



Just Like Where You and I Live

**Integrated Housing Options for
People with Mental Illnesses**

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by Michael Allen¹

Community integration stands in stark contrast to outdated views of people with psychiatric disabilities—whether held by professionals, family members, or the general public—as perennial patients, helpless and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.²

INTRODUCTION

More than a decade after Carling observed a “paradigm shift” in thinking about full community participation by and integration of people with psychiatric disabilities,³ 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,⁴ in large part because such arrangements stigmatize mental illnesses and make recovery and integration even more difficult.

If we believe that housing is 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.⁵

A PARADIGM SHIFT

With respect to housing, the paradigm shift involves a fundamental redefinition of the relationship between consumers and housing and service providers.⁶ 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. A number of commentators have suggested that such housing is on precarious legal footing.⁷ A growing number of other mental health stakeholders, including mental health commissioners,⁸ advocacy organizations,⁹ providers¹⁰ and federal government agencies,¹¹ have made it clear that such coercive housing practices no longer have a place in the mental health system. They suggest that the principles of person-centered planning and choice must prevail over administrative convenience and familiar modes of administration.¹²

The central question is not what policies will promote compliance with mental health treatment, but rather, what role stable, integrated, unbundled housing can play in securing good life outcomes.¹³ 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.¹⁴ Although there may be a fine line between linking and bundling, that line is defined in terms of voluntariness.¹⁵

“SPECIALIZED” HOUSING STIGMATIZES PEOPLE WITH MENTAL ILLNESSES

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

But most tenants with psychiatric disabilities are too poor to afford housing at market rates,¹⁶ and many operators of public and subsidized housing are unwilling to rent to them.¹⁷ 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.¹⁸ 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...”¹⁹ Given 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.”²⁰

Living in the community implies the room to make one’s own decisions (and mistakes), and to learn from the experience.²¹ 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.²² 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 choices deemed acceptable by

the agencies themselves.²³

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 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), written for providers’ convenience, often prevent consumers from taking an active role in community affairs.

People with psychiatric disabilities generally want the same kinds of housing that other citizens want.²⁴ 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.²⁵ In short, they want housing that is not identifiable as “mental health housing.” Obviously, there is some risk in considering only consumer housing preferences,²⁶ but failure to give them appropriate weight may also lead to disappointing outcomes.²⁷

OLMSTEAD PLACES LIMITATIONS ON “MENTAL HEALTH” HOUSING

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*²⁸ 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* 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

...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.

42 U.S.C.A. § 12132

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. 28 C.F.R. pt. 35, App. A, p. 450

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. . . .

[C]onfinement 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. 527 U.S. 581, 600-601
(1999)

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 which 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.²⁹

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. That 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."³⁰

Consumers who live in congregate housing find that there is often little due process accorded prior to termination or eviction.³¹ 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 decisionmaker³²—a situation exacerbated by the lack of review by a disinterested decisionmaker 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.³³

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.³⁴ The inherent characteristics of the congregate, service-mandated model—“fixed facilities with fixed staffing patterns”³⁵—nurture operational practices that mirror those of mental health institutions and do little to prepare consumers to live independently.³⁶

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.³⁷ At the most concrete level, if people with psychiatric disabilities are considered tenants,³⁸ 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.³⁹ 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.

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....”⁴⁰ As outlined above, the Supreme Court adopted this view in its *Olmstead* decision.

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. Innovative mental health commissioners have committed their states' systems to integrated housing⁴¹ and to ridding the system of coercion (except in emergency circumstances).⁴² 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.

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.⁴³

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—like 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?⁴⁴

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 individuals with psychiatric disabilities need residential treatment, or do they need help establishing themselves in a place to live that feels like home?”⁴⁵

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.⁴⁶ State agencies adopt such goals, understanding the critical relationship between self-determination and recovery.⁴⁷

WHAT WORKS?

We know that poor housing correlates with poor community adjustment outcomes,⁴⁸ and that residents of supportive housing have experienced stability in housing, greater satisfaction and a dramatic reductions in hospital days.⁴⁹ Greater choice in housing is also positively correlated with happiness and life satisfaction ratings and, ultimately, with community success.⁵⁰ Some research even suggests that client preference may predict success in different housing options better than any other single criterion.⁵¹ Reliance on congregate models has led to poor quality housing in many states.⁵²

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 be successfully placed 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.⁵³ 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.”⁵⁴

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?”⁵⁵

The result: “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.”⁵⁶

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.”⁵⁷ 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,⁵⁸ 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.⁵⁹

The Corporation for Supportive Housing (CSH), a national financial and technical assistance intermediary, has worked with local programs in eight states⁶⁰ in a proven approach, with verifiable results.⁶¹ 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 engagement strategies will facilitate access to and retention of housing by people who might otherwise be rejected by most landlords. It has recently published a manual on the policy, legal and therapeutic ramifications of supportive housing.⁶²

A number of other models have demonstrated great success in “unbundling” housing and services and in creating integrated housing opportunities in the community, including:

▣ **Ohio Department of Mental Health: Housing as Housing.** Instead of group-living designs, housing-as-housing emphasizes scattered-site, mixed-site design, meaning that buildings are geographically dispersed and that tenancy at a given site includes both mental health consumers and the general public.

▣ **The Village Integrated Service Agency.** A program of the Mental Health Association of Los Angeles, the Village allows its “members” to select the type of housing they want and need as part of their personal service plan, which outlines members’ living, work, social and educational goals. A personal service coordinator advocates with the local housing authority for rent subsidies for eligible members, and the Village’s financial services division makes loans available for security deposits and moving expenses.

▣ **Vinfen Corporation in Massachusetts.** Employing a “zero reject” policy, Vinfen is committed to meeting the needs of every individual referred regardless of the cultural or linguistic background, medical needs or the severity of the disability.

▣ **Housing Unlimited.** In Rockville, Maryland, HUI separates housing from psychiatric services, concentrates on housing only, and offers permanent housing

one needs.” Available at <http://www.newhousingopp.org/hah.htm> (last visited Jan. 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.

NASMPHD Housing Work Group, *Best Practices in Housing and Supports for People with Psychiatric Disabilities*, Apr. 1996, at 1.

9 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/ps1.cfm> (last visited Jan. 30, 2003).

10 For 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 p. 6.

11 The 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).

12 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 5, 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.”)

13 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.

14 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. & POLICY IN MENTAL HEALTH 199 (1994). *See also* Ohio Department of Mental Health, *supra* note 8 (“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.”)

15 *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.”)

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- 16 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).
- 17 See Allen, *supra* note 7, at 722-23.
- 18 *Id.* at 723-27.
- 19 Carling, *supra* note 3, at 441.
- 20 Rita Ogilvie, *The State of Supported Housing for Mental Health Consumers: A Literature Review*, 21 PSYCHIATRIC REHABILITATION J. 122 (1997).
- 21 *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).
- 22 Bonnie Milstein & Steven Hitov, *Housing and the ADA*, in IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT 137, 145 (Lawrence Gostin & Henry Beyer eds., 1993).
- 23 Kendrick, *supra* note 5, at 111.
- 24 Beth 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 21, 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.”).
- 25 Cathy Owen et al., *Housing Accommodation Preferences of People with Psychiatric Disabilities*, 47 PSYCHIATRIC SERVICES 628 (1996).
- 26 Stephen M. Goldfinger et al., *Housing Placement and Subsequent Days Homeless Among Formerly Homeless Adults with Mental Illness*, 50 PSYCHIATRIC SERVICES 674, 678 (1999).
- 27 Don Fitz & Richard C. Evenson, *Recommending Client Residence: A Comparison of the St. Louis Inventory of Community Living Skills and Global Assessment*, 23 PSYCHIATRIC REHABILITATION J. 107 (1999).
- 28 527 U.S. 581 (1999).
- 29 Arlene S. Kanter, *A Home of One's Own: The Fair Housing Amendments Act of 1988 and Housing Discrimination Against People with Mental Disabilities*, 43 AM. U. L. REV. 925, 932-33 (1994).
- 30 Carling, *supra* note 3, at 442-443, 446.
- 31 See generally, e.g., Allen, *supra* note 7; Jennifer Honig, *Impact of Community Residence Tenancy Law on the Use of Housing to Coerce Treatment*, THE ADVISOR, Spring 1997.
- 32 One 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.” Jennifer Honig, *Impact of Community Residence Tenancy Law on the Use of Housing to Coerce Treatment*, THE ADVISOR, Spring 1997, at 23 (emphasis added).

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

34 See, e.g., Community Information Exchange, *supra* note 10, 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.”)

35 Robert S. Frazier & Howard T. Baker-Smith, *Predicting Appropriate Level of Care in an Innovative Residential Program Design for People with Mental Illness*, 21 PSYCHIATRIC REHABILITATION J. 181, 182 (1997).

36 *Id.* 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.”)

37 See “What Works,” *infra*.

38 See Allen, *supra* note 7, at 732-36.

39 See CORPORATION FOR SUPPORTIVE HOUSING, BETWEEN THE LINES: A QUESTION AND ANSWER GUIDE ON LEGAL ISSUES IN SUPPORTIVE HOUSING 92-93 (2001).

40 Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L.REV. 393, 431 (1991) (emphasis in original) (citing 56 Fed. Reg. 35,703-04 (1991)).

41 See note 8, *supra*.

42 Howard Copeland, *Vermont's Vision of a Public System For Developmental and Mental Health Services Without Coercion*, available at <http://www.state.vt.us/dmh/rod.pdf> (last visited Jan. 31, 2003).

43 Kendrick, *supra* note 5, 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.”).

44 *Id.*, 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.”).

45 Ronald J. Diamond, *The Psychiatrist's Role in Supported Housing*, 44 HOSP. & COMMUNITY PSYCHIATRY 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.”).

46 See BAZELON CENTER FOR MENTAL HEALTH LAW, AN ACT PROVIDING A RIGHT TO MENTAL HEALTH SERVICES AND SUPPORTS (2002).

47 William A. Anthony, *Recovery from Mental Illness: the Guiding Vision of the Mental Health Service System*, 16(4) PSYCHOSOCIAL REHABILITATION J. 11, 11-24 (1993); DEBRA S. SREBNICK, PERCEIVED CHOICE AND SUCCESS IN COMMUNITY LIVING FOR PEOPLE WITH PSYCHIATRIC DISABILITIES (1992).

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- 48 F. Baker & C. Douglas, *Housing Environments and Community Adjustment of Severely Mentally Ill Persons*, 26(6) COMMUNITY MENTAL HEALTH J. (1990).
- 49 Debra J. Rog & John Hornik, Research to Practice: Implications of a National Study of Supported Housing, Presentation at the Institute of State Olmstead Coordinators, October 2, 2002 (on file with author) (While consumers in supportive housing programs tended to receive fewer mental health and housing-related services than consumers living in group homes and supervised apartments, they show no significant differences in outcomes). J. McCarthy & G. Nelson, *An Evaluation of Supportive Housing for Current and Former Psychiatric Patients*, 42 HOSP. & COMMUNITY PSYCHIATRY 1254 (1991).
- 50 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).
- 51 Priscilla Ridgeway & Anthony M. Zippel, *The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches*, 13(4) PSYCHOSOCIAL REHABILITATION J. 11 (1990).
- 52 See Clifford Levy, *For Mentally Ill, Death and Misery*, N.Y. TIMES, April 28, 2002, at A1; Eyal Press & Jennifer Washburn, *Neglect for Sale*, 11(12) AM. PROSPECT 1 (May 8, 2000); Katherine Boo, *Invisible Deaths: the Fatal Neglect of D.C.'s Retarded: System Loses Lives and Trust*, WASH. POST, December 5, 1999, at A1.
- 53 Sam Tsemberis & Ronda Eisenberg, *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*, 51 PSYCHIATRIC SERVICES 487, 489 (2000)
- 54 *Id.* at 489.
- 55 *Id.*
- 56 *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).
- 57 Tsemberis & Eisenberg, *supra* note 53, at 492.
- 58 CONN. GEN. STAT. ' 17a-484b (2001).
- 59 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, INTERIM REPORT TO THE PRESIDENT (2002) at Box 4.
- 60 California, Michigan, Illinois, Ohio, Minnesota, New York, New Jersey and Connecticut. See CSH website, at www.csh.org for more details on efforts in these states.
- 61 See, e.g., Dennis P. Culhane et al., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13(1) HOUSING POL’Y DEBATE 107 (2002).
- 62 See CORPORATION FOR SUPPORTIVE HOUSING, *supra* note 39.

63 Carling, *supra* note 3, at 445 (Answering the questions about where people with psychiatric disabilities live, where they want to live and how we can help them succeed in their preferred settings “requires a shift from research as defined by mental health professionals to that defined by consumers....begin defining ‘success’ in terms of quality of life variables such as physical and material well-being; relations with other people; social, community and civic activities; personal development and fulfillment; and recreation.”).