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Separate and Unequal: The Struggle of Tenants with Mental Illness to Maintain Housing

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I. Introduction

Kristina, a young woman with mental illness, sought treatment and housing from a local mental health agency. The agency placed her in its supported apartment program, where she held a lease in her own name and shared a two-bedroom apartment with another woman. Relations with her case manager became difficult when Kristina complained that she was not having enough input into her treatment plan. When she missed several meetings with the case manager and dropped out of day treatment to attend college, she was labeled "treatment resistant" and summarily locked out of her apartment in late November. "Go to the emergency shelter," she was told. "Come back when you are ready to behave." /1/

Despite a revolution in thinking about the rights of tenants generally /2/ and the passage of two major civil rights statutes /3/ designed to protect their rights, Kristina and many others with severe mental illness /4/ do not yet enjoy status as full tenants. As a consequence, the very housing stability so vital to their recovery has often eluded them. /5/ The history of physical segregation of and discrimination against these "consumers" /6/ of mental health services is well known. /7/ Less apparent is how societal stigma and a paternalistic attitude of "deep and abiding charity" /8/ toward mental health consumers have stifled the development of a civil rights and empowerment perspective on their rights as tenants, especially within the mental health system -- an increasingly important provider of housing for people with mental illness. As happened with Kristina, consumers are often treated as if they were incapable of making decisions about their own lives -- in fact, as if they were children whose every decision must be made for them. While mental illness can be incapacitating at times, most consumers are able to make rational, informed decisions about their lives and their treatment. /9/

The last ten years have witnessed enactment of the landmark Fair Housing Amendments Act, which prohibits discrimination against people with psychiatric disabilities, the flowering of a sophisticated consumer movement, and dramatic advances in community-based treatment. But instead of new thinking about consumers' ability to live independently, we see inadequate attention to enforcement of these rights for the hundreds of thousands of consumers involved in community residential programs run by local mental health authorities (MHAs) and their contractors.

This article assesses the current state of the law and challenges poverty and disability advocates to marshal new resources and arguments in an effort to secure full tenancy rights for these consumers. Part I briefly reviews the historical segregation of people with psychiatric disabilities and the chaos resulting from their discharge into communities that were not willing or prepared to provide housing and community-based treatment for them. Part II considers the decisions of state and local mental health authorities -- directly and through contractors -- to become housing providers and examines whether the resulting housing programs meet consumers' needs. Part III discusses the "bundling" of housing and support services -- the requirement that consumers comply with a treatment program in order to retain housing -- and suggests that the practice is counterproductive and of questionable legality after passage of the Americans with Disabilities Act (ADA) and the Fair Housing Amendments Act of 1988. Part IV examines the procedural protections against eviction available to consumers under most states' landlord-tenant laws. Part V reviews the emerging professional and consumer consensus in favor of "unbundling" of housing and services. In Part VI, the article concludes that the legal tools are in place to enhance consumers' power to secure and maintain stable housing but that vigorous enforcement of federal and state laws and a new vigilance by advocates are required.

II. The Historical Segregation of People with Psychiatric Disabilities

For the better part of a century, the official policy of the United States was to segregate people with disabilities from "normal" society. /10/ They were isolated in large institutions and hospitals, "consistent with a deep and abiding charity [that] . . . permits all to live under circumstances best suited to make each useful and happy." /11/ Beginning in the late 1950s and early 1960s, a national policy of community living developed, inspired in part by notions of civil rights and human decency and driven by concern about the huge expense of warehousing people in large institutions. The core principle of this "normalization" movement was that individuals with disabilities are entitled to the cultural opportunities, surroundings, experiences, risks, and associations enjoyed by people without disabilities. In housing, normalization means living in a normal-size home in a residential neighborhood that offers opportunities for normal social integration and interaction.

For people whose mental illness is episodic or mild, or for people with sufficient resources, mental illness is often a manageable challenge. For people with serious mental illness who are poor and therefore dependent on the social services system for housing and supports, the effects of their illness can be much more debilitating. /12/

In the private and public housing sectors, housing discrimination closes off large segments of the housing market. The persistent problem of NIMBYism ("Not In My Back Yard"), has dramatically limited housing choice for people with psychiatric disabilities, "often regardless of the individual's financial resources. In many states, people with mental disabilities have been, and continue to be, restricted to the least attractive parts of a community -- to neighborhoods where housing is relatively inexpensive and often unsafe." /13/ As a consequence, for lack of housing in the community, many consumers face prolonged hospitalization or are forced into inappropriately restrictive housing.

Historically, public housing authorities have been unresponsive to the needs of people with disabilities. /14/ This is driven in part by bias and prejudice at the local level, and in part by the federal government's de facto policy of supporting segregated housing for people with disabilities /15/ and underemphasizing access to mainstream public and assisted housing programs. /16/

III. Mental Health Authorities as Housing Providers

Against this backdrop of neglect, and with federal support for public and assisted housing rapidly declining, many consumers fell through the cracks of the social services system and were unable to find decent, safe and affordable housing. /17/ The result was a dramatic escalation of the number of consumers who found themselves homeless. /18/ Faced with this crisis and the increasing specter of reinstitutionalization, /19/ many state and local MHAs became housing providers. /20/

Guided by their experience with treatment programs, however, MHAs set up housing options and management structures that bore little resemblance to mainstream housing. Instead of focusing on the need for permanence and stability in housing, many early MHA-sponsored housing programs emphasized continuity of mental health treatment. They proposed to move consumers through a "residential continuum," /21/ stretching from the hospital to emergency shelter, through group homes to supported apartments and, eventually, to independent living in mainstream housing. At every stage, progress is linked to acceptance of mental health services.

Unfortunately, very little housing was produced at the high end of this continuum; rather, most MHAs never progressed beyond the group-home stage of development. This arrested development is due in large part to MHAs' views that the housing they supply is merely a place for consumers to receive treatment, /22/ and not their long-term homes. This myopic view yields two results of critical importance, which are the focus of this article. First, as long as MHAs emphasize the administrative convenience of providing on-site mental health services, they will remain stuck on the group-home or congregate-living model, will not respond to consumer choice about housing, /23/ and will foster the kind of dependency in residents that undermines the goal of independent living. As one commentator has put it,

Providers of services to people with mental disabilities also must share some of the blame in promoting segregation of people with mental disabilities. These providers continue to view housing as part of the service continuum rather than as a person's 'home.' Service providers have developed housing programs based on general models, often without giving attention to individual needs or desires. Group homes and other 'congregate living facilities' have been viewed as the best alternative to institutionalization. Such homes, however, 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. The residents of such homes are seldom asked where or with whom they want to live. /24/

Second, by insisting that they provide "residential treatment programs" rather than housing, MHAs expose themselves to liability under the ADA which requires that they "shall administer services,

programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." /25/ They may also face exposure under Section 504 of the Rehabilitation Act, /26/ the Fair Housing Act, /27/ and state landlord-tenant laws which regulate the operation of residential housing. In short, despite their best intentions, many MHAs and their contractors are simply unprepared for their responsibilities as landlords.

Research uniformly reflects consumers' desire for stable, affordable housing with flexible support services available on demand. /28/ And at least one study makes clear that symptoms of mental illness did not appear to interfere with study participants' rational decision making about where to live. /29/ From a therapeutic perspective, the requirement that consumers progress through a continuum of service-based housing may be counterproductive. /30/ Most mental health systems, however, have not identified or created sufficient independent-living housing. As a consequence, many consumers remain in group homes and other congregate settings that mandate acceptance of services.

IV. The "Bundling" of Housing and Services

Many MHAs and other groups that develop and manage housing programs for consumers consider them 'residential treatment' rather than housing. /31/ When sponsoring groups with no previous experience in housing view themselves as treatment and service providers rather than landlords, they are likely to run afoul of legal and ethical constraints, including the ADA, the Fair Housing Act, state landlord-tenant laws and, conceivably, confidentiality in the context of therapist and patient. Providers who believe that no landlord-tenant relationships exists between the agency and its residents feel free to impose conditions that have little to do with whether a person can fulfill the typical obligations of tenancy, such as timely payment of rent, maintaining the premises in good condition, and not disturbing neighboring tenants.

A. Bundling and Extraordinary Lease Requirements

Because of their primary focus on therapeutic services, MHAs may believe that conditioning occupancy on acceptance of services is an appropriate incentive structure to ensure treatment compliance. /32/ Even where MHAs have accepted the role of landlord, many have incorporated highly detailed "house rules" concerning daily behavior into their leases. These may include curfews, restrictions on guests, mandatory attendance at day programs, prohibitions on marriage or childbirth, /33/ adherence to medication regimens, or regular therapy. /34/ These substantial limitations on liberty and privacy may work at cross-purposes with the eventual goal of independence.

Consumers find themselves in a precarious position because of the requirement that they comply with a treatment program in order to retain their housing. The inherent coercion involved in such "bundling" leaves them unwilling to question aggressively the treatment program prescribed for them because they fear such a challenge will put their housing in jeopardy. Similarly, overly restrictive rules (such as curfews), generally written for providers' convenience, are only tangentially related to a person's ability to fulfill the core obligations of tenancy.

Bundling, and lease provisions allowing eviction of noncompliant tenants, are frequently instituted for the convenience of agency staff, which is often more concerned about maintaining order in residential programs than promoting consumer independence and choice. MHA staff members are typically trained according to the "medical model," /35/ which presumes that clinicians and other professionals know what is best for consumers and limits consumer involvement in decision making. Further, researchers have noted that diversion of time away from providing treatment and support is an inevitable, though unintended, consequence of operating an on-site, congregate services program. /36/

Beyond constraining their choice and privacy, the continued emphasis on treatment compliance as a condition for housing prevents consumers from assuming the normal responsibilities of tenancy and the consequences of success or failure in that role. The law teaches, and common sense confirms, that tenants -- with or without disabilities -- who are able to fulfill the core responsibilities of tenancy will maintain their housing for a longer period than those who cannot. MHAs that provide voluntary, flexible supportive services are more likely to achieve this goal than those that do not. /37/ It also creates an atmosphere for the use of housing in that a provider can condition continued occupancy on adherence to a mandatory set of services. It is in this context that the provision of housing can be most coercive.

A significant step toward ending housing as a "tool of coercion" /38/ is to separate housing from services. Until that is accomplished, our efforts must be directed to mitigating the coercive nature of the relationship. Careful attention to defining roles of MHAs and consumers, and to enforcing the rights and responsibilities of each, is the best way to embark upon such an endeavor. The dispute is not about whether supportive services are useful; many consumers will need supportive services in order to stay in the community. /39/ The real issue is the coercive nature of mandatory acceptance of such services. /40/

B. Substantive Protections Against Bundling

Where house rules or other mandatory service regulations are imposed without flexibility to a particular consumer's needs and without the consumer's full participation in both planning and implementation, they may violate the federal civil rights laws. The primary federal laws affecting the housing rights of consumers are the ADA, /41/ to the extent that the housing can be deemed a public service under Title II; the Fair Housing Amendments Act of 1988 (FHAA) /42/ and Section 504 of the Rehabilitation Act of 1973, /43/ to the extent that the provider is a recipient of federal funds. While each prohibits discrimination on the basis of disability, the ADA also requires that public services be provided in the most integrated setting appropriate to the needs of people with disabilities.

Legal protections and tools, such as those found in the ADA, Fair Housing Act, and Section 504 of the Rehabilitation Act are often overlooked by mental health and housing organizations alike as an important component of assisting people with psychiatric disabilities with their housing needs. The legislative history makes clear that these three statutes represent a "clear and comprehensive

national mandate to end discrimination against individuals with disabilities and to bring those individuals into the economic and social mainstream of American life." /44/

1. Americans with Disabilities Act

Under the ADA, a state or local MHA is required to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." /45/ Further, MHAs are prohibited from imposing eligibility criteria which screen out or tend to screen out certain people with disabilities from full enjoyment of any service, program, or activity. /46/ Section 202 of Title II of the ADA provides: "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the service, programs, or activities of a public entity, or be subjected to discrimination by any such entity." /47/ In addition to overt discriminatory treatment, the ADA also "define[s] unnecessary segregation as a form of illegal discrimination against the disabled." /48/

In *Helen L. v. Didario*, the most significant ADA Title II case decided to date, the Third Circuit struck down a state policy requiring a woman with disabilities to receive care in a nursing home rather than through an attendant care program, for which she was qualified, in her own home. The court sustained her claim that "DPW's failure to provide those services in the 'most integrated setting appropriate' to her needs (without a proper justification) violates the ADA"; /49/ it noted that, in the nursing home, the woman had no contact at all with people without disabilities. The court held that providing attendant care services to the resident in her home would not be a fundamental alteration in the state's attendant care program or its nursing home program, and therefore the state was required to offer them to promote the goal of integration. Mere administrative convenience, the court said, "does not constitute valid justification for separate or different services . . . under [title II of the ADA]." /50/

In passing the ADA, Congress relied heavily on the analogy to race discrimination, essentially finding policies of "separate but equal" impermissible. Congress was moved by the continuing destructive effect of segregation, and [is] acting now to reverse these practices, root and branch, and to eliminate their legacy. In short, [Congress concluded] that a severe, lifelong disability may be handicapping, but more handicapping has been the practice of congregating services for persons with disabilities in settings different or separate from those in which [others] are provided those services. /51/

One commentator has concluded that, under the ADA,

classifications that segregate persons with disabilities are . . . to be presumptively illegal and given the same scrutiny under the ADA as classifications based upon race are given under the [F]ourteenth [A]mendment's Equal Protection Clause and the Civil Rights Act of 1964. . . . [and that] Congress expressed in the ADA its determination that 'segregation,' isolat[ion], and 'institutionalization' of persons with disabilities were 'forms of discrimination' to be disestablished. /52/

As noted earlier, group homes and other communal living arrangements are developed and maintained largely for the administrative convenience of the service provider from whom residents seek treatment and other supports. Under the ADA, and the holding in *Helen L.*, this is insufficient justification for segregating people with psychiatric disabilities. /53/

The *Helen L.* opinion articulates the standard against which MHA-sponsored, service-linked housing must be measured. As noted above, while the MHA may find it administratively convenient to conduct on-site services, that in itself is not enough to save such a practice if it has the effect of segregating consumers. And it is precisely this policy, and the conditioning of occupancy on the acceptance of services, that causes the segregation. While there has been no reported decision under the ADA on the legality of bundling housing and services, it is clear from *Helen L.* that MHAs would have a substantial burden in justifying this practice. Just as the state defendant in *Helen L.* could not carry its burden with respect to fundamental alteration, it will be difficult for MHAs to argue that providing mental health services off-site, or in a manner that is not tied to occupancy of housing, constitutes a fundamental alteration of the mental health treatment program.

While one cannot know with certainty what justifications an MHA would offer if challenged, /54/ the ADA makes clear that it is insufficient to claim that "it has always been done this way." And because the ADA does not distinguish between the provision of mental health services and the provision of housing for purposes of Title II, MHAs will find no refuge in the argument that they are supplying "residential services" rather than housing. Further, unlike many other statutes, "[t]he ADA does not require deference to the judgment of state officials because Congress knew that the states' treatment of persons with disabilities has been fraught with illegitimate judgments concerning the supposed efficacy of separate, isolated public services." /55/ In the view of one commentator, MHAs, because of the nature of the services they provide, may not raise the issue of cost to defeat a claim for integrated services. /56/ Finally, in the face of a changing professional and consumer paradigm of housing for people with mental illness, /57/ it will become more and more difficult to defend such practices.

The promise of full integration of consumers into the community depends on equal treatment. Under such a scenario, access to housing would be a function of an individual's ability to comply with the same rules of tenancy that apply to all tenants: payment of rent, keeping an apartment in clean condition, abiding by terms of the lease, and not disturbing neighbors. With these rights come a full panoply of responsibilities. Many consumers had their liberty dramatically curtailed in state mental hospitals. Their return to the community was supposed to herald a new day in which they would exercise choice and enjoy or suffer the consequences of those choices. Instead, the coercion experienced in the institution has, in many instances, followed them into the community and threatens to undermine their independence and recovery. In her exploration of whether people with mental disabilities have achieved true integration into our residential communities, one commentator has concluded that the answer is clearly no. /58/ The goal of the ADA, and of the movement to unbundle housing and services, is to change that answer to a resounding yes.

2. Fair Housing Act

While the Fair Housing Act "is a clear pronouncement of a national commitment to end the unnecessary exclusion of persons with handicaps from the American mainstream," /59/ its applicability to mandatory-service housing is not clear-cut. The Fair Housing Act, focused on leveling the playing field for people with disabilities, seeks to ensure that they are treated in the same fashion as people without disabilities. Because MHAs, by definition, seek to serve only people with psychiatric disabilities, the equal treatment mandate is difficult to apply. However, there may be some promise, as outlined below, in its mandate that landlords, including MHAs, provide reasonable accommodation for people with disabilities.

While the Fair Housing Act has been effective in preventing the eviction of persons with mental illness from mainstream housing, /60/ and there has been some litigation concerning whether residents in transitional or temporary housing have Fair Housing Act defenses to eviction, /61/ the Act has not been applied to the bundling issue.

3. The Reasonable Accommodation Requirement

The ADA "mandates significant accommodation for the capabilities and conditions of the handicapped." /62/ It is a "form of discrimination" to "fai[l] to make modifications to existing facilities and practices," /63/ and the statute prohibits any similar conduct that results in persons with disabilities' being "relegat[ed] to lesser services, programs, activities, [and] benefits" /64/

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. . . . /65/

Specifically, paragraphs (d) and (e) of 28 C.F.R. Sec.35.130 provide that the public entity must administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities, i.e., in a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible, and that persons with disabilities must be provided the option of declining to accept a particular accommodation. /66/

Similarly, the Fair Housing Act requires MHAs to provide reasonable accommodations in their rules, policies, practices, or services if necessary to give persons with disabilities an equal opportunity to participate in or benefit from a program. /67/

By its very nature, reasonable accommodation requires an individualized consideration of the needs of a person with disabilities and a conscious weighing of the requested change in light of the benefit to the tenant and the burden upon the MHA. This makes even more important a clear definition of the MHA's role and the nature of its housing program goals because reference to these goals must be made in assessing each request for reasonable accommodation. MHAs must have in place a process to handle requests for such reasonable accommodations to house rules as necessary

to allow a tenant to use and enjoy the dwelling fully. The refusal of or failure to consider a request for reasonable accommodation is, in itself, a violation of the applicable statute and can subject an MHA to liability for money damages.

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."

. . . Thus, reasonable accommodation promotes a dialogue in which program violations and program purposes are scrutinized in a context of individual circumstances and needs. If the purpose of a program rule can be served by some arrangement other than exclusion, then the law requires continued participation. This view understands the breaking of rules not as conduct subject to sanction, but as an expression of a need or desire that may or may not conflict with the purpose of the residential program. Reasonable accommodation thus strives for a way to maintain the relationship between the rule-breaker and the rule-maker by accommodating both. /68/

IV. Landlord-Tenant Law Provides Protection Against Arbitrary Eviction

Sanctity of the home has been a powerful ideal in the American legal tradition. The home not only provides the basic necessity of shelter but is also central to an individual's emotional and personal life. The intangible connection between an individual and her home is not limited to homeowners. For tenants as well an involuntary removal from the home can be devastating, depriving the tenant of both physical and emotional security. /69/

When consumers are not treated as full tenants, they may be at risk of losing their homes without any due process. Most state laws hold that a landlord-tenant relationship is created when -- with or without a written lease -- one party pays some amount of rent, is required to abide by the core responsibilities of tenancy, and is given a right to use and occupy a dwelling. By that definition, most consumers occupying housing units administered by an MHA are considered tenants and given the concomitant protection of state and federal law. Likewise, service providers acting in the role of landlords, who accept rent payments and impose conditions of tenancy, must abide by FHAA and ADA requirements.

These protections come into sharpest focus, as they do in the private sector, when a tenant allegedly violates some lease provision or rule and the landlord contemplates termination from the program and eviction. In this context, the essential question is whether the conduct complained of is so serious and, in legal parlance, so material to the underlying landlord-tenant relationship, that eviction is warranted. Are there limits to the enforceability of onerous "house rules"? Can we limit eviction to "serious" violations of "material" lease terms? That is, are some violations so innocuous as not to support eviction? What are the other forms of sanction for "noncompliant" tenants?

As with evictions from public housing or private market housing, it is equally important in MHA-sponsored housing that tenants have due process protections against arbitrary eviction. Courts that have considered this issue have spoken fairly uniformly in saying that all landlords, including MHAs and their contractors, must use state court eviction processes to protect the rights of tenants. /70/

State courts with jurisdiction to hear eviction cases are well suited to resolving disputes between MHAs and tenants in that they routinely handle similar cases concerning public and private market housing. These courts must uniformly apply preexisting rules to cases involving alleged violations and must measure whether the violations are serious enough under state law to warrant eviction. The mere requirement of a fair process with an impartial decision maker often prevents arbitrary decisions to deprive a tenant of MHA-sponsored housing. Resort to such a process is also likely to mitigate against a claim that an MHA has violated the Fair Housing Act by evicting a tenant without providing reasonable accommodation.

While states have adopted radically different substantive landlord-tenant laws, virtually every state now prohibits self-help eviction without judicial process. /71/ Some states have created heightened protection for people with disabilities. For instance, Connecticut chose, in the early 1980s, to create "protected tenancies" for the elderly, blind and people with certain disabilities. /72/ While the statutory definition appears to exclude people with mental disabilities, /73/ the approach used in Connecticut is instructive. Once a tenant meets the definitional test, she may not be evicted except for specified good cause. /74/ Massachusetts offers the greatest and most specific protection against eviction in legislation recently enacted to allow removal from programs of community-based residential care and services licensed, funded, or operated by the department of mental health only if "the occupant has substantially violated an essential provision of a written agreement containing the conditions of occupancy or if the occupant is likely, in spite of reasonable accommodation, to impair the emotional or physical well-being of other occupants, program staff or neighbors." /75/

The application of landlord-tenant laws, of course, requires a threshold determination that a person is a tenant or otherwise enjoys procedural protections set down by law. The concept of "exclusive possession" is an important factor in determining the status of a consumer's occupancy. The possessory interest of a lodger, occupant, or licensee is represented by a sliding scale, with a licensee having no possessory interest in a piece of property. A lease imparts the strongest legal possessory interest and transfers a "possessory interest" to the tenant; this factor chiefly distinguishes a lease from a license, easement, or covenant. /76/

A tenant is ordinarily considered an occupant who has not only an interest in land but also some estate, be it ever so small. A written lease or other document can be a guide to the intentions of the

parties, /77/ but the absence of a lease is not fatal if intention can be determined through other means. Courts look at other factors, including length of stay, whether the occupant has another abode and the extent to which the person has made the dwelling his home for the time being. If the person has considerable control over his unit, his occupancy tends toward that of tenant. /78/ Payment of rent has been seen as enough to establish a landlord-tenant relationship. /79/

Courts must distinguish between what are essentially "institutional facilities" and what are essentially "residential properties." /80/ In *Fischer v. Taub*, the court found that the rent stabilization law did not apply to licensed adult care facilities where residents were not living "independently." The court held that residents, by operation of the adult care licensing statute, held mere licenses and therefore could not enjoy the protections of landlord-tenant law. In *Metalsky v. Mercy Haven, Inc.*, however, where a resident with mental illness had lived in licensed community residence for 18 months, the court

reject[ed] Mercy Haven's contention that because it is a 'treatment program' and not a 'landlord' it is entitled to utilize self-help in ejecting 'undesirables' from the community residence. While the court recognizes that Mercy Haven functions not only to provide shelter, but also to afford therapeutic and other support services, the provision of long term supervised shelter is an integral and primary function of this community residence. /81/

A tenant who is unable to comply with the terms of a lease, even with accommodation, is protected by state landlord-tenant law, which says that a tenant cannot be evicted without due process of law and the uniform application of preexisting rules to the particular situation.

Basic rules of fairness require a formal process for termination of housing rights. Fairness means that a participant knows what program rule she violated and what acts or events led to the program violation. Fairness also demands that there be a forum for the participant to tell her side of the story to an unbiased decision maker, who at the least can determine if 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. /82/

Courts have been called upon to determine the rights of people in combined housing and services programs under state landlord-tenant laws. Two in particular merit attention. *Serreze v. YWCA of Western Massachusetts* involved a treatment program for battered women which was designed to help them make the transition to independent living. /83/ Women in the program paid a portion of their incomes toward rent and were assigned an apartment. They were required to find a job (or go to school) and attend individual and group counseling sessions. For various reasons, the women stopped attending the counseling sessions, and they were terminated from the program and advised to find alternative housing. During a state conciliation hearing requested by the women, agency representatives returned to the apartments and changed the locks; they argued that the protections against self-help eviction did not protect the women because they were not tenants.

The women filed suit, arguing that they paid rent, each had exclusive possession of their units, they were required to put down security deposits, they were responsible for payment of utilities, and the

occupancy agreement made clear that they had an expectation of privacy in their units. Although the court found that the transitional housing program suggested an intention to "depart from the traditional concepts of the landlord-tenant relationship," the women paid for the exclusive right of possession and control, which was sufficient to require a court proceeding before eviction could take place. "The mere fact that the [Transitional Living Program] is a condition of the occupancy agreement, and the services provided are inherently restorative, should not preclude the application of [statute banning self-help eviction]." /84/

The other case, Carr v. Friends of the Homeless, Inc., an occupant of a single-room occupancy building operated by a nonprofit homeless services provider was locked out of his room after being discharged from a vocational training program (run by an independent agency) because of a disagreement with his supervisor. /85/ Carr filed suit, and the court entered a temporary restraining order, holding that the relationship between Carr and the service provider was that of landlord and tenant. The court relied principally upon the written agreement between the parties to find the existence of a tenancy relationship and found that even where the primary purpose of the program was service, rather than housing, a tenancy could be created by the agreement of the parties relative to the housing portion of the program.

VI. The Emerging Consensus Among Mental Health Professionals and Consumers Concerning the "Unbundling" of Housing and Services

During the past ten years, MHAs have begun to change their approach to consumers on issues including treatment and housing, for reasons related to the passage of state and federal consumer-protection laws and those related to forces in the mental health field. This evolution to a model of consumer involvement and empowerment is happening slowly and is mirrored in the larger disability movement's activism on this issue. This section briefly treats the elements of this emerging consensus:

The mental health field is in the midst of a paradigm shift from an era of institutional and facility-based thinking through a transitional period in which people were seen principally as service recipients needing a comprehensive community support system to a view of people principally as citizens with a potential for, and a right to, full community participation and integration. /86/

Groups as diverse as state mental health directors /87/, consumers /88/, providers, /89/ disability advocates /90/ and academicians /91/ now oppose the bundling of housing with mandatory services and are calling for a new approach that embodies greater involvement of consumers, emphasizes permanent housing, and makes treatment and services available on an as-needed basis. This emerging consensus has come to be called supported housing.

The central principles of supported housing can be stated simply: "Housing is a person's home, not a residential treatment setting. Supported housing is permanent and affordable and consumers have all the rights and responsibilities of tenancy. The mental health system respects and supports a consumer's abilities to fulfill and manage these new rights and responsibilities." /92/

It is important to note that supported housing emphasizes responsibilities as well as rights. For too long, according to proponents, consumers have been subjected to a system that limits choice and attempts to protect them from the consequences of choice. The new paradigm requires that consumers be treated as full tenants -- indeed, as full citizens. The lease demands imposed on consumers should be the same as those imposed on all tenants: pay the rent, keep the dwelling in good condition, abide by the reasonable terms of the lease, and refrain from disturbing neighbors. Similarly, consumers should, with the benefit of reasonable accommodation for their disabilities, face the same consequences as other tenants if they violate the lease. The supported housing model practices what the ADA has preached: that people with mental illness have a right to "full community participation and membership." /93/

Necessarily, this view of "community integration assumes that

[p]eople's needs change over time; hence services and supports should be available at varying levels of support for as long as a person needs them, and regardless of where the person lives. People's relationships with service providers also change over time, so that continued access to housing, work situations or social networks should not depend on whether or not a person is using mental health services at the time, or whether the person is 'getting along' with a service provider. /94/

But while the leaders of the public mental health systems in each state are on record in favor of supported housing principles, /95/ and support for this new paradigm is growing, there is still resistance to giving up familiar ways in which "things have always been done." As a longtime observer of the subject has written:

This view of community integration represents a fundamental shift in the way that mental health systems have 'done business' over the last century or more. Therefore change will not come easily, even if it will come eventually. 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. /96/

VII. Conclusion

Many mental health professionals, especially those trained according to the "medical model," find the concepts of community integration and rights protection difficult to understand and even more difficult to implement. Ultimately, the prospects for change within the system will depend on changing this mind-set. While one of the vehicles for accomplishing this is rights enforcement and litigation, energy must also be devoted to educating MHA staff about the benefits of the supported housing paradigm and providing technical assistance in implementing its principles.

The housing crisis for people with mental illness will undoubtedly continue, and MHAs increasingly will find it necessary to provide, secure, or broker housing for consumers in order to support their recovery. This article is written in the hope that MHAs and advocates can work together to make community integration and rights protection central elements of any housing program.

Footnotes

/1/ Emily J. Kaufmann, Legal Services of Northern Virginia (attorney for Kristina) (personal communication).

/2/ See, e.g., Edward H. Rabin, *The Revolution in Landlord-Tenant Laws: Causes and Consequences*, 69 *Cornell L. Rev.* 517, 537 -- 38 (1984); Deborah Hodges Bell, *Providing Security of Tenure for Residential Tenants: Good Faith as a Limitation on the Landlord's Right to Terminate*, 19 *Ga. L. Rev.* 483 (1985).

/3/ The Fair Housing Amendments Act of 1988, 42 U.S.C. Sec. 3601, and the Americans with Disabilities Act (1990) (ADA), 42 U.S.C. Sec. 12101. I acknowledge that Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Sec. 794, essentially built the foundation for later laws and that Congress has explicitly instructed courts to consider Section 504 cases as having precedential value under the Fair Housing Act and the ADA. However, because the courts have analyzed cases involving the tenancy of people with mental illness under the later-passed statutes, this article contains only a limited discussion of Section 504.

/4/ The federal government defines "severe mental illness" as "mental or emotional disorders (including, but not limited to, schizophrenia, schizoaffective disorders, mood disorders, and severe personality disorders) that significantly interfere with a person's ability to carry out such primary aspects of daily life as self-care, household management, interpersonal relationships, and work or school." Task Force on Homelessness and Severe Mental Illness, *Outcasts on Main Street 7* (1992). The federal Center for Mental Health Services estimates that 5.5 million Americans are disabled by severe mental illness. Center for Mental Health Services, *Mental Health Statistics* (1993).

/5/ See, e.g., Paul J. Carling, *Return to Community: Building Support Systems for People with Psychiatric Disabilities* 206 -- 26 (1995).

/6/ While there has been much debate among people with mental illness about appropriate terms to use in describing themselves, a rough consensus has formed around the terms "consumer," "psychiatric survivor" and "ex-patient." For brevity, this article will use "consumer" to refer to people with severe mental illness who currently use, or have used, support services provided by a mental health system.

/7/ See Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 *Temp. L. Rev.* 393 (1991).

/8/ Id. at 406. See also 135 Cong. Rec. S10,717 (daily ed. Sept. 7, 1989) (statement of Sen. Edward M. Kennedy) ("The road to discrimination is paved with good intentions. For years, because of our concern for the less fortunate, we have tolerated a status of second class citizenship for our disabled fellow citizens.").

/9/ Russell K. Schutt & Stephen M. Goldfinger, Housing Preferences and Perceptions of Health and Functioning Among Homeless Mentally Ill Persons, 47 *Psychiatric Servs.* 381 (1996).

/10/ See Cook, *supra* note 7, at 401 (1991) (noting that people with severe disabilities were considered, in the view of one state agency, "a defect . . . [that] wounds our citizenry a thousand times more than any plague"); Jonathan C. Drimmer, Cripples, Overcomers, and Civil Rights: Tracing the Evolution of Federal Legislation and Social Policy for People with Disabilities, 40 *U.C.L.A. L. Rev.* 1341, 1342 (1993). See also *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 460 -- 63 (1985) (Marshall, J., concurring in part and dissenting in part) (noting that, as a result of Social Darwinism and other forces which led many experts to consider people with mental disabilities as menaces to society, "[a] regime of state-mandated segregation and degradation soon emerged that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow").

/11/ Cook, *supra* note 7, at 406 (quoting C.S. Yoakum, *Care of the Feeble-minded and Insane in Texas*, *Bull. U. Tex.*, Nov. 5, 1914, at 83).

/12/ There is not a single county in the United States where a person with a psychiatric disability, supported by disability benefits, could afford an efficiency or one-bedroom apartment, according to the federal standard of affordability. McCabe, Sinikka, et al., *A National Study of Housing Affordability for Recipients of Supplemental Security Income*, 44 *Hosp. & Community Psychiatry* 494 -- 95 (1993).

/13/ 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, 993 (1994), citing Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 *Emory L.J.* 375, 388 (1982).

/14/ See, e.g., Consortium for Citizens with Disabilities Housing Task Force and Technical Assistance Collaborative, *Opening Doors: Recommendations for a Federal Policy to Address the Needs of People with Disabilities* (1996); see also National Action Coalition for Disability Rights in Housing, *Responding to HUD's "Housing for Persons with Disabilities": Debunking the Myths and Recommending Policies We Can Live with* (Jan. 1995)

/15/ Disability groups have recently expressed their displeasure with the housing policies of the U.S. Department of Housing and Urban Development (HUD): "With few exception[s], HUD's housing programs for people with disabilities are paternalistic, demeaning mini-institutions with program requirements that violate the spirit and the letter of fair housing and civil rights Laws." National Action Coalition for Disability Rights in Housing, *supra* note 14, at 1.

/16/ Id. at 8: "[T]he already acute housing crisis faced by people with disabilities became even more severe with the enactment of Title VI of the Housing and Community Development Act of 1992 (P.L. 102-550). Another blow came with the passage of Section 10 of the Housing Opportunity Extension Act of 1996 (P.L. 104-20). With this legislation, hundreds of thousands of HUD public and assisted housing units previously available to people with disabilities have been and will increasingly be designated exclusively for elderly households." See also Diane Engster et al., *Housing as a Tool of Coercion*, in *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law* (Deborah L. Dennis & John Monahan eds., 1996).

/17/ See Paul J. Carling, *Housing and Supports for Persons with Mental Illness: Emerging Approaches to Research and Practice*, 44 *Hosp. & Community Psychiatry* 439, 440 (1993). ("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.").

/18/ See, e.g., Task Force on Homelessness and Severe Mental Illness, *supra* note 4; see also U.S. Dep't of Hous. & Urban Dev., *Priority Home!: The Federal Plan to Break the Cycle of Homelessness* (HUD-1454-CPD) (Mar. 1994).

/19/ Carling, *supra* note 17, 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).

/20/ See Corporation for Supportive Housing, *Housing and Support Services for Persons with Mental Illness: Creating Effective Partnerships at the State Level* (unpublished concept paper, May 1996). Some mental health authorities (MHAs) have responded creatively to the problem of admission by entering into cooperative agreements with public housing authorities (PHAs) to ensure that consumers' access is expanded; curiously, consumers' rights are better protected in these PHAs than if they resided in MHA-sponsored housing. Interest in such cooperative agreements was so significant in the early 1990s that the Center for Mental Health Services created a *Blueprint for a Cooperative Agreement Between Public Housing Agencies and Local Mental Health Authorities* (available from the Judge David L. Bazelon Center for Mental Health Law), with the following provisions, among others: (1) "Individuals with serious mental illness will have fair and equitable access to public housing and admission will be based solely on meeting eligibility criteria, not on participation in service programs." (2) "No resident will be evicted or otherwise penalized by the PHA solely for terminating status as a recipient of services from the MHA, provided they continue to fulfill essential residency requirements specified in the lease signed by all applicants." (3) "A resident who begins to fail to meet residency requirements and who ceases receiving services from the MHA will, to the extent possible, have the opportunity to re-establish the service relationship with the MHA, or alternatively to make similar, equivalent arrangements with another agency chosen by the individual, which result in meeting residency requirements." Id. at 1, 6.

/21/ See Carling, *supra* note 5, at 33 -- 36.

/22/ Id.

/23/ Research on consumer preferences consistently shows that the overwhelming majority of people with histories of psychiatric illness prefer to live on their own in an apartment or house. Beth Tanzman, *An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services*, 44 *Hosp. & Community Psychiatry* 450 -- 55 (1993); E. Sally Rogers et al., *The Residential Needs and Preferences of Persons with Serious Mental Illness: A Comparison of Consumers and Family Members*, 21 *J. Mental Health Admin.* 42 (1994). See Russell K. Schutt & Stephen M. Goldfinger, *Housing Preferences and Perceptions of Health and Functioning Among Homeless Mentally Ill Persons*, 47 *Psychiatric Servs.* 381, 382 (1996), citing Paul Carling, *Major Mental Illness, Housing and Supports: The Promise of Community Integration*, 45 *Am. Psychologist* 969 -- 75 (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."). See also Stephen M. Goldfinger & Russell K. Schutt, *Comparison of Clinicians' Housing and Recommendations and Preferences of Homeless Mentally Ill Persons*, 47 *Psychiatric Servs.* 413, 414 (1996) ("Our research confirms the existence of a marked divergence in the housing preferences of consumers and the type of housing clinicians recommend. . . . We believe that clinicians and consumers must work together to identify housing arrangements that are most likely to be in accord with consumers' needs and preferences and that mental health agencies must attempt to provide such housing arrangements.").

/24/ Kanter, *supra* note 13, at 932 -- 33.

/25/ 28 C.F.R. Sec. 35.130(d).

/26/ Section 504 of the Rehabilitation Act, 29 U.S.C. Secs. 794 et seq.

/27/ Fair Housing Act, 42 U.S.C. Secs. 3601 et seq.

/28/ See, e.g., Tanzman, *supra* note 23, at 450 -- 55.

/29/ Schutt & Goldfinger, *supra* note 23, at 381 -- 86.

/30/ See, e.g., Lisa B. Dixon & Fred C. Osher, *Housing for People with Severe Mental Illness and Substance Use Disorders*, *Hous. Ctr. Bull.*, Oct. 1993, at 7.

/31/ Engster et al., *supra* note 16, *passim*.

/32/ See, e.g., Community Information Exchange, *Would You Live There? Housing for People with Special Needs*, 45 *Strategy Alert* 6 (Fall -- Winter 1995) ("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.").

/33/ The standard lease used by the Alliance for the Mentally Ill of Delaware (AMID), which operates under contract with the state MHA, contains the following addendum: "To the extent permitted by HUD regulations and federal and state laws, the marriage of tenant or birth of a child to tenant shall be deemed material non-compliance with this agreement [if] said family members reside with tenant at the dwelling unit specified above. Because of the communal nature of each site, the program cannot adequately deliver services to clients who marry or who have children."

/34/ The AMID lease, *supra* note 33, also contains the following provision: "Refusing to continue with mental health treatment means that I do not believe I need mental health services, which include[] Woodmont Gardens housing. I understand that since I am no longer a consumer of mental health services, it is expected that I will find alternate housing. I understand that if I do not, I may face eviction." After finding a legal services lawyer, Kristina, the woman described at the beginning of this article, was able to get back into her apartment. Shortly thereafter, she received a notice which said: "Residential Treatment was terminated in response to your decision to not adhere to the mutually agreed upon terms, rules and regulations of the treatment program, which were set up to ensure your safety and sobriety. . . . In addition, you have clearly stated that you are not interested in the therapeutic support of [the apartment program], and are motivated primarily by housing needs. The [agency] provides treatment programs, not housing programs. . . .[Y]our occupancy of the apartment . . . is an integrated part of your treatment program . . . and not a separate program."

/35/ Carling, *supra* note 5, at 72, 75 -- 76.

/36/ "Investigators . . . have noted what they term the 'coffee pot syndrome' -- when all services are congregated in the same setting, service providers tend to spend less time providing services needed by their clients with disabilities and more time socializing with one another." Cook, *supra* note 7, at 456, citing Voeltz, Program and Curriculum Innovations to Prepare Children for Integration, in *Public School Integration of Severely Handicapped Students: Rational Issues and Progressive Alternatives* 155 (N. Certo et al. eds., 1984).

/37/ Lexi Turner & Ann O'Hara, Supported Housing and Services: A View from the Field, *Hous. Ctr. Bull.*, May 1995, at 6 -- 7.

/38/ Engster et al., *supra* note 16, *passim*.

/39/ Once consumers have found appropriate, community-based housing, they may need supports to ensure that they can maintain it. These services -- which run the gamut from budget counseling, to "conciliation" of disputes with rental managers, to negotiating for reasonable changes in rules and policies to accommodate the disability of a tenant, and which are distinct from the type of treatment or therapeutic services which are at the core of the MHA's expertise -- must be available on a flexible, as-needed basis by the MHA. Such services are particularly important when a landlord-tenant relationship begins to break down and where appropriate intervention and request for accommodation may help preserve the relationship.

/40/ There is an interesting parallel concerning the "continuum of care" and bundling in HUD's homelessness programs and to a certain extent in its Family Self-Sufficiency Program within the

Section 8 tenant-based assistance programs. Continuum of care approach emphasizes the integration of mental health services into housing programs and granting broad discretion to states, localities, and providers to determine what service components will be included (or mandated). See, e.g., U.S. Dep't of Hous. & Urban Dev., *supra* note 18, at 75 -- 79. With respect to bundling, compare 24 C.F.R. Sec. 583.300(i) (1993) (Supportive Housing Program, which permits termination of a participant "who violates program requirements") ; 42 U.S.C. Sec. 11386(j) (Shelter Plus Care Program, which targets assistance to homeless people with disabilities and provides for termination of assistance if an individual or family, "violates program requirements"); and 24 C.F.R. pt. 984 (Family Self-Sufficiency (FSS) Program, which allows for termination of the Section 8 rental subsidy for failure to comply with an FSS contract).

/41/ 42 U.S.C. Sec. 12101.

/42/ *Id.* Sec. 3601.

/43/ 29 U.S.C. Sec. 794.

/44/ House Comm. on the Judiciary, H.R. Rep. No. 485 (III), 101st Cong. 2d Sess. 23, reprinted in 1990 U.S.C.C.A.N. 445, 446.

/45/ 28 C.F.R. Sec. 35.130(d) (1995).

/46/ *Id.* Sec. 35.130(b)(8)

/47/ 42 U.S.C. Sec. 12132.

/48/ *Helen L. v. Didario*, 46 F.3d 325, 333 (3d Cir. 1995), cert denied sub nom. *Pennsylvania Secretary of Public Welfare v. Idell S.*, 116 S. Ct. 64 (1995). The court in *Helen L.* also quoted with approval from the Justice Department's amicus brief: "The 504 coordination regulations, and the ADA 'make clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination within the meaning of those statutes, independent of the discrimination that arises when individuals with disabilities receive different services than those provided to individuals without disabilities.'" 46 F.3d at 335 (citation omitted).

/49/ *Id.* at 336.

/50/ *Id.* at 338, quoting from House Comm. on the Judiciary, *supra* note 44, at 50, reprinted in 1990 U.S.C.C.A.N. at 473.

/51/ 136 Cong. Rec. H2639 (daily ed. May 22, 1990) (statement of Cong. Ronald V. Dellums).

/52/ *Cook*, *supra* note 7, at 397, 419 (citations omitted).

/53/ But see *Williams v. Secretary of the Executive Office of Human Servs.*, 609 N.E.2d 447, 453 (Mass. 1993), which held, in part that "nothing in the ADA requires that a specific proportion of housing placements provided by a public mental health service be in 'integrated' housing." There

the plaintiff's proof rested almost entirely on a statistical argument that a large number of people with mental disabilities were required to live in service-linked housing. The court rejected the claims of three individuals who, it said, had not shown that their own placements were inappropriate, or had been inappropriately placed after passage of the ADA. The holding, premised as it was on the holdings of several federal courts pre-ADA and pre-Helen L., is certainly limited, although not formally superseded by the Third Circuit's holding in Helen L., which the Supreme Court refused to review.

/54/ Cook describes, and discredits, justifications for continuing segregated services into five categories, the last three of which are particularly relevant to the question of bundling housing and services: "(C) Higher quality services can be delivered in congregate settings; (D) on a cost-benefit analysis, ending segregation is financially and administratively too costly; and (E) Courts should defer to the judgments of state professionals and officials as to the services to be provided to persons with disabilities." Cook, *supra* note 7, at 440 -- 50.

/55/ *Id.* at 466.

/56/ See *id.* at 462 ("Congress adopted the weaker standard permitting waivers for undue burdens and fundamental alterations of programs, but only for those portions of the ADA rules governing 'program accessibility, existing facilities,' and 'communications,' (i.e., architectural and communications barriers). Congress then specified that every other aspect of the public services title was to be governed by the more stringent HEW regulation, which permitted no waiver of obligation based upon cost" (citing 42 U.S.C. Sec.12134(b)).

/57/ See pt. VI, *infra*.

/58/ Kanter, *supra* note 13, at 993 (concluding that efforts to "integrate" people with disabilities have failed and must give way to an effort to create inclusive or nonsegregated housing that is equally available to all).

/59/ H.R. Rep. No. 711, 100th Cong., 2d Sess. 18, reprinted in 1988 U.S.C.C.A.N. 2173, 2179.

/60/ *Roe v. Sugar River Mills Assoc.*, 820 F. Supp. 636 (D.N.H. 1993) (Clearinghouse No. 48,843) (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*, 909 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). See also *Citywide Associates v. Penfield*, 564 N.E.2d 1003 (Mass. 1991) (analogous Section 504 reasonable accommodation provision requires landlord to absorb minor repair costs and give an occasionally delusional tenant time to secure heightened services).

/61/ In one such case, after a state trial court declined to hear his Fair Housing Act defenses, a resident of an emergency shelter commenced a case in federal court in order to seek relief from the eviction proceeding under the Fair Housing Act and the ADA. *Rodriguez v. Westhab, Inc.*, 833 F.

Supp. 425 (S.D.N.Y. 1993). In *Rodriguez* the federal court, declining to rule, held that an appeal through the state court system was the proper means of asserting defenses under the two statutes. In dicta the Court indicated that the Fair Housing Act and the ADA had an important antidiscrimination purpose, but "[t]hey are not intended to make it impossible for institutions such as Westhab to function effectively, or to prevent them from being in a position to provide quality service to other persons, or to prevent them from avoiding events threatening injury to others." *Id.* at 427. But far from holding that the Fair Housing Act provided no defense to allegations of disruptive behavior, the Court actually went on to say that the eviction could be subject to challenge (in the state appellate court) on a number of theories, including failure to make a reasonable accommodation. Notwithstanding the dicta concerning the scope of the Fair Housing Act and the ADA, *Rodriguez* must be read very narrowly. The holding of the case does not touch on the merits of the parties' claims; rather, it simply provides justification for the court's abstention by saying that the claims are more properly heard in the state court system, where an appeal had been perfected and a stay of execution agreed to.

/62/ House Comm. On the Judiciary, *supra* note 44, at 51, reprinted in 1990 U.S.C.C.A.N. at 474 (quoting *Bentivegna v. Department of Labor*, 694 F.2d 619, 621 (9th Cir. 1982)).

/63/ 42 U.S.C.A. Sec. 12101(a)(5). See also 28 C.F.R. Sec. 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.").

/64/ 42 U.S.C.A. Sec. 12101(a)(5).

/65/ *Cook*, *supra* note 7, at 431, citing 56 Fed. Reg. 35703 -- 4 (July 26, 1991).

/66/ 56 Fed. Reg. 35694, 35705 (July 26, 1991) (preamble to ADA Title II regulations).

/67/ 24 C.F.R. Sec. 100.204.

/68/ *Id.*

/69/ *Bell*, *supra* note 2, at 517.

/70/ See, e.g., *Mann v. 125 E. 50th St. Corp.*, 475 N.Y.S.2d 777 (New York City Civ. Court 1984); *Serreze v. YWCA of Western Mass.*, 572 N.E.2d 581 (Mass. App. Ct. 1991) (Clearinghouse No. 46,987); *Thomas v. Lenhart*, 444 A.2d 246 (Conn. 1982); *Metalsky v. Mercy Haven, Inc.*, 594 N.Y.S.2d 129 (N.Y. Sup. Ct. Nassau County 1993); *Daniels v. Christofeletti*, 542 N.Y.S.2d 482 (New York City Civ. Ct. 1989); *Bosse v. Duval*, Chancery No. 14076 (Va. Cir. Ct. Loudoun Cty. Mar. 6, 1992) (Clearinghouse No. 47,977).

/71/ See, e.g., *Rabin*, *supra* note 2, at 537 -- 38. E.g., the following states which have adopted a version of the Uniform Residential Landlord Tenant Act all prohibit self-help eviction and require landlords to regain possession through a court proceeding: Alaska, Arizona, Florida, Hawaii, Iowa,

Kansas, Kentucky, Montana, Nebraska, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, and Virginia. Other states and the District of Columbia have enacted much more stringent procedural protections for tenants; they include California, Wisconsin, Illinois, Massachusetts, and New York.

/72/ Conn. Gen. Stat. Sec. 47a-23c (1980).

/73/ Connecticut deems a person to have a disability if "he has any chronic physical handicap, infirmity or impairment, whether congenital or resulting from bodily injury, organic processes or changes or from illness, including, but not limited to, epilepsy, deafness or hearing impairment or reliance on a wheelchair or other remedial appliance or device." Conn. Gen. Stat. Sec. 1-1f(b)(1991).

/74/ The "good cause" requirement largely mirrors that historically applicable to public and subsidized housing programs. See, e.g., 24 C.F.R. Sec. 966.4(l) (public housing); *id.* pt. 982 (Section 8 tenant -- based programs). Aside from little-used grounds, such as removing the unit from the housing market, the statute requires nonpayment of rent or material noncompliance with a material lease term (or reasonable rule or regulation incorporated therein) to support an eviction. See also Note, O'Brien Properties, Inc. v. Rodriguez: Upholding Statutory Eviction Protection for Elderly, Disabled and Blind Tenants in Connecticut, 24 Conn. L. Rev. 599, 600 (1992) (noting that "the General Assembly . . . fully intended to extend lifetime leases to particular classes of tenants").

/75/ Mass. Stat. 1995, c.38, Sec. 308, approved June 21, 1995, and Sec. 358, made effective July 1, 1995.

/76/ See Richard R. Powell, Powell on Real Property Para. 221[3] (1991).

/77/ Courts look to the language of the written instrument to determine the intent of the parties. The factors considered are the language employed, the subject matter, and the surrounding circumstances to determine whether an instrument is a lease or creates something other than a landlord-tenant relationship. *Misco Industries v. Board of County Commissioners*, 685 P.2d 866, 872 (Kan. 1984).

/78/ See Restatement 2d, Property Law, Landlord-Tenant Relationship, Sec. 1.2.

/79/ *Osborn v. Brown*, 361 So. 2d 82 (Ala. 1978); *New York City Hous. Auth. v. Padmore*, 531 N.Y.S.2d 873 (New York City Civ. Ct. 1988)

/80/ *Fischer v. Taub*, 491 N.Y.S.2d 538 (N.Y. Sup. Ct. App. Term 1984).

/81/ *Metalsky*, 594 N.Y.S.2d at 130.

/82/ *Citywide Associates*, 564 N.E. 2d at 1003 (Section 504 reasonable accommodation provision requires landlord to absorb minor repair costs and give an occasionally delusional tenant time to secure heightened services); *Sugar River Mills Assoc.*, 820 F.Supp. at 636 (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*, 908 F.Supp. at 814 (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).

/83/ *Serreze*, 572 N.E.2d at 581.

/84/ *Id.* at 644.

/85/ *Carr v. Friends of the Homeless, Inc.*, No. 89-LE-3492-S, (Mass. Hampden Div., Housing Court Dept., Mar. 17, 1989)

/86/ *Carling*, *supra* note 17, at 442.

/87/ Since 1987, the National Association of State Mental Health Project Directors (NASMHPD) has been on record as supporting the rights of all consumers "to live in decent, stable, affordable and safe housing, in settings that maximize their integration into community activities and their ability to function independently. . . . Necessary supports . . . should be available at appropriate levels and for as long as needed by persons with psychiatric disabilities regardless of their choices of living arrangements. Services should be flexible, individualized and promote respect and dignity." Position Statement of the National Association of State Mental Health Project Directors on Housing and Supports for People with Long Term Mental Illness (1987). NASMHPD's Housing Work Group has adopted the following position on 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." NASMHPD Housing Work Group, *Best Practices in Housing and Supports for People with Psychiatric Disabilities*, at 1 (April 1996).

/88/ The National Action Coalition for Disability Rights in Housing adopted the following statement of principles in 1995: "There should be a clear and complete separation between the housing and any services a person with a disability might receive. Any services a person needs and freely chooses to receive should be provided in a way that is distinct from the housing and should be 'attached' to the PERSON, not the housing -- so that wherever a person chooses to live, the services will follow the person and be there regardless of the type of housing chosen. . . . Requiring supportive services only in housing programs for persons with disabilities is a 'special term and condition' imposed because of the disability of the tenants. Imposing special terms and conditions on the basis of disability is a violation of fair housing law, the ADA and section 504." See also Xenia Williams, "Consumer Empowerment" vs. "Bundling of Services": Why Bundling of Services is Counterproductive, *Consumer Connection*, Spring 1994, at 1 (Bundling of services "means that a client is required to take an unwanted service as a condition for getting a service the person desires. Otherwise, the individual is refused access to all agency services." This results in a loss of choice, reinforces dependency, and "going along with the program" in order to retain housing).

/89/ E.g., 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 at 6 (Fall -- Winter 1995).

/90/ 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, A Decade of Progress in Disability Policy, Setting an Agenda for the Future* (July 26, 1996), at 115 -- 20.

/91/ See Carling, *supra* note 5, *passim*.

/92/ Turner & O'Hara, *supra* note 37, at 2.

/93/ Carling, *supra* note 5, at 21.

/94/ *Id.* at 22.

/95/ See note 87, *supra*.

/96/ Carling, *supra* note 5, at 93 -- 95.