

The Myth of Clinical Judgment

Douglas
Syracuse University

Professions that provide services to people with disabilities typically do so from a clinical perspective. Yet evidence on the exercise of clinical judgment raises a number of questions about its influence. Other factors such as economics, bureaucratic exigency, politics, service traditions, and societal prejudice may render reliance on clinical judgment little more than a mythology. This paper examines the status of clinical judgment in two areas of policy and practice, namely, placement of students in special education settings, and residential placements and programs for people with developmental disabilities.

Client or Minority?

Deinstitutionalization and community integration for people classified as retarded have been on the national policy agenda for nearly two decades (Blatt & Kaplan, 1966; Kugel & Shearer, 1976; Kugel & Wolfensberger, 1969). Yet over 100,000 retarded people remain institutionalized. After a precipitous drop in the early 1970s, the population of institutions for the retarded now decreases only one or two percent annually (Bruininks & Lakin, 1985). Some states that claim a commitment to community programming appear intent upon accomplishing this goal through the construction of mini-institutions in the community (Taylor, McCord, & Scarl, 1981), and at least two states have begun to construct "group homes" on the grounds of old institutions. In education, despite a federal law that requires students with disabilities to be served in the "least restrictive"

This article was prepared with support from the Research and Training Center on Community Integration, funded by the National Institute on Handicapped Research, U.S. Department of Education (Cooperative Agreement No. G0085C03503). The opinions expressed herein are solely those of the author, and no official endorsement of the U.S. Department of Education should be inferred.

Correspondence regarding this article should be addressed to Douglas Dittlen, Syracuse University, 805 South Colosse Avenue, Syracuse, NY 13244.

treated as disabled during their school years than at any other time in their lives (Mercer, 1973; Sarason & Doris, 1969). In the areas of jobs and joblessness, medical insurance, and income maintenance, social policies require people with disabilities to prove they are "truly" disabled, "truly" needy, and "truly" worthy of patient or dependent status in order to receive benefits or services. Interestingly, even with such seemingly limiting conditions as mental retardation, many people escape identification upon leaving social-processing institutions (e.g., schools and state asylums; see Mercer, 1973; Sarason & Doris, 1969; Bogdan & Taylor, 1982).

Patient status also develops when people's basic individual rights are negated by professionals to whom society grants authority over those judged in need of treatment (Blatt & Kaplan, 1966; Blatt, Ozolins, & McNally, 1979; *Parham v. J.R.*, 1978; Szasz, 1961, 1970; *Youngberg v. Romeo*, 1982). The technical language of treatment typically communicates a quasi-medical mystique, a status difference, and an aura of professional specialization—all of which imply that persons targeted for treatment are patients who must be handled by highly trained experts in specialized locations (Tomlinson, 1982). Because the clinical paradigm so dominates how society defines people with disabilities, it also manifests itself in day-to-day interactions between disabled and nondisabled people. People with disabilities report being seen and treated as "sick" rather than as people whose disability is but one personal quality (Bogdan & Taylor, 1982; Brightman, 1984; Kriegel, 1969; Rohl, 1981). Interestingly, while disability rights organizations and other groups have pushed to reduce the medicalization of disability and the unnecessary professionalization of treatment, both phenomena seem to be growing (Szasz, 1970; Tomlinson, 1982; U.S. Department of Education, 1985).

Clinical Treatment/Clinical Judgment in Special Education

Disability treatment professions (e.g., special education, psychology, and rehabilitation) operate on a model of individual assessment, diagnosis, and placement. That is, in order to determine the best strategy for educating, rehabilitating, or otherwise serving people with disabilities, professionals must first consider individual needs and the findings of research about the best approaches for meeting such needs. But what is the range of freedom available to professionals' decision making? On a day-to-day basis, professionals do make placement decisions, for example. But what options are available to them? Are the best practices typically among their possible choices? In other words, how does the professional environment frame the professional's work? Do professionals truly have the freedom to exercise professional judgment, or are professionals and consumers alike merely functionaries and pawns in a world of narrowly restricted, love-it-or-leave-it "choices"? As one example, what are the judgment parameters in educational placement?

settings possible, some states exclude more than two-thirds of certain disability groups from regular schools (U.S. Department of Education, 1985). In the area of employment, by nearly any available analysis, two-thirds of all persons with disabilities are unemployed (Dowe, 1978, 1984). Those who seek more independence in their lives often find their efforts stifled by limited physical access, social rejection, and insufficient economic support (Brightman, 1984; Conley, 1985).

Such conditions exemplify the meaning of marginality: People with disabilities are institutionalized, segregated and undereducated, socially rejected, physically excluded from public places, and unemployed. Any other group subjected to these circumstances would most likely be characterized as a minority. Yet the more common tendency has been to view people with disabilities as (a) victimized by a disabling condition and (b) in need of treatment—not of rights.

This perspective keeps the person with a disability from being seen as a minority group member. The notion that people with disabilities suffer at the hands of their disabilities rather than from social ostracism and discrimination sets this group apart from other minority groups. While psychological and physiological differences have certainly been claimed as excuses for sex and race inequality, such claims do not enjoy the apparent face validity and centrality for women and blacks that they historically have had and still have for people with disabilities (*City of Cleburne v. Cleburne Living Center*, 1984a,b; Sarason & Doris, 1969). In other words, people who are at risk for social processing and social control because of their individual, disability-related needs become the captives of a treatment model; they and their lives become medicalized (Bogdan & Taylor, 1976; Gould, 1981; Sarason & Doris, 1969; Szasz, 1961, 1970). The more severe the disability, the greater the likelihood that the person will be regarded more as a "patient" than as an object of discrimination. Indeed, identity as a patient would seem to preclude identification or status as an oppressed minority.

Obviously, people with disabilities, like anyone, may need certain services, such as treatment (e.g., physical therapy, speech-language therapy, medical care) or adaptive help (e.g., prostheses, augmented communication, individualized or adaptive instruction). But to be transformed from a socially valued individual, albeit one needing and receiving some treatment, to the status of perpetual clinical subject, client, or patient is a far more encompassing phenomenon, and one that people with disabilities frequently resist (Bogdan & Taylor, 1982; Karuh, 1985; Kriegel, 1969).

The making of a patient takes numerous forms. It occurs, for example, through diagnosis, classification and labeling, and placement. In education, federal law as well as conventional practice requires classification and placement before students with disabilities can receive specialized or individualized educational assistance. This fact helps explain why more people are identified and

tion, particularly in the last five years, suggests substantial support for educating all students, no matter how severely disabled, in typical schools (Knoblock, 1982; Certo, Haring, & York, 1984; Wilcox & Bellamy, 1982; Stainback & Stainback, 1984; Biklen, 1985). The major research findings can be summarized briefly as follows:

- There appears no evidence that segregated schooling produces educational results (e.g., change in intellectual or adaptive behavior) superior to those achieved in integrated schools. Literature reviews on the subject note the difficulties of matching children of like disabilities in different environments and of controlling for variables other than those associated with integration or segregation (Blatt, 1977). Given these problems, however, the literature does not provide evidence for segregated schooling (i.e., separate schools for disabled students only).
- School programs that include disabled and nondisabled students, whether in school-based or community-based settings, minimize the problems that severely retarded students typically experience in generalizing their learning from one setting to another. When they attend typical schools, severely disabled students are consistently exposed to models of the full range of student behavior, in academic as well as social situations (Drinker & Thorpe, 1984; Knoblock, 1982). Particularly where integrated schools utilize community-based nonschool environments, such as shopping centers, public transportation, and work locations for functional training, disabled students can learn from real rather than simulated experiences (Brown et al., 1983a,b, 1986).
- When mildly disabled students have been systematically supported in regular classrooms, they have equaled or outperformed their peers in resource-room programs (Wang & Birch, 1984).
- Integration breeds acceptance by students toward each other. More physical integration leads to greater acceptance (Towfighy-Hooshyar & Zingle, 1984) by nondisabled students toward students who have been classified as disabled. Planned or structured interaction produces even greater tolerance, acceptance, and interaction than mere proximity (Biklen, 1985; Knoblock, 1982; Voeltz, 1982). In return, autobiographical accounts of integrated disabled students and former students suggest that they view themselves as peers of nondisabled students (e.g., Kaye, 1981).
- When interaction between disabled and nondisabled students is systematically supported, the resulting increase in student-to-student interaction has been shown to predict greater success in achieving IEP goals (Brinker & Thorpe, 1984). In other words, although interaction was once expected to be principally a side benefit of integration, it now appears to constitute a significant factor in skill development.

In mandating the procedure of educating students with disabilities in the least restrictive setting, as articulated in Public Law 94-142, The Education for All Handicapped Children Act of 1975, Congress relied heavily on the language of clinical judgment. Specifically, the law required

procedures to assure that to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. (Section 612(f)(1)(B))

The courts have further interpreted legislative intent to indicate that in deciding upon appropriateness of service, the state shall have fulfilled its mandate if it has enlisted qualified professionals to make the decisions (*Board v. Rowley*, 1982). Federal enforcement and state implementation of the "least restrictive environment" provision have similarly relied on clinical judgment. For example, when mechanisms have been designed for monitoring student placements, they have generally increased expectations that case-by-case clinical judgment would ensure individualization and neutral decision making in placement recommendations. In the words of the 1985 report to Congress on the implementation of the act (U.S. Department of Education, 1985):

Typically, these policies establish a placement process that marshals a wide range of professional expertise and involves several levels of professional review. In order to assure that children are placed in appropriate settings. In some States, these more elaborate placement procedures are used only when the normal IEP (individual education plan) process has identified a child for whom (1) no appropriate placement is readily available; (2) an out-of-district placement is recommended; or (3) payment for services is contested. (p. 39)

The presumption of the U.S. government has been that there should be no segregation (i.e., special class placement or separate school placement) in the absence of demonstrable benefits from proposed segregation and evidence that integration in a regular class or in a typical school is not possible:

Separation or segregation is permissible only when education itself cannot be successful without it, and even then, . . . separation or segregation must be limited by a concept of maximum appropriate integration (e.g., opportunities for peer interaction). (Will, 1985)

Furthermore, segregation could not be justified by administrative excuses, even including the greater availability of special equipment, instructional specialists, or special programs in separate settings (*Runkler v. Walters*, 1983; Will, 1985).

It is not possible to devote much space in this article to the integration/segregation debate (see Bersoff, Kohler, Fiscus, & Ankney, 1972; Biklen, 1982; Blatt, 1977; Dunn, 1968; Goldstein, Moss, & Jordan, 1965; Guralnick, 1978). However, it is noteworthy that recent research on integration and segrega-

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abled students and speech-impaired students from the total numbers of disabled students—two groups of which only 1.2% and 0.6% respectively are segregated, but which constitute 67% of all disabled students—the extent of segregation of the remaining disabled students jumps from 5.5% to anywhere from 10 to 55%, depending on the group considered (U.S. Department of Education, 1985, pp. 239–250).

The state-by-state variation in whether students receive their education in regular schools or in special disabled-only schools is nothing less than extraordinary. In certain states, a large proportion of students labeled retarded attend special schools for the disabled only: Delaware and the District of Columbia (37% each), Maryland (40%), Louisiana (23%), New York (30%), Nevada (29%), New Jersey (23%), and Texas (20%) (U.S. Department of Education, 1985, p. 242). Yet remarkably, Nebraska segregates none of its retarded students, and 13 states segregate less than 3% of students classified as retarded. In New York State, 10,793 emotionally disturbed students, 26% of those so labeled, are segregated (U.S. Department of Education, 1985, p. 243). Other states that educationally segregate substantial proportions of students labeled emotionally disturbed include California (21%), Delaware (25%), Illinois (32%), Kentucky (38%), Maryland (61%), Minnesota (33%), New Jersey (25%), Ohio (49%), and Pennsylvania (23%) (U.S. Department of Education, 1985, p. 243). In sharp contrast, Wisconsin and Nebraska segregate none of their students classified as emotionally disturbed.

The group most likely to be segregated is multihandicapped students. Among states with more than 1000 multihandicapped students identified, those that segregate the highest proportions are Maryland and Texas (80%) and New York (61%) (U.S. Department of Education, 1985, p. 245). Yet California and Massachusetts, two other states with over 1000 students identified as multihandicapped, segregate 5 and 4%, respectively.

The foregoing data raise troubling questions. It appears place of residence, for example, whether students live in Maryland or in Nebraska, determines whether or not they will attend regular or special (i.e., separate) schools. Why is this? Are clinicians in Nebraska of a different mind about school integration than those in Maryland? Or are there other, nonclinical factors that determine the patterns of school placements? In other words, does the context for professional decision making allow for the independent exercise of clinical judgment or, instead, are professionals severely constrained to make decisions within limits that may not be supported by research, stated policy, or clinical judgment?

Second, if the enormous disparities between states in the proportion of disabled students educated in regular schools cannot be rationally explained as a function of differences in professionals' judgment, then what other factors shape such conditions? Several factors have been identified as having major influence in school placement practices. One obvious explanation is state funding policies.

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- Integrated schooling provides expanded options for informal learning and utilization of natural-environment instruction and natural cues (as opposed to highly structured, laboratory-like situations), all of which are now seen as beneficial, particularly when used in conjunction with looser behavioral teaching techniques than were frequently used in the past (Brown et al., 1983a,b, 1986; Coon, Vogelsberg, & Williams, 1981; Halle, 1982; Liberty, Haring, & Martin, 1981).
- Several recent follow-up studies on postschool employment experiences of special education students suggest the benefit of early integrated schooling (Brown et al., 1986; Wehman et al., 1982; Wilcox & Bellamy, 1982). It correlates with successful job placement and job retention.
- Educators' expectations for student performance appear greater for students involved in useful and age-appropriate (and more integrated) rather than nonfunctional (and potentially more segregated) activities (Bates, Morrow, Pancsofar, & Sedlak, 1984).
- Individual education plans of students in regular schools are more likely to reflect research-based "best practices" than are the IEPs of students in schools for disabled students only (Hunt, Goetz, & Anderson, 1986).
- Certain schools and school districts have demonstrated that they can provide effective educational programs to even the most severely disabled students in regular schools (Taylor & Ferguson, 1985).
- Although this is not an educational quality consideration, the cost of educating students of all disability levels is less in regular schools than in disability-only schools (Kakalik, Furry, Thomas, & Carney, 1981).

On the basis of research findings and government policy, it appears that educators should be expected to select typical schools and, to a large extent, regular classes as the placements of choice. In this regard, a recent report to the U.S. Congress indicates the Department of Education's interest in and pleasure with the extent of integrated placement:

During school year 1982-83, the majority of handicapped students continued to be served in regular education buildings. . . . 68 percent of all handicapped children received most of their education in regular classes. . . . An additional 25 percent received services in separate classes within a regular education building. Taken together, these settings accounted for 93 percent of the handicapped students, who received special education and related services in environments that included non-handicapped peers. Only 7 percent of all handicapped children were educated in separate schools or other environments, such as hospitals or homebound instruction. (U.S. Department of Education, 1985, p. 36)

For students aged 6-17, the core school years, less than 5.5% are currently segregated (U.S. Department of Education, 1985, p. 239).

But the summary data obscure the extent of segregation for particular groups of students labeled handicapped, most notably mentally retarded, emotionally disturbed, and multihandicapped students. If we subtract learning-dis-

If, for example, a state provides 100% of the funding for institutional placements, local school districts will find this an attractive option for eligible students. Similarly, if a state provides substantially greater funding for private school placements of students with disabilities than it does for placements within local districts, this too can lead to greater reliance on segregated placements (Blatt, 1972). Several of the states having high levels of segregation of students with moderate and severe retardation and multiple handicaps are ones in which state funding has been provided to construct regional separate special schools, for example, Ohio, New York, New Jersey, and Missouri. Similarly, where states have established special school districts to take referrals of students with disabilities from local districts, segregated schooling is commonplace—for example, in Ohio and New York.

Third, if one state, Nebraska, can educate all of its students in regular schools, and more than a dozen others can achieve nearly complete integration, does this not suggest the possibility that all students can be educated in typical schools? In addition to the national data on school placements, several studies report schools and school districts that serve the total population of school-aged children, disabled and nondisabled alike (Biklen, 1985; Knoblock, 1982; Taylor & Ferguson, 1985; U.S. Department of Education, 1986). These schools and school districts impose no admissions test to establish eligibility. Thus, the question must be asked whether all schools and school districts could not integrate fully, since some have already done so with no negative effects.

Clinical Treatment/Clinical Judgment In Residential Placement and Programs

Policies affecting residential placements and programs for people with retardation and other developmental disabilities, like educational policies, also presume the central importance of clinical judgment. In articulating a goal of adequate treatment, for example, the U.S. Congress charged the states with ensuring *appropriate* services in "the least restrictive" setting:

Persons with developmental disabilities have a right to appropriate treatment, services and habilitation for such disabilities.

The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's liberty. (Developmentally Disabled Assistance and Bill of Rights Act, 1973, Sec. 6010)

As in the field of education, the courts defer to professionals concerning the appropriateness of particular treatments or placements:

In determining whether the state has met its obligations in these respects, decisions made by the appropriate professional are entitled to a presumption of correctness. (*Youngberg v. Romero*, 1982, p. 333)

In other words, decisions about residential placement and treatment strategies are in the hands of professionals, even if these treatments or placements limit individual liberty interests (see also Biklen, 1981; *Parham v. J.R.*, 1978).

Research findings on residential programming and policy, as in education, support a high degree of physical as well as social and programmatic integration for people with disabilities and their nondisabled peers. In residential policies this would include, for example, cash support and home services for families to help them maintain a disabled family member at home, support staff to assist people living in apartments, and small, highly personalized group-living situations for people who need assistance in daily living. The research on residential policy and practice for people with retardation can be summarized briefly as follows:

- Even those people whose disabilities include behavior problems have a high rate of success in community placement if they are provided support services (Schalock, Harper, & Genuing, 1981).
- When provided "increased training opportunity, increased opportunity to assume responsibility for in-house tasks, more autonomy, clear expectations . . . residents are more likely to perform mastered skills and be satisfied with the residential setting" (Seltzer, 1981, p. 629).
- Even when given little support and when faced with seemingly very difficult life circumstances, people with mild retardation typically retain an optimistic outlook on life (Edgerton, Bollinger, & Herr, 1984).
- People who live in small community residences show greater development in adaptive behavior than do those who reside in large institutions (Sokol-Kessler, Conroy, Feinstein, Lemanowicz, & McCurtin, 1983).
- Community-living arrangements in residential areas and ones that promote "socially integrated vocational, educational, recreational, and social activities" enable people to achieve more socially appropriate behavior than do isolated residences and arrangements that do less to promote social interaction (Hull & Thompson, 1980, p. 260).
- Community-living programs, including family support, are no more expensive and may be less expensive than institutional placements (Inagliata, Wilder, & Cooley, 1979).
- Although public policy specialists originally assumed that people with mild disabilities would benefit the most from community placements and from increased social interaction with nondisabled persons, the benefits are as great for people with severe disabilities. In fact, in terms of improved social circumstances and individual skills, people with severe disabilities show the greatest positive change from access to community living (Hemming, Lavender, & Pill, 1981; Raynes, 1980; Conroy, Efthimiou, & Lemanowicz, 1982).

- By definition, institutionalization denies people a range of social experiences (e.g., interaction with people in the community, typical living quarters, participation in work and recreation with people who do not have disabilities). In contrast, while community placement does not guarantee social interaction, it does create the circumstances where interaction becomes possible (Taylor, Bikien, & Knoll, 1987).
- A number of states, municipalities, and service organizations have successfully demonstrated the ability to serve people with the most severe, multiple disabilities, including significant medical complications, in family and small-group settings (Taylor, Racino, Knoll, & Lutfiyya, 1986).

On the basis of these and other similar findings, a number of researchers (Bruininks & Lakin, 1985; Center on Human Policy, 1979; Lakin & Bruininks, 1985; Taylor et al., 1987) have recommended various forms of community integration, typically including family support, supported apartments and homes, and small residences (e.g., three persons).

Interestingly, however, when researchers have explored the reasons behind actual patterns of placements and differences in approaches to residential policy, they have found many nonclinical factors responsible. Why, for example, do some states use community residential programs for 50 or more people per 100,000 of the general population, while others use them for 5 or fewer (Bruininks, Hauber, & Kudla, 1979)? Why do some states use Medicaid funds to support institutions while others use them only for small community-living programs (Taylor et al., 1981)? Why do some states use institutional placements at a rate seven times greater than other states (Epple, Jacobson, & Janicki, 1985)? Some of the nonclinical factors in such policies include politics, state budgetary agendas, labor interests, past traditions in retardation services, court oversight, public prejudice toward people with disabilities, bureaucratic impediments, and jurisdictional disputes between human service agencies (Rohman & Rothman, 1984; Blatt, 1970; Blatt et al., 1979).

A national survey of institutional closure suggests that states close institutions not simply because professional judgment has resulted in fewer people being institutionalized, but primarily for other nonclinical reasons: increased pressure to convert mental retardation and mental health institutions into prisons, federal funding for new institutional construction; pressure on states to cut costs, availability of alternatives to institutions (although in some cases this means nursing-home or other congregate-care placement), and pressure from advocacy groups (Bradnick & Heller, 1985, pp. 172-173). One obvious factor shaping placement decisions has been the federal Medicaid law, which facilitated extensive reconstruction of old, large, state mental retardation institutions, the construction of many smaller nursing homes and other congregate-care facilities ranging in size from 50 to 250 persons, and the emergence of large group homes for 8-15 persons (Taylor et al., 1981).

Conclusion

Society places people with disabilities in the client role, and thus many aspects of their lives become subject to professional authority. Educational experts exercise professional judgment to determine appropriate educational programs and program decisions for them. Residential or other clinical specialists decide who shall live in a group home, who shall be institutionalized, who shall be let out of institutions, and who shall receive assistance to live in apartments or other community settings. Society reinforces such professional authority by establishing it in statute and case law.

In fact, however, clinical judgment does not operate in this idealized form. Often, in education, in residential policy, and undoubtedly in many other areas of professional practice, clinical judgment is drastically limited by the influence of other nonclinical forces. It may even be mere window dressing for practices that in fact contradict clinical judgment. Certainly, it is mistaken to believe that clinical judgment could ever be so influential as to supersede all other social, economic, and political factors that affect people's lives.

The solution to the problem of clinical judgment being overwhelmed by nonclinical forces is not more, better, and therefore more influential clinical judgment. Rather, the problem is in the current model of disability services, which treats questions that are both political and professional—such as where and how people shall live or be educated—as if they were purely professional ones. Clinical judgment and assistance surely have a role in people's lives. For example, to explain the effects of different teaching methods, to help people understand their relations with each other, or to enable individuals to develop new skills. But clinical judgment always occurs in a political context and therefore cannot reasonably be viewed as independent of it.

The conditions faced by people with disabilities are those that plague other minorities: social isolation, insufficient and unequal treatment, economic dependency, high unemployment, poor housing, and an unusually high rate of institutionalization. It serves the interests of neither professionals nor their clients—indeed, it perpetuates a myth—to ignore people's need for political and economic change while offering them only clinical treatment. This seems particularly wrong and harmful when the treatment itself becomes an extension of political and economic disenfranchisement. Put another way, people with disabilities are more likely to achieve increased self-determination, real choice, and power if they cease being defined as clients whose future rests in the hands of professionals, and are instead recognized as a minority group.

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