disability insurance beneficiaries were identified with a primary DA&A impairment. An additional 18,984 were identified as concurrent beneficiaries (SSI recipients also receiving disability benefits) with a DA&A indicator. The three categories totaled 122,587 individuals. Office of Disability, SSA, MBR Extract and Title XVI DA/A Files (Aug. 1994).

/8/ The statute utilizes the standard for medically determined drug addicts and alcoholics currently applied for SSI beneficiaries, found in 20 C.F.R. Sec. 416.935. Section 416.936 states that SSI recipients determined by SSA to be drug addicts or alcoholics must take appropriate treatment at an approved institution or facility, "when this treatment is available. They are not expected to pay for this treatment."

/9/ Pub. L. No. 103-296, Secs. 201(a)(3)(F), (b)(3)(A).

/10/ Id. Sec. 201(b)(3)(A).

/11/ Discussion with staff at SSA.

/12/ Id.

/13/ Pub. L. No. 103-296, Secs. 201(a)(3)(D), (b)(3)(D).

/14/ This could prove difficult. The conference report advises SSA to "continue to treat" organizations such as Alcoholics Anonymous as qualified treatment providers, H.R. Conf. Rep. No. 670, 103d Cong., 2d Sess. 113 (1994), but existing regulations, 20 C.F.R. Sec. 416.938, define an approved treatment facility as one that furnishes medically recognized treatment for drug addiction or alcoholism in conformity with applicable federal and state laws and regulations. Alcoholics Anonymous does not meet these requirements.

/15/ Pub. L. No. 103-296, Secs. 201(a)(3)(A), (b)(3)(A).

/16/ Id.

/17/ Id. Secs. 201(a)(3)(A), (B). The conference report states: "In requiring SSI to provide drug testing, the conferees intend that this authority be used as a tool for assessing compliance with treatment in those instances where a test is likely to yield important information. This provision should not be interpreted as requiring random drug or alcohol testing of all DI and SSI beneficiaries who are disabled by alcoholism or drug addiction." H.R. Conf. Rep. No. 670, 103d Cong., 2d Sess. 114 (1994).

/18/ Pub. L. No. 103-296, Secs. 201(a)(2), (b)(2). To ease SSA administrative burdens, the law distinguishes between new beneficiaries and those currently on the rolls. For individuals who become eligible beginning 180 days after the law's enactment, the representative payee requirement takes effect with the first benefit check. For a DI beneficiary now on the rolls, the requirement becomes effective the month after the month SSA notifies the beneficiary that (1) the beneficiary's eligibility for benefits is limited to 36 months and (2) payments must be made through a representative payee. The law provides that, where SSA has difficulty finding a representative payee, direct payment to the individual could be made for up to 90 days after their notification.

/19/ Id. Secs. 201(a)(3)(A), (b)(3)(A). Exceptions to the rule apply (1) to individuals who are at high risk of homelessness because they have incurred housing-related debts while waiting for their eligibility decision and who could receive, through their representative payee, an amount equal to the amount of the debt and (2) to individuals who die, are terminated after 12 months of suspension, or reach the 36-month limit before receiving all the prorated payments, who would receive, through their estate or representative payee, the remainder of the lump-sum payment.

/20/ Id. Secs. 201(a)(4), (b)(4). See also Dotson v Shalala, 1 F.3d 571 (7th Cir. 1993), and Corrao v Shalala, 20 F.3d 943 (9th Cir. 1994).

/21/ Pub. L. No. 103-296, Sec. 201(a)(3).

/22/ U.S. Gen. Accounting Office, Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations 2 (Sept. 1994).

/23/ Data from SSA (June 1994).

/24/ Social Security Admin., Division of Program Management, Research, and Demonstration, Children Receiving SSI (June 1994).

/25/ According to the Disability Process Reengineering Team's March 1994 report, Disability Process Redesign: The Proposal and Background Report from the SSA Disability Process Reengineering Team, approximately 77 percent of denied disability claims are approved by an ALJ.

/26/ Community Legal Services of Philadelphia (CLS) provides free consultation on appeals of children's SSI cases. For a copy of their memorandum on common errors they have found in ALJ decisions, call the CLS Zebley Implementation Project at (800) 523-0000. In addition, at CLS's urging, the SSA Office of Hearings and Appeals has prepared an SSI Childhood Disability Evaluation Form. This checklist is used by SSA Appeals Council Staff to determine whether ALJs have complied with the new childhood disability rules. It is available from the Clearinghouse, No. 49,915.

/27/ The Advocate's Guide to SSI for Children, a 390-page loose-leaf manual by the Bazelon Center, is being revised, and an entirely new edition will be published in 1995. For information about the Guide or its 1994 update, call the Center's publications staff at (202) 467-5730.

/28/ See supra note 22.

/29/ SSA, Office of Disability, Findings from the Study of Title XVI Childhood Disability Claims (May 1994).

/30/ Pub. L. No. 103-296, Sec. 202.

/31/ Id. Sec. 207.

/32/ Id. Sec. 203 (to be codified at 42 U.S.C. Sec. 1383b(d)).

/33/ Individuals with Disabilities Education Act, 28 U.S.C. Secs.1400 et seq.

/34/ Honig v. Doe, 484 U.S. 305 (1988).

/35/ Pub. L. No. 103-382, 103d Cong., 2d Sess. (1994).

/36/ These protections, however, do not apply to children with disabilities if their bringing a gun to school is unrelated to their disability. In that event, the general provision requiring schools to have a policy for one-year expulsion of students bringing weapons to school would apply to students with disabilities.

/37/ 42 U.S.C. Secs. 12101 et seq.

/38/ For a discussion of these terms, see 29 C.F.R. Sec. 1630.2.

/39/ Weiler v. Household Fin. Corp., 1994 WL 262175 (N.D. Ill. June 10, 1994); Fehr v. McLean Packaging Corp., No. 93-6108 (E.D. Pa. July 13, 1994).

/40/ See Castorena v. Runyon, 1994 WL 240762 (D. Kan. May 23, 1994); see also Thompson v. City of Arlington, 838 F. Supp. 1137 (N.D. Tex. 1993); Horton v. Delta Airlines, 1994 WL 356894 (N.D. Cal. Sept. 3, 1993).

/41/ Chandler v. City of Dallas, 2 F.3d 1385 (5th Cir. 1993), reh'g denied, 9 F.3d 105 (1993), cert. denied, 114 S. Ct. 1386 (1994); Coghlan v. H.J. Heintz Co., 851 F. Supp. 808 (N.D. Tex. 1994).

/42/ Jackson v. VA, 22 F.3d 277 (11th Cir. 1994), reh'g & suggestion for reh'g en banc denied, 30 F.3d 1500 (11th Cir. 1994), petition for cert. filed, 63 U.S.L.W. 3180 (U.S. Sept. 2, 1994); Tyndall v. National Educ. Centers, Inc., 31 F.3d 209 (4th Cir. 1994).

/43/ Larkins v. CIBA Vision Corp., 1994 WL 370138 (N.D. Ga. July 6, 1994).

/44/ Johnston v. Morrison Inc., 849 F. Supp. 777 (N.D. Ala. 1994).

/45/ Dutton v. Johnson County Bd. of County. Comm'rs, 1994 WL 409607 (D. Kan. July 20, 1994) (plaintiff with migraine headaches had taken allowed number of sick days and asked to use vacation days for medical absences as a reasonable accommodation).

/46/ EEOC, Preemployment Disability-Related Inquiries and Medical Examinations Under the Americans with Disabilities Act of 1990 (1994).

/47/ 28 C.F.R. Sec. 35.130(d) (1992).

/48/ Brief for Amicus Curiae Department of Justice, Helen L. v. Didario, No. 94-1243 (3d Cir. filed Sept. 6, 1994), appeal from Beverly D. v. Didario, No. 92-CV-6054 (E.D. Pa. 1992) (Clearinghouse No. 49,584).

/49/ Medical Soc'y of N.J. v. Jacobs. 1993 WL 413016 (D.N.J. Oct. 5, 1993) (Clearinghouse No. 49,586).

/50/ Clark v. Virginia Bd. of Bar Examiners, 1994 WL 482885 (E.D. Va. Aug. 31, 1994); Ellen S. v. Florida Bd. of Bar Examiners, No. 94-0429-CIV-KING (S.D. Fla. Aug. 1, 1994). Neither of these decisions addressed the merits of the ADA claim.

/51/ Easley v. Snider, 1994 WL 513970 (3d Cir. Sept. 22, 1994) (Clearinghouse No. 49,576).

/52/ Bosteder v. Soliz, No. 93 2 01817 4 (Wash. Super. Ct. Thurston County Feb. 3, 1994) (Clearinghouse No. 49,439).

/53/ Concerned Parents to Save Dreher Park Center v. City of West Palm Beach, 846 F. Supp. 986 (S.D. Fla. 1994).

/54/ Compare Martin v. Voinovich, 840 F. Supp. 1175 (S.D. Ohio 1993), and Eric L. v. Bird, 848 F. Supp. 303, 314 (D.N.H. Mar. 31, 1994) (ADA claim stated), with Conner v. Branstad, 839 F. Supp. 1346 (S.D. Iowa 1993) (no ADA claim stated).

/55/ Dees v. Austin Travis County Mental Health & Mental Retardation, 1994 WL 462916 (W.D. Tex. June 16, 1994).

/56/ Tugg v. Towey, No. 94-1063-CIV-MOORE (S.D. Fla. June 30, 1994).

/57/ Tyler v. City of Manhattan, 849 F. Supp. 1429 (D. Kan. 1994).

/58/ The Public and Assisted Housing Occupancy Task Force Report and Recommendations (1994). The task force was established by the Housing and Community Development Act of 1992, Pub. L. No. 102-55, 106 Stat. 3821 (1992). Copies of its report are available from the Clearinghouse, No. 50,125.

/59/ 59 Fed. Reg. 17652 (Apr. 13, 1994) (public housing); 59 Fed. Reg. 22916 (May 3, 1994) (assisted housing).

/60/ Memorandum for Fair Housing and Equal Opportunity Directors et al. from Roberta Achtenberg re Substantive and Procedural Limitations on Filing and Investigating Fair Housing Act, Complaints That May Implicate the First Amendment (Sept. 2, 1994).

/61/ United States v. City of Philadelphia, No. 93-2095 & 93-2096 (3d Cir. June 10, 1994).

/62/ City of Edmonds v. Washington State Bldg. Code Council, 18 F.3d 802 (9th Cir. 1994), cert. granted, 62 U.S.L.W. 2572 (U.S. Oct. 31, 1994).

/63/ Elliott v. Athens, 960 F.2d 975 (11th Cir.), cert. denied, 113 S. Ct. 376 (1992).

/64/ City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985).

/65/ Coffelt v. Department of Developmental Disabilities, No. 916401 (Cal. Sup. Ct. Jan. 19, 1994) (Clearinghouse No. 49,741).

/66/ Joan S. v. Gudeman, No. 91-C-717 (E.D. Wis. Feb. 17, 1994) (Clearinghouse No. 46,863).

/67/ Civil Rights of Institutionalized Persons Act, 42 U.S.C. Secs. 1997 et seq.

/68/ Wyatt v. King, 344 F. Supp. 373 (M.D. Ala. 1972), aff'd in relevant part sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) (Clearinghouse No. 6874).

/69/ The United States had entered the case in July 1971 and moved to withdraw in August 1992. The motion was granted September 16, 1992.

/70/ United States' Motion to be Reinstated as a Litigating Amicus Curiae, September 15, 1994, Wyatt v. King, No. 3195 (M.D. Ala. filed Sept. 15, 1994). The motion was granted on September 27, 1994.

/71/ Halderman v. Pennhurst School & Hosp., No. 74-1345 (E.D. Pa. May 12, 1994) (Clearinghouse No. 49,489).

/72/ Dixon v. Kelly, No. 74-285 (D.D.C. 1994) (Clearinghouse No. 17,175).