Waking Rip van Winkle: Why Developments in the Last 20 Years Should Teach the Mental Health System Not to Use Housing as a Tool of Coercion

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Many housing programs for people with mental illnesses rely on models that require the person to adhere to treatment as a condition of continuing access to housing. These models that “bundle” housing and treatment are relics of a past in which persons with mental illnesses were afforded little real choice in treatment, housing and other social supports. Conditioning access to housing in this manner is coercive and at odds with current thinking regarding treatment, as well as legal principles that shape the environment in which treatment is provided. This article summarizes the reasons why housing for people with mental illnesses should be provided free of the use of coercion.

Community integration stands in stark contrast to outdated views of people with psychiatric disabilities—whether held by professionals, family members, or the general public—as perennial patients, helpless and dependent, with hopeless futures. These outmoded beliefs about people with psychiatric disabilities . . . will die hard in the mental health field. This will be so not only because no group with power typically gives up that power easily, but also because so many of those currently involved (whether individuals, their families, professionals, or advocates) have come to believe these fundamental assumptions.²

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¹In selecting the subtitle and in writing this article, I acknowledge my deep gratitude to Henry Korman, Diane Engster, and Bonnie Milstein, and their 1996 article that has shaped my thinking on this topic. Henry Korman et al., Housing as a Tool of Coercion, In Coercion and Aggressive Community Treatment 95 (Deborah L. Dennis & John Monahan eds., 1996).


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INTRODUCTION

After decades of strong *de facto* coercion in housing and other programs serving people with psychiatric disabilities, the mental health establishment now asks itself whether such coercion can be justified on therapeutic, ethical or legal grounds if it leads to greater compliance with prescribed mental health treatment. While fully supporting an effort to develop an evidence-based approach to these issues, I am compelled to suggest an empirical and normative framework that invalidates the question itself, and firmly rejects the use of such coercion.

More than a decade after Carling observed a “paradigm shift” in thinking about full community participation by and integration of people with psychiatric disabilities, the idea that mental health professionals should use housing as leverage to induce consumers to comply with mental health treatment plans seems oddly out of step. More than two decades ago, Test and Stein warned that “special living arrangements” should be avoided, in large part because such arrangements stigmatize mental illnesses and make recovery and integration even more difficult. The last 20 years have taught us much about what works and what does not in the field of mental health interventions, and the ethical and legal implications of programs that separate people with disabilities from the American mainstream, but, like Rip van Winkle, segments of the mental health system find themselves waking up to a new world in which old habits of thinking no longer suffice.

If we believe in housing as an integral part of community integration, then we should resist the kind of housing models that segregate people by psychiatric diagnosis and communicate to the world that the residents are different. If the objective is successful community integration, then housing for people with psychiatric disabilities should look like where you and I live.
Perhaps the desire to use housing in a coercive manner is motivated by intense frustration that outcomes, particularly for very poor people with psychiatric disabilities, are not improving, and the accompanying urge to investigate whether there is some “stick” that will be more effective in reaching the desired end. However, it is the very formulation of the question and the identification of that desired end that are flawed, and threaten to take the mental health system down the wrong road.

As common as it is to confuse our means with our ends, we must focus on an objective that is broader and longer term than simply securing treatment compliance, and we must define that objective carefully. If we aim only to “ensure that beneficiaries adhere to mental health treatment in the community,” or seek “leverage to induce people to adhere to mental health treatment recommendations,” then we might accept any manner of restrictive housing that leads to those ends. If the objective is to promote full community integration, consistent with the stated values of all mental health systems and as required by the United States Supreme Court, then our housing policy must have decidedly different features.

Research as early as the mid-1980s suggested that coercion tends to push people with psychiatric disabilities even further away from the mental health system, and that use of coercive practices tends to preclude the ability to use more creative forms of engagement. Some observers suggest that “refusal override [is] a short-term solution” that may have adverse long-term consequences. There is general...
agreement that the field lacks hard data on the effectiveness of coercive interventions in improving treatment compliance. However, even if such studies demonstrated some effectiveness, we would still have to ask two more questions: (i) What else might work? and (ii) What collateral damage does coercion cause to the effort to provide good housing for people with psychiatric disabilities? When treatment compliance is seen as an end in itself, there is a very real danger that coercive practices taken in pursuit of that end will result in diminished outcomes for consumers.

With respect to housing, the paradigm shift involves a fundamental redefinition of the relationship between consumers and housing and service providers. While group homes and other congregate models that “bundled” housing and services may have been cutting edge technology in the 1970s, they have become dinosaurs, just like the state hospitals before them. I and others have argued that such housing is on precarious legal footing. A growing number of other mental health stakeholders, including mental health commissioners, advocacy organizations, and federal government agencies, have made it clear that such coercive housing practices no longer have a place in the mental health system. They suggest

17Monahan et al., supra note 3, at 1204.
18Carling, supra note 4, at 443 (“More specifically, in the area of housing, the paradigm is shifting toward homes, not residential treatment settings; choices, not placement; normal roles not client roles; client control, not staff control; physical and social integration, not segregated and congregate grouping by disability; in vivo learning in permanent settings, not preparatory learning in transitional settings; individualized flexible services and supports, not standardized levels of service; most facilitative, not least restrictive, environments; and long-term supports and independence.’
19Michael Allen, Separate and Unequal: The Struggle of Tenants with Mental Illness to Maintain Housing, 30 CLEARINGHOUSE REV. 720 (Nov. 1996); Korman et al., supra note 1.
20In 1988, the Ohio Department of Mental Health adopted a policy known as “Housing as Housing,” which provides “Persons living in their own housing may need or desire a great many services of considerable frequency and intensity, or they may need few, if any, services. The choice to live in one’s own home should not be contingent on the level and frequency of services one needs.” Available at http://www.newhousingopp.org/hah.htm (last visited January 28, 2003). In 1996, the Housing Work Group of the National Association of State Mental Health Project Directors (NASMHPD) adopted a statement disapproving the bundling of housing and services:

Housing and services are separate needs, and should not be “bundled” together; rather, they should be provided in partnership with each other. There should be no service requirements for getting or keeping housing; attaching service agreements to housing leases is illegal. Termination of tenancy must only occur based on the same conditions of tenancy that apply to non-disabled tenants.”

21The National Mental Health Association believes that every consumer has the right to be fully informed of treatment side effects and treatment alternatives in order to make informed decisions without coercion or the threat of discontinued services. Statement on Rights of Persons with Mental Illness, at http://www.nmha.org/position/p1.cfm (last visited January 30, 2003).
22For example, Community Housing Associates, a group formed in Baltimore to create and demonstrate holistic ways to combine housing and services for individuals and families with members who have mental illness, describes its approach as follows: “By separating housing from services, we believe it can encourage residents to lead independent, stable lives.” Community Housing Associates, quoted in Community Information Exchange, Would You Live There? Housing for People with Special Needs, 45 STRATEGY ALERT, Fall/Winter 1995, at 6.
23The National Council on Disability, an agency chartered by Congress, and whose members are appointed by the President, has asked Congress to prohibit federal support for housing with mandatory services. NATIONAL COUNCIL ON DISABILITY, Achieving Independence: The Challenge of the 21st Century 115–120 (1996).
that the principles of person-centered planning and choice must prevail over administrative convenience and familiar modes of administration.\(^\text{24}\)

That is why we must frame the question in an entirely different way. We must ask not merely what policies will promote compliance, but rather, what role stable, integrated, unbundled housing can play in securing good life outcomes.\(^\text{25}\) As part of that discussion, we must make clear that people with psychiatric disabilities may need and want supportive services, and that such service linkages may be critical in helping them to succeed in the community.\(^\text{26}\) While there may be a fine line between linking and bundling, that line is defined in terms of voluntariness.\(^\text{27}\)

In the balance of this article, I suggest there are at least four reasons that housing should not be used as leverage to compel treatment compliance.

(i) It undermines the therapeutic alliance, which requires a high degree of trust between service provider and consumer.\(^\text{28}\)

(ii) It violates ethical principles of the mental health professionals involved in the coercion.

(iii) It does not work as well as programs that take a "housing first" approach, and it may in fact prevent residents from assuming the risks and responsibilities that make life worth while (and that help them to become less dependent).\(^\text{29}\)

\(^{24}\)See Richard C. Surles, *Free Choice, Informed Choice, and Dangerous Choice*, in *CHOICE AND RESPONSIBILITY: LEGAL AND ETHICAL DILEMMAS FOR PERSONS WITH MENTAL DISABILITIES*, supra note 7, at 21 ("If we are to promote choice, we have to be prepared to accept consequences. And if we give priority to patient safety, we should give up the pretense of defending patient choice.").

\(^{25}\)Success must be measured by other than the traditional indices (reduction in hospital days, days homeless, or days in jail/prison), and examine connection to community life, satisfaction with living arrangements, feelings of empowerment, and similar issues.

\(^{26}\)Most observers agree that mental health services and supports continue to be important to community success after a consumer moves out of the institution or congregate setting. *See*, e.g., *Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring in judgment) ("It would be wrong to place people with serious mental illnesses into community settings ‘devoid of the services and attention necessary for their condition."); Sandra Newman & M. Susan Ridgely, *Independent Housing for Persons with Chronic Mental Illness*, 21 ADMIN. & POL'Y IN MENTAL HEALTH 199 (1994). *See also* Ohio Department of Mental Health, supra note 20 ("The housing-as-housing approach separates housing from treatment services, in that the need for decent, stable, affordable housing is different from the need for services. However, the housing must be connected to services, in the sense that supportive services must be available to people in their own homes to assist and sustain them in a natural environment. The housing-as-housing concept is not like the idea of ‘independent living’...in which having an ‘independent’ living arrangement is equated with minimal or no need for services.").

\(^{27}\)See *CORPORATION FOR SUPPORTIVE HOUSING, BETWEEN THE LINES: A QUESTION AND ANSWER GUIDE ON LEGAL ISSUES IN SUPPORTIVE HOUSING* 92–93 (2001) (except in specified federal programs permitting the practice, “requirements that a tenant participate in a service program may present discrimination problems for housing providers and may not be enforceable.”)

\(^{28}\)Carling, supra note 4, at 442 ("Thus community integration approaches to housing avoid congregation and segregation and focus instead on building relationships between disabled and non-disabled individuals or those with various income levels.").

\(^{29}\)Grunberg and Eagle have described a process called shelterization, which is similar to early accounts of learned helplessness in psychiatric hospitals. Jeffrey Grunberg & Paula F. Eagle, *Shelterization: How the Homeless Adapt to Shelter Living*, 41 HOSP. & COMMUNITY PSYCHIATRY 521 (1990); Carling, supra note 4, at 439, 440 ("Shelterization is characterized by decreased interpersonal responsiveness, neglect of personal hygiene, increased passivity, and increased dependence on others.") *See also* BAZELON CENTER FOR MENTAL HEALTH LAW, *AN ACT PROVIDING A RIGHT TO MENTAL HEALTH SERVICES AND SUPPORTS* (2002); PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, *INTERIM REPORT TO THE PRESIDENT* (2002) (concern expressed about current disability programs maintaining people with psychiatric disabilities in a state of dependence); NATIONAL COUNCIL ON DISABILITY, *THE WELL-BEING OF OUR NATION: AN INTER-GENERATIONAL VISION OF EFFECTIVE MENTAL HEALTH SERVICES AND SUPPORTS* (2002).
(iv) It violates federal law, which requires that mental health services be provided in the most integrated setting, and provide people with psychiatric disabilities an opportunity to be fully integrated into the community.

WHY COERCION IS LIKELY TO OCCUR

In the mainstream housing market, tenants are required to comply with the core responsibilities of tenancy. These usually include paying the rent, complying with the lease, living at peace with neighbors, and keeping the rental property in good condition. Under principles that date back to medieval England, a tenant who abided by these core obligations was entitled to exclusive use of the premises, and the landlord gave up its right to re-enter except for a breach of the lease.30

However most tenants with psychiatric disabilities are too poor to afford housing at market rates,31 and many operators of public and subsidized housing are unwilling to rent to them.32 As a consequence, state and local mental health agencies began to develop their own housing programs, even though many had little or no experience in the housing field.33 Because mental health systems developed models to combine housing and services in a single setting, such programs were “typically segregated, professionally staffed, and congregate in nature . . . .”34 Given the fact that consumers had received the entire bundle of housing and mental health services almost exclusively in hospital settings, it is not surprising that “what developed were residential programs, located in the community, that simply replicated institutional programs.”35

By its control of both housing and services, its decision to co-locate them, and the lack of other housing opportunities in the rental market, mental health systems can exercise enormous control over the lives and behavior of people with psychiatric disabilities. To the extent that such control can be exercised without the consent of its objects, it is properly called coercion.36 Living in the community implies the room to make one’s own decisions (and mistakes), and to learn from the experience.37 The use of housing programs that shield consumers and mental health systems from the consequences of such freedom of choice undermines the very premise of community integration.38

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31 See, e.g., TECHNICAL ASSISTANCE COLLABORATIVE AND CONSORTIUM FOR CITIZENS WITH DISABILITIES, PRICED OUT IN 2000: THE CRISIS CONTINUES (2001) (there is no housing market in the country where a person with a disability receiving SSI benefits can afford to rent a modest efficiency or one-bedroom unit).
32 See Allen, supra note 19, at 722–723.
33 Id. at 723–727.
34 Carling, supra note 4, at 441.
36 Ronald J. Diamond, Coercion and Tenacious Treatment in the Community: Applications to the Real World, in COERCION AND AGGRESSIVE COMMUNITY TREATMENT, supra note 1, at 56.
37 Id. at 66. See Russell K. Schutt & Stephen M. Goldfinger, Housing Preferences and Perceptions of Health and Functioning Among Homeless Mentally Ill Persons, 47 PSYCHIATRIC SERVICES 381 (1996) (diagnosis of mental illness does not interfere with rational decision making about where to live).
38 Bonnie Milstein & Steven Hitov, Housing and the ADA, in IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT 137, 145 (Lawrence Gostin & Henry Beyer eds., 1993).
Jennifer Honig has written about three principal times when housing is used as a source of leverage to encourage treatment compliance.
(i) At hospital discharge, when hospital staff largely dictate the place to which a patient is discharged, and where “a patient may be obliged to accept placement in a more restrictive setting, such as a group home, as opposed to a less restrictive one, such as a supported apartment.”
(ii) Entering a community residence, when the mental health authority provides both housing and services (or where it contracts for them through a private provider that handles both aspects).
(iii) Living in a residence, which may have incorporated highly detailed “house rules” concerning daily behavior into their leases, such as curfews, prohibitions on guests or marriage, and requirements to attend day treatment, even though these do not fall within the core obligations of tenancy.

**COERCION AT THE INTERSECTION OF MENTAL HEALTH AND HOUSING**

In its simplest form, power is our ability to control events around us. Power also measures the extent to which we can get what we want and consequently the extent to which we influence others to contribute to what we want. Power typically carries the potential for control, and continues to exist whether the control is actually used or not. The fact that this potential for control exists inevitably influences our relationship. Coercion may be considered the use of this power to actually control or influence events.

Coercion clearly exists along a continuum, from subtle influence or persuasion to forcible compulsion. Compared with involuntary commitment or seclusion and restraint, using housing as leverage to force treatment compliance may be seen as relatively mild. However, the ongoing and implicit threat that one may lose stable housing has a very powerful effect on consumers’ choices. Further, the lack of residential stability may exacerbate psychiatric symptoms and make it harder to form the social connections that are necessary to sustain consumers successfully in the community.

Most mental health agencies acknowledge the centrality of choice and self-determination to the process of recovery. Even with this guiding philosophy, though, the range of choice is often constrained to those deemed acceptable by the agencies themselves.

Coercive interventions are often used as short-cuts, with insufficient attention to long-term implications. While permissible as an emergency intervention, coercion should not be relied upon to routinely achieve the objectives of the mental health system where less restrictive means are available. Where there is imminent risk of serious harm immediate action should be taken to prevent harm and preserve the

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40Curtis & Diamond, *supra* note 9 at 99.
42Kendrick, *supra* note 7, at 111.
43Diamond, *supra* note 36; see also Curtis & Diamond, *supra* note 9, at 117.
situations until other strategies can be considered, but in the absence of such a predicate other methods of intervention should be employed.44

Beginning in the 1970s and 1980s, many consumers fell through the cracks of the social services system45 and were unable to find decent, safe, and affordable housing. The result was a dramatic escalation of the number of consumers who found themselves homeless.46 Faced with this crisis and the increasing specter of re-institutionalization,47 many state and local mental health authorities (MHAs) became housing providers.48

As I have written elsewhere,49 many mental health systems responded by setting up their own housing programs, but they bore little resemblance to mainstream housing. They emphasized continuity of mental health treatment, and proposed to move consumers through a “residential continuum,”50 stretching from the hospital to mainstream housing, with many intermediate steps through which consumers would be required to graduate.51 At every stage, progress is linked to acceptance of mental health services. Over the last two decades, with some notable exceptions,52 most states have devoted the lion’s share of resources to group homes and other models that condition continued residence on treatment compliance.

Many states still take the view that people with disabilities (or people who are homeless) need “beds” or “slots” rather than homes. In this view, every person served represents an income stream that can help to support the operation of a group home, shelter or other congregate facility. This view is shared by many state and private agencies who feel they have a substantial stake in maintaining the current system of contracting and procurement, and thereby supporting their financial

45See Carling, supra note 4, at 439–440 (“Historically, mental health agencies have viewed housing as a social welfare problem and have defined their role exclusively in terms of treatment. Public housing agencies, in turn, have contended that consumers need specialized residential programs and have viewed housing needs as a responsibility of mental health agencies. Thus housing needs have often been ignored.”).
46See, e.g., TASK FORCE ON HOMELESSNESS AND SEVERE MENTAL ILLNESS, OUTCASTS ON MAIN STREET (1992); see also U.S. DEP’T OF HOUSING AND URBAN DEVELOPMENT, PRIORITY HOME!: THE FEDERAL PLAN TO BREAK THE CYCLE OF HOMELESSNESS (1994).
47Carling, supra note 4, at 441 (noting that many individuals remain in psychiatric hospitals because of the lack of housing, or cycle through emergency rooms and general hospitals in costly and often inappropriate stays).
48See Corporation for Supportive Housing, Housing and Support Services for Persons with Mental Illness: Creating Effective Partnerships at the State Level (May 1996) (unpublished concept paper, on file with author).
49Allen, supra note 19, at 723–724.
50See Carling, supra note 4, at 33–36.
51From a therapeutic perspective, the requirement that people with disabilities progress through a continuum of service-based housing may be counterproductive. See, e.g., Lisa B. Dixon & Fred C. Osher, Housing for People with Severe Mental Illness and Substance Use Disorders, 2 THE HOUSING CENTER BULL., vol. II, No. 3, at 7 (Oct. 1993). See also Jennifer Pyke & Joanne Lowe, Supporting People, Not Structures: Changes in the Provision of Housing Support, 19 PSYCHIATRIC REHABILITATION J. 5 (1996) (“Two easily identifiable problems with [the linear housing] approach are: 1) the needs of the individual are subsumed into service providers’ stereotypical assumption of need, and 2) people must move from setting to setting as either their needs change and/or their (program determined) length of time in setting expires. In effect, consumers/residents are penalized both by success and by failure.”).
52Ohio’s “housing-as-housing” policy remains one of the few comprehensive strategies to provide housing for people with psychiatric disabilities that is well integrated and provides opportunities to interact with people who do not have disabilities. See note 20, supra.
investments in congregate facilities. When people with disabilities are reduced to commodities in this fashion, community integration and responding to individual needs are not the primary objectives; rather, supposed efficiencies in the delivery of mental health services and preservation of the status quo are paramount.

Consumers find themselves in a precarious position because of the “bundling” of housing and services, with the attendant requirement that they comply with a treatment program in order to retain their housing. The inherent coercion involved in such an approach leaves consumers with little voice in their recovery plans. In other words, they do not aggressively question the treatment program prescribed for them because they fear they will put their housing in jeopardy. Similarly, overly restrictive rules (such as curfews), which are written for the convenience of providers, often prevent consumers from taking an active role in community affairs.53

People with psychiatric disabilities generally want the same kinds of housing that other citizens want.54 They want a range of housing options, and many express a preference to live on their own and not be grouped with other people on the basis of mental health service needs. They also prefer housing without high levels of behavioral demand, and that preference appears to be unrelated to diagnosis or severity thereof.55 In short, they want housing that is not identifiable as “mental health housing.” Obviously, there is some risk in considering only consumer housing preferences,56 but failure to give them appropriate weight may also lead to disappointing outcomes.57

Finally, any mental health housing policy must take into consideration the very considerable opposition among neighbors and local elected officials to the siting of group homes in residential neighborhoods.58 The phenomenon of NIMBYism (for “not in my back yard) is growing,59 and will make it increasingly difficult to develop more congregate housing.

53Even if such rules are ultimately found to be unenforceable, most people with mental illnesses believe they will be bound, and so will “behave” themselves, and not question the legitimacy of “treatment requirements.” Honig, supra note 39, at 19.
54Beth Tanzman, An Overview of Surveys of Mental Health Consumers’ Preferences for Housing and Support Services, 44 Hosp. & Community Psychiatry 450 (1993). See also E. Sally Rogers et al., The Residential Needs and Preferences of Persons with Serious Mental Illness: A Comparison of Consumers and Family Members, 21(1) J. Mental Health Admin. 42 (1994). See Schutt & Goldfinger, supra note 37, at 382 (citing Paul Carling, Major Mental Illness, Housing and Supports: The Promise of Community Integration, 45 Am. Psychologist 969–975 (1990)) (“The belief that consumer choice should be a central principle of housing placement is based on the philosophy that persons who are mentally ill have the right to make their own decisions and the belief that these persons will make appropriate choices about the supports they need.”).
56Stephen M. Goldfinger et al., Housing Placement and Subsequent Days Homeless Among Formerly Homeless Adults with Mental Illness, 50 Psychiatric Services 674, 678 (1999).
58Because of the proliferation of successful lawsuits challenging discriminatory zoning practices under the federal Fair Housing Act, see, e.g., Bazelon Center for Mental Health Law, Digest of Cases and Other Resources on Fair Housing for People with Disabilities (2000), the National League of Cities sponsored federal legislation in 1998 to repeal important protections of the Act. See, e.g., Annys Shin, Not in My Neighborhood, Nat’l J., April 18, 1998, at 877–879.
USING HOUSING AS LEVERAGE MAY VIOLATE FEDERAL AND STATE LAW

In addition to the therapeutic and ethical reasons to disfavor the use of housing as leverage to secure treatment compliance, the Supreme Court’s decision in *L.C. v. Olmstead* suggests that such an approach may violate the Americans with Disabilities Act (ADA).

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that the unnecessary segregation of people with disabilities in institutions may constitute discrimination based on disability. The court ruled that integration is fundamental to the purposes of the Americans with Disabilities Act, and that states may be required to provide community-based services rather than institutional placements for individuals with disabilities. The decision has far-reaching consequences for how states provide housing for people being discharged from state institutions, and for those at risk of being institutionalized.

The *Olmstead* case involved two women who were unnecessarily detained in a state psychiatric hospital long after their treating professionals determined they were prepared to live in the community. When the state of Georgia refused to move them out of the institution, citing the lack of community-based housing and supports, the women sued under the Americans with Disabilities Act (ADA).

The ADA says, among other things, that

\[\text{no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.}\]

Congress instructed the Department of Justice (DOJ) to promulgate regulations that would provide further guidance on the meaning of this provision of the ADA. Consistent with Section 504 of the Rehabilitation Act of 1973 (which governs recipients of federal funds), DOJ’s regulations provide that

A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities

28 C.F.R. §130(d).

DOJ defined “most integrated setting” to mean

...a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible


The Supreme Court concluded that “unjustified isolation... is properly regarded as discrimination based on disability.” In determining that the ADA required community-based housing and supports for people who were unnecessarily institutionalized, the Supreme Court said

[I]nstitutional 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....

*527 U.S. 581 (1999).*
Confined in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.

While the Olmstead case involved a state psychiatric hospital, its principles apply equally to other institutions, like residential schools, intermediate care facilities for people with mental retardation, nursing homes, residential treatment programs, and congregate or group homes.

Group homes and other congregate housing models that segregate people with disabilities and isolate them from community life can violate the ADA in the same way that larger institutions do, by perpetuating unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, and because confinement in a restrictive group home severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. As one commentator has put it,

Such homes...are often simply an extension of the institutions left behind. Group homes, halfway houses, quarterway houses, and board and care homes are hardly ‘homes’ at all. Like institutions, they segregate people with disabilities and confine them with little, if any, attention to individual choice.61

Olmstead virtually commands states to offer services in non-institutional settings. A state mental health system that offered community-based treatment only in group homes, which, by definition, segregate people on the basis of psychiatric diagnosis, would be committing a form of discrimination prohibited by the ADA. This is because the use of large congregate settings perpetuates unwarranted assumptions that residents are incapable or unworthy of participating in community life, and tends to diminish the everyday life activities of the residents.

Presaging the reasoning of Olmstead, Carling identified the key ingredients for achieving community integration as including “a focus on consumers’ goals and preferences, an individualized and flexible rehabilitation process, and a strong emphasis on normal housing, work and social networks,” and suggests that “[i]ntegration of tenants could be measured by the number and type of their relationships and activities that involve people without disabilities.”62

Monahan and colleagues63 have suggested that people with psychiatric disabilities perceive less coercion, at least on the question of involuntary hospitalization, when they feel they have gotten “procedural justice.” Similarly, consumers appear more likely to go along with a treatment plan where they feel they have had input and that their views have been respected.64 However, this principal of procedural justice often has little application to the admission to mental health housing, because

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61 Kanter, supra note 5, at 932–933.
62 Carling, supra note 4, at 442–443, 446.
63 John Monahan et al., Coercion to Inpatient Treatment: Initial Results and Implications for Assertive Community Treatment in the Community, in COERCION AND AGGRESSIVE COMMUNITY TREATMENT 95, supra note 1, at 13.

consumers are more likely to be placed in an available “bed” or “slot” rather than offered a range of choices. This concept of “placement” is a holdover from hospital discharge planning, which is almost entirely driven by staff, and is particularly ill suited to providing truly integrated housing in the community. In these circumstances, mental health professionals might confuse the need for services and supports in determining what housing is best, rather than finding the most integrated housing and seeking to mobilize the necessary services and supports.

Once in congregate housing, there is often little due process accorded prior to termination or eviction. Where compliance with treatment is mandated as a condition of keeping housing, consumers are told “it’s my way or the highway,” and there is typically no established process by which to challenge an adverse decision, or to get a decision by an impartial decision maker, a situation exacerbated by the lack of review by a disinterested decision maker and the absence of rights/recourse for residents. There is little “procedural justice” in bundled housing, where a person can lose housing for refusing to follow treatment recommendations.

Because of their primary focus on therapeutic services, mental health providers may believe that conditioning occupancy on acceptance of services is an appropriate incentive structure to ensure treatment compliance. The inherent characteristics of the congregate, service-mandated model—“fixed facilities with fixed staffing patterns”—nurture operational practices that mirror those of mental health institutions and that do little to prepare consumers to live independently.

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65Ronald J. Diamond, The Psychiatrist’s Role in Supported Housing, 44 Hosp. & Community Psychiatry 461, 462 (1993) (“In this dichotomous situation, psychiatrists either had total control over a patient’s living situation or completely abdicated involvement in residential needs.”)

66Id. (“A psychiatrist who is knowledgeable about community options and understands how to use available resources can greatly facilitate a client’s ability to live more independently. Psychiatrists with less information may feel that group homes or other kinds of congregate housing are the only way to provide adequate supervision.”)

67See generally, e.g., Allen, supra note 19; Honig, supra note 39.

68One notable exception is the Massachusetts Community Residence Tenancy (CRT) Law, under which the state has established such a formal procedure, and given precedential effect to hearing decisions. One seasoned advocate has concluded that the CRT Law “spotlights a widespread practice of [the Department of Mental Health] and residential service providers which cannot survive its promulgation: requiring residents to engage in mental health treatment as a condition of occupancy. This requirement is inconsistent with the CRT law and must be discontinued.” Honig, supra note 39, at 23 (emphasis added).

69The pressure to participate in mental health treatment may subside when residents become more aware of their rights, see Honig, id., but mental health systems and private providers do little to educate residents about their rights.

70See, e.g., Community Information Exchange, supra note 22, at 6 (“Some providers think there must be a mechanism to force people to change their lives, such as making housing contingent upon fulfillment of a behavioral contract. . . . These providers tie a fixed bundle of services to the housing and require residents to take the treatment or services offered.”); See also Sam Tsemberis & Ronda Eisenberg, Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities, 51 Psychiatric Services 487, 489 (2000) (“Most service providers favor the linear residential treatment model that uses clinically managed residential treatment settings and that regards homeless mentally ill persons as too fragile and too clinically unstable to cope with “normal” life. Proponents of the supported housing model regard consumer choice rather than treatment compliance as the necessary first step in the recovery process.”) (internal citations omitted).


72Id. at 182 (“These large facilities may have a tendency to teach the skills required for living in congregate living situations rather than the skills necessary to live independently. Sometimes the larger facilities actually impose barriers to the acquisition of independent living skills.”).
While the exercise of leverage is theoretically possible in any housing program, on-site services and a congregate setting are more strongly correlated with coercion. Conversely, when a person with a psychiatric disability is living in an apartment or other independent setting, state and federal law make it much more difficult to use housing as leverage. At the most concrete level, if people with psychiatric disabilities are considered tenants, then state law is likely to prohibit the termination (or threatened termination) of housing for “treatment noncompliance” as long as they were abiding by the basic obligations of tenancy. Many judges would be unlikely to enforce mental health service requirements under these circumstances. In this fashion, the rule of law inhibits the unwarranted use of coercion, and weeds out frivolous attempts to evict or terminate. Without the ability to resort to coercion, mental health systems would have to make more frequent use of constructive engagement strategies to secure compliance with treatment.

Notwithstanding the analysis above, there are federal funding programs that appear to permit, but not require, as a condition of housing assistance that residents be engaged in services. All appear to have statutory authorization, suggesting that Congress intended these discrete exceptions to federal civil rights laws. None of the program regulations diminishes the state law requirements for eviction; rather, they merely provide that financial assistance can be conditioned on treatment compliance. Moreover, in each case, it is clear that termination of assistance may occur only in the most severe cases, and only when rigorous procedures are followed to ensure due process of law. In each program, providers are also given discretion to reinstate participants.

Regulations for the Shelter + Care Program, which, by statute, is required to limit eligibility to people who have been homeless and have a psychiatric disability or addiction disorder, provide that, in addition to standard lease provisions, “the occupancy agreement may also include a provision requiring the participant to take part in the supportive services provided through the program as a condition of continued occupancy.” A related regulation permits a provider to terminate assistance to a participant who violates program requirements or conditions of occupancy, but requires providers to “exercise judgment and examine all extenuating circumstances in determining when violations are serious enough to warrant termination, so that a participant’s assistance is terminated only in the most severe cases.”

The Supportive Housing Program (SHP) permits a provider, in the most severe cases, to “terminate assistance to a participant who violates program requirements.” The operable regulation does not define “program requirement.” While not explicitly clear on the point, the Housing Opportunity for Persons with AIDS (HOPWA) program regulations can also be read to permit providers to require

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73 See “What Works,” infra.
74 See Allen, supra note 19, at 732–736.
75 See CORPORATION FOR SUPPORTIVE HOUSING, supra note 28.
77 24 C.F.R. §582.315(b).
78 24 C.F.R. §582.320.
79 24 C.F.R. §583.300(i).
residents to be engaged in a treatment program. The regulation provides that rental assistance to a tenant may be terminated if the tenant violates program requirements or conditions of occupancy. Other federal housing programs explicitly prohibit the bundling of housing and services, recognizing that such a practice can have a discriminatory effect.

The fairest reading of federal policy on the issue of bundling or leverage is that it may be permissible in a narrow range of programs where Congress has made a finding that adherence to programmatic requirements by people who have been homeless amounts to an essential element of recovery and community integration, notwithstanding federal civil rights laws that might dictate another outcome. In the absence of such a finding and exemption from federal law, providers face liability for imposing services or treatment requirements as a condition for housing.

Regardless of whether leverage is legal in a given program, all programs have an affirmative obligation to make modifications in program rules, policies, practices and services to ensure that people with disabilities are not excluded. The ADA "mandates significant accommodation for the capabilities and conditions of the handicapped." It is a "form of discrimination" to "fail[ ] to make modifications to existing facilities and practices," and the statute prohibits any similar conduct that results in persons with disabilities being "relegat[ed] to lesser services, programs, activities, [and] benefits . . . ."

In promulgating the ADA regulations, "the Attorney General expressly acknowledged in the ADA rule the obligation of all public entities to modify regular programs and provide auxiliary aids and services for persons with disabilities in regular programs, even where such program modifications and services already are appropriately offered to persons with disabilities in a segregated setting. If an individual with a disability chooses not to participate in the separate program, the public entity is required to provide the necessary program modifications and auxiliary aids and services in the regular setting . . . ." As outlined above, the Supreme Court adopted this view in its Olmstead decision.

80 24 C.F.R. §574.310(e)(2): Violation of requirements. (i) Basis. Assistance to participants who reside in housing programs assisted under this part may be terminated if the participant violates program requirements or conditions of occupancy. Grantees must ensure that supportive services are provided, so that a participant's assistance is terminated only in the most severe cases.
81 See, e.g., U.S. Department of Housing and Urban Development, Notice H-98-12, "Use of Section 202 Projects to Support Assisted Living Activities for Frail Elderly and People with Disabilities," at p. 10 ("The acceptance of any supportive service by a resident is totally voluntary.").
84 42 U.S.C.A. §12101(a)(5). See also 28 C.F.R. §35.130(b)(7) ("A public entity shall make reasonable modifications in policies, practices, and procedures when modifications are necessary to avoid discrimination on the basis of disability unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.").
85 Id.
Whether derived from the ADA or the Fair Housing Act, the concept of reasonable accommodation, as interpreted by the courts

...suggest[s] an outcome far different from eviction when a person with a disability fails to attend a training program, refuses his medications, or simply disagrees with the quality and management of a residential treatment program. Rather, the requirement that the application of rules be consistent with program goals anticipates an examination of what prompted the violation in the first place, whether individual treatment goals can still be accomplished even if the violation continues, and whether alternative treatment methods are available that are consistent with program objectives. By this measure, sanction is only appropriate if enforcement of an underlying rule is "manifestly related to the accomplishment of an objective of a program or activity."

In other words, reasonable accommodation "strives for a way to maintain the relationship between the rule-breaker and the rule-maker by accommodating both." As expressed in state and federal law, procedural fairness demands that there be a forum for the participant to tell her side of the story to an unbiased decision-maker who can at the least determine whether the offensive conduct actually took place, and if it did, whether it truly constitutes a sanctionable offense. This principle has been explicitly recognized in the context of mental health consumers by a number of state and federal courts.

RE-EXAMINING THE CORE VALUES OF COMMUNITY MENTAL HEALTH

Whether out of commitment to a philosophy of person-centered planning, or out of concern for legal liability, state mental health systems are struggling with how to balance old-fashioned ways of thinking with 21st century mandates. Nowhere is this clearer than in the question posed by this special section on coercion. Innovative mental health commissioners have committed their states’ systems to integrated housing and to ridding the system of coercion (except in emergency circumstances). Such clear and strong statements of values can change the whole system by creating disincentives for frivolous coercion and making it safer to speak out about rights and abuses within the system.

87Korman, supra note 1, at 110.
88Id.
89Citywide Associates v. Penfield, 564 N.E.2d 1003, 409 Mass. 140 (Mass. 1991) (Section 504 reasonable accommodation provision requires landlord to absorb minor repair costs and give an occasionally delusional tenant time to secure heightened services); Roe v. Sugar River Mills Assoc., 820 F.Supp. 636 (D.N.H. 1993) (Apartment complex is required to attempt to accommodate plaintiff's mental handicap before it can evict him on the grounds that he constitutes a threat to safety of others); and Roe v. Housing Authority, 908 F.Supp. 814 (D.Colo. 1995) (Apartment complex is required to demonstrate that no reasonable accommodation would eliminate or acceptably minimize any risk posed by tenant with mental illness who exhibited abusive behavior before it can evict him on the grounds that he constitutes a threat to safety of others).
90See note 20, supra.
92Curtis & Diamond, supra note 9, at 101 ("The enumeration and establishment of human, civil and consumer rights helps establish and legitimize a base of personal power for individuals who are typically viewed as having less power within the system.").
When faced with the question about whether bundling housing and services is effective, our answer has much to say about our aspirations for people with psychiatric disabilities. Certainly, we could put everyone with a diagnosis in a secure congregate facility in the community and claim to be in favor of community integration. However, federal law and common sense suggest that this would be inappropriate. The degree to which a mental health system is prepared to take risks, and to allow consumers to take risks with regard to housing and service use, is a fair measure of its commitment to person-centered planning and community integration. 93

If the housing is conceptualized as permanent, and as a “home” rather than a residential treatment site, then it is counterintuitive to take (or threaten to take) the housing away because of treatment issues. In many cases, it is the very unavailability or withholding of a basic human need—such as housing—that exacerbates the symptoms of mental illnesses. How can a system that pledges fealty to the goal of community integration maintain policies that permit such withholding as a form of behavior control? And how can the ethical codes of psychiatrists, psychologists, social workers, and other mental health professionals permit them to enforce such policies? 94

Mental health professionals are called upon to identify appropriate housing for consumers on a regular basis. But when their own conception of what is possible is constrained by a system that thinks in terms of “beds” and “slots” rather than “homes,” and where there are powerful, inertial forces with a stake in the current approach, it is not surprising that congregate housing is over-prescribed. A place to restart the inquiry would be to have every mental health system ask itself the following question: “Do persons with psychiatric disabilities need residential treatment, or do they need help establishing themselves in a place to live that feels like home?” 95

More and more mental health systems acknowledge that recovery should be an important goal of the mental health system, and at least one model statute makes it the central focus. 96 State agencies adopt such goals, understanding the critical relationship between self-determination and recovery. 97

93Kendrick, supra note 7, at 111 (“While the availability of choices may be a relative improvement, it is notable that the choice [consumers] might exercise are always subject to the initiative and approval of the authorities who control their life circumstances.”). See also, Curtis, supra note 9, at 108 (“There is growing concern about how paternalism may negatively impact on the ability or motivation of an individual to move naturally through stages of adult maturation or engage in a recovery process. The degree of paternalism exhibited directly impacts on the options of an individual to exercise autonomy or choice, and consequently may directly or indirectly shape an individual’s perception of his/her abilities and potential. For many persons, this becomes a self-reinforcing cycle in which an individual begins to believe and then fulfill diminished expectations. Risk-taking behavior is also restricted which limits the opportunity of individuals to learn and grow from mistakes. Paternalism may also result in anger by an individual and an avoidance of treatment or support services, minimizing any potential benefit.”) (internal citations omitted).

94Id., at 105–106 (“ ... at least some of those leaders and professionals in the field are either doubtful that ‘home’ can be achieved as a practical matter, or are actively resistant to the proposition. When a field is dominated by a view of clients as pathologically or irreversibly different, it is understandable that the dominant residential model will not be normative and probably significantly deficient.”).

95Diamond, supra note 65, at 461, 462 (“A stable living situation is critical in the successful treatment and rehabilitation of persons with serious mental illness. What is required is not just a warm warehouse where persons with mental illness can be stored, but a residence of reasonable quality that is acceptable to the client and that has the potential for becoming a home as well as providing housing.”).

96See BAZELON CENTER, supra note 29.

In this vein, consumer desire for normalized, low demand housing should not be read as opposition to services altogether. One study suggests that many individuals who are labeled uncooperative by providers are willing to accept help if they view that help as relevant to them. As Diamond concludes, “[C]onsumers appear to understand that independence is facilitated by supports. The challenge to mental health systems is to support clients effectively wherever they live, rather than limiting supports to those people living in traditional residential programs.”

WHAT WORKS?

As I suggested at the beginning of this article, a focus on whether leverage results in greater treatment compliance is short sighted. Instead, the analysis should consider the broader question of the respective impact of bundled and unbundled housing on real life outcomes. We know that poor housing is correlated with poor community adjustment outcomes, and that residents of supportive housing experienced stability in housing, greater satisfaction, and a dramatic reductions in hospital days. Greater choice in housing is also positively correlated with happiness and life satisfaction ratings and, ultimately, with community success. Some research even suggests that client preference may predict success in different housing options better than any other single criterion. Reliance on congregate models has led to poor quality housing in many states.

The irony is that recent research indicates that housing programs serving people with even very severe psychiatric disabilities (and, in many instances, co-occurring substance abuse problems) can result in successful placement in independent housing that complies with the ADA and the Olmstead mandate, and which produces outcomes which are significantly better than the old bundled models. Pathways to Housing has demonstrated that such outcomes are possible, even for people coming in directly off the street, and even in a hyper-inflated market like New York.

98 David L. Shern et al., A Psychiatric Rehabilitation Demonstration for Individuals Who are Street Dwelling and Seriously Disabled, in MENTALLY ILL AND HOMELESS: SPECIAL PROGRAMS FOR SPECIAL NEEDS (William R. Breakey & James W. Thompson eds., 1997).
102 Debra Srebnik et al., Housing Choice and Community Success for Individuals with Serious and Persistent Mental Illness, 31(2) COMMUNITY MENTAL HEALTH J. 139 (1995).
105 Tsemberis & Eisenberg, supra note 70.
The key has been the provision of comprehensive, but entirely voluntary, mental health, addiction, and other services. Pathways ‘allows clients to determine the type and intensity of services or refuse them entirely.’\textsuperscript{106}

The Pathways study attempted to answer two questions: “First, can homeless individuals who live on the streets and who have psychiatric disabilities or substance addictions successfully obtain and maintain an independent apartment of their own without prior treatment? And second, do housing programs that require clients to participate in psychiatric treatment and maintain sobriety have a greater housing retention rate than a program that first offers clients access to independent living without requiring treatment?”\textsuperscript{107}

The study concluded “After five years, 88 percent of those in the Pathways program and 47 percent of those in the comparison group remained housed . . . . [T]enants of the Pathways program achieved greater housing tenure than those in the linear residential treatment settings when the analysis controlled for the effects of the other client variables in the equation. Specifically, the risk of discontinuous housing was approximately four times greater for a person in the linear residential treatment sample than for a person in the Pathways program.”\textsuperscript{108}

Most importantly, “[f]or the homeless clients in these programs, living in apartments of their own with assistance from a supportive and available clinical staff teaches them the skills and provides them with the necessary support to continue to live successfully in the community.”\textsuperscript{109} Ironically, Pathways’ commitment to providing permanent housing equips its residents with the skills that will allow them to leave Pathways housing and find integrated housing on the private market.

A number of other communities have developed outreach services and housing programs that have proven effective with “treatment resistant” or “hard to serve” clients, and have implemented them with virtually no coercion. In 2000, the Connecticut legislature authorized and funded the Pilot Peer Engagement Specialist Program,\textsuperscript{110} which employs people with psychiatric disabilities to conduct outreach to consumers who have not been engaged with the community mental health system. During the past three years, under the rubric of “AB 34” programs, the California Department of Mental Health has funded innovative outreach and engagement practices which have shown significant promise.\textsuperscript{111}

\textsuperscript{106}Id. at 489.
\textsuperscript{107}Id.
\textsuperscript{108}Id. at 491. See also James M. Mandelberg & Lawrence Telles, The Santa Clara County Clustered Apartment Project, 14 PSYCHIATRIC REHABILITATION J. 21 (1990) (even people with severe impairments can succeed in the right housing model; also deals with issues of social isolation by establishing scattered site housing in a small geographic area where people can walk to see one another, and where consumers are actively encouraged to provide social support for one another).
\textsuperscript{109}Tsemberis & Eisenberg, supra note 70, at 492.
\textsuperscript{110}CONN. GEN. STAT. §17a–484b (2001).
\textsuperscript{111}In September 1999, the California legislature enacted Assembly Bill 34 (AB 34) to provide funding for three counties (Los Angeles, Sacramento, and Stanislaus) for Demonstration Pilot programs to provide comprehensive services to severely mentally ill persons who are “homeless recently released from a County jail or the State prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them.” Since that time, the California Department of Mental Health estimates that people served by AB 34 programs have experienced a 66% decrease in number of days of psychiatric hospitalization, an 82% decrease in days of incarceration, and 80% fewer days of homelessness. See President’s New Freedom Commission on Mental Health, supra note 29, at Box 4.
The Corporation for Supportive Housing (CSH), a national financial and technical assistance intermediary, has worked with local programs in eight states and is a proven approach, with verifiable results. CSH has consistently advocated for approaches that link housing and services in ways that are not coercive—that is, housing is not contingent upon participation in services, but the availability of voluntary services and the use of engagement strategies will facilitate access to and retention of housing by people who might otherwise be rejected by most landlords. CHS has recently published a manual on the policy, legal, and therapeutic ramifications of supportive housing.

CONCLUSION

Without much data, mental health systems have believed that using housing as leverage was effective in keeping people with psychiatric disabilities in treatment and on the road to recovery. Many mental health housing programs were built on an assumption that using housing as leverage was permissible, in terms of agency philosophy, professional ethics, and the law. The past 20 years have seen a revolution in thinking in each of these three areas—most prominently the passage of the ADA—and an increasing awareness that programs that rely too heavily on leverage and coercion may actually impede recovery and community integration.

As we stand at the threshold of a new era, ushered in by the Supreme Court’s decision in Olmstead, we have the opportunity to remake mental health housing programs. If we simply replicate the old congregate models, we will be left with “fixed facilities and fixed staffs” and we will have lost an opportunity to qualitatively improve the lives of people with psychiatric disabilities. Our task as researchers, advocates and policy makers begins with asking the right questions.