COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

SUFFOLK, ss:

No. 6048

ALBERT WILLIAMS, et al.,

Plaintiffs,

v.

DAVID P. FORSBERG, et al.,

Defendants.

J.S. and D.M., by their next friends,

Plaintiffs,

v.

The GOVERNOR, et al.,

Defendants.

On Direct Appellate Review of a
Report from the Superior Court

MOTION FOR LEAVE TO FILE
AMICUS CURIAE BRIEF ON
BEHALF OF PLAINTIFFS

Pursuant to Rule 17 of the Rules of Appellate Procedure, the Mental Health Law Project respectfully requests leave of the Court to file the attached amicus curiae brief on behalf of the plaintiffs.

The Mental Health Law Project is a public interest law firm

which has been in continuous operation since 1972. MHLP filed its first suits on behalf of people with mental illness and mental retardation in Alabama, Florida, New York, Texas, and Washington, D.C. to halt the abuse of adults and children confined in institutions and to require that they receive appropriate treatment and training. The results of these cases include:

* the right to adequate treatment for people committed to state mental hospitals and mental retardation facilities (Wyatt v. Stickney) and for children and adolescents confined in juvenile delinquency facilities (Morales v. Turman).

* the right of a nondangerous person to freedom from purely custodial confinement (O'Connor v. Donaldson).

* the right of all children with disabilities to a public education (Mills v. Board of Education), supporting enactment of the federal program that now serves 4.6 million children with disabilities through the nation's public school systems.

* an end to exploitation of patient labor (Souder v. Brennan), applying federal labor standards to workers at public and private institutions.

* the right to treatment in the least restrictive setting (Dixon v. Weinberger).

* the right to protection from harm for institutional residents with developmental disabilities, defined to require their transfer to community-based programs (New York Association for Retarded Children v. Carey).

In succeeding years, MHLP has not only continued to defend people in mental institutions and mental retardation facilities but

to assert their rights to make their own decisions about their lives, wherever they live. We participated in the drafting and enactment of the Fair Housing Amendments Act, ensuring that people with mental and physical disabilities were brought within the law's protections. MHLP is litigating test cases and training advocates, consumers and housing providers in every state to enforce the law's new mandates.

MHLP also participated in the advocacy, negotiation and drafting that led to the enactment of the Americans with Disabilities Act or 1990. (Pub. L. No. 101-336, 42 U.S.C. 12101). We worked with other civil rights advocates and with the Department of Justice to ensure that people with mental disabilities would be afforded the same rights and protections as people with physical disabilities.

The Mental Health Law Project has been carefully following the progress of the instant case. It is uniquely important because it is the first case construing both the Americans with Disabilities Act and the Fair Housing Amendments Act as they apply to a public mental health agency. We are submitting the attached amicus curiae brief because we hope that the expertise that we have acquired over the past two decades will help clarify and elucidate how the federal civil rights laws apply to this case.

Respectfully submitted,

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O R D E R

Upon consideration of the Mental Health Law Project's Motion for Leave to file their amicus curiae brief, it is hereby,

ORDERED that the Mental Health Law Project may file its brief amicus curiae on October 2, 1992.

Clerk

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

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AMICUS CURIAE BRIEF
ON BEHALF OF THE PLAINTIFFS

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INTRODUCTION

The application of the Americans with Disabilities Act[1] to the Commonwealth's housing of people with mental disabilities through its Department of Mental Health is one of the issues in this case. Plaintiffs have alleged that defendants are violating the ADA in two ways. First, the DMH is alleged to have developed and to be operating community residential placements that are not in "the most integrated setting appropriate to the needs of their clients" (Complaint, ¶¶ 129-132), and to be using a system of community placements that disproportionately denies access to clients who have both mental illness and alcohol addiction, in violation of the ADA at 42 U.S.C. §§ 12132 and 12182(b)(1)(B).

Unlike Medicaid and other federal statutes that impose requirements on states as a condition of the receipt of federal funds, the ADA is a civil rights statute. Its requirements are intended to fulfill a national purpose of identifying and eradicating discrimination, segregation and exclusion. It, like Section 504

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[1] 42 U.S.C. § 12101, et seq.

of the Rehabilitation Act of 1973[2] and the 1964 Civil Rights Act[3] on which the ADA and Section 504 were based, require all political and most private entities to re-evaluate and to change the ways in which they treat people with disabilities.

Unlike racial discrimination, disability discrimination is often harder to recognize. Attitudes toward people with disabilities are culturally ingrained and usually unquestioned.[4] The purpose of this brief is to explore why and how the ADA requires the DMH to re-evaluate and to re-order the ways in which it delivers mental health and housing services to its clients.

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[2] 29 U.S.C. § 794 (1988)).

[3] 42 U.S.C. §§ 2000a-2000e (1988) and other scattered sections of 42 U.S.C.

[4] In a very thoughtful study of race, sex and disability discrimination, Martha Minow explores the lack of consciousness with which we label each other, all the while protesting our impartiality. She posits a variety of common experiences to demonstrate that "[i]mpartiality is the guise that partiality takes to seal bias against exposure." Martha Minow, Making All the Difference: Inclusion, Exclusion and American Law, Ithaca: Cornell University Press, 1990, at 376.

I. ATTITUDES TOWARD PEOPLE WITH MENTAL DISABILITIES

From media representations of people with mental disabilities as "crazed lunatics" to Jerry Lewis and Cerebral Palsy TV telethons, people with disabilities have been and continue to be portrayed through stereotyped images. The cute but pitiful poster children become unfortunate and frightening adults. They are, according to stereotype, people who need medical help. If no cure exists, then they ought to be put someplace where nurses can make them as comfortable as possible, probably with people like themselves, while the rest of us support research to discover the cure for their disabilities.

Since people with disabilities are prisoners of their own bodies and/or minds, the stereotype continues, we must be sure that they are taken care of. They should be assured of food, clothing and shelter. Some of the disabled are so impaired, like those with schizophrenia or severe mental retardation who also have physical disabilities, they are best off in closed institutions. Their basic needs can be addressed there, it's safe, and they don't have to be

subjected to the stares and jeers of normal people. For those who are able to live in the community, group homes and mini-institutions where they can live with others like themselves will make them the most comfortable.

Those who cling to this stereotype also believe that people with disabilities approve of this approach. They are most concerned about their own safety and therefore like to be taken care of. They prefer to work in sheltered workshops where they aren't faced with competing with people who do not have disabilities and where they are guaranteed a steady source of income and companionship. They don't mind being paid below the minimum wage because they know that they are not qualified to earn the minimum wage.

The stereotype encourages the belief that people with disabilities wouldn't be that way if they or their parents hadn't done something wrong. If the parents had obtained the correct prenatal care, or had chosen the right doctor, or had acted on behalf of their infant sooner, or had followed the advice of their priest/minister/rabbi/ marriage counselor/social worker/next-door

neighbor, the child would not have been born/would have been ok/would have died, mercifully, at birth. If the child hadn't swallowed the poison or dived into the pool or taken drugs or gone driving with irresponsible friends or had paid attention, she wouldn't have become such a burden to her family and her community.

Finally, those disabilities which have no clear etiology and no known cure, like mental illness, generate their own fantasies and fears. They become more than simply diseases or disabilities; they are regarded as "evil, invincible predators" which are "intractable and capricious -- that is, a disease not understood in an era in which medicine's central premise is that all diseases can be cured. Such a disease is, by definition, mysterious."[5] At the turn of the century, tuberculosis assumed this mantle. Once a cure was found for TB, cancer became the "mysterious malevolence."[6] Then, insanity became

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[5] Susan Sontag, Illness as a Metaphor, N.Y.: Farrar, Straus, & Giroux (1978), p.5.

[6] Id. at 6.

"the repellant harrowing disease,"[7] of the 20th century, to be joined by AIDS and infection with the HIV virus.

II. THE IMPACT OF THE AMERICANS WITH DISABILITIES ACT

After fourteen Congressional hearings (eleven by the House of Representatives and three by the Senate), sixty-three public hearings throughout the country, and four days of floor debates, the Congress enacted the Americans with Disabilities Act. People with disabilities and their advocates understood that they would never break free of their segregated, isolated lives and be accepted into the mainstream unless they were able to address the stereotypes that permeated society. People with disabilities were encouraged to write diaries and to send them to their Congressional representatives detailing the daily discrimination they were forced to endure.

Congress and the Administration were convinced. They crafted legislation that detailed the ways in which public and private entities would be required to change policies and practices

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[7] Id. at 35.

so that people with disabilities could participate in American life. In Title II of the ADA, Congress admonished public services to evaluate and change the ways in which they conducted their programs not only to promote the integration of their clients but actually to integrate them.

Both the statute and its implementing regulations prohibit the use of "different or separate" public services,[8] unless the service provider can demonstrate that separate services are necessary to be effective.[9] Nonetheless, the client retains the right to choose to participate in the regular program.[10] The Attorney General explained that this requirement was

> an important and overarching principle of the Americans with Disabilities Act. Separate, special, or different programs that are designed to provide a benefit to persons with disabilities cannot be used to restrict the participation of persons with disabilities in general, integrated activities.[11]

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[8] 28 C.F.R. § 35.130(b)(1)(iv).

[9] Id.

[10] 28 C.F.R § 35.130(b)(2).

[11] 56 Fed. Reg. 35,703 (July 26, 1991).

In the instant case, the benefit consists of housing for clients of the Department of Mental Health. Applying the Attorney General's explanation of the ADA, DMH must review its policy of creating mental health housing ghettos. It may no longer house upwards of 65% of its clients in housing that is restricted to other people with mental disabilities unless it can demonstrate that it is necessary to provide separate housing for it to be "effective." The DMH must also demonstrate that their clients have the opportunity to reject the segregated housing in favor of integrated housing.

DMH is unlikely to be able to satisfy either criterion. In affidavits from experts in the field of mental health and housing and in depositions of DMH's own administrators, there is consensus that providing DMH's clients with housing available on the open market paired with services made available through a community support network, is both feasible and yields

better results than does limiting the clients' housing choices to DMH's segregated buildings.[12]

III. THE IMPORTANCE OF INTEGRATION

Does it really make a difference to someone with chronic and severe mental illness where he or she lives? Is it harmful to house him in a building that has on-site support staff, where others with mental illness can be treated at the same time, rather than in his own apartment? The ADA's affirmative answer is supported by the experience, testimony, and research produced by and about people with disabilities.

The benefits of integration for people with disabilities mirrors those for African Americans and other minorities. Segregation, and the discrimination that inevitably accompanies it, produce self-fulfilling prophecies about the inability of the segregated group to function at the same level as the majority group. It has been proven true for people with every level and type of disability.

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[12] Affidavits of Dr. Carling and Dr. Diamond; depositions of Dr. Nakomoto and Dr. Anzer.

In his seminal article, "The Americans with Disabilities Act: The Move to Integration,"[13] Tim Cook discusses and substantiates four significant benefits which result when people with disabilities live in integrated and not segregated settings. First, integration substantially improves the perspective of nondisabled people regarding disability thereby ameliorating the level of stigma and prejudice that prevents people with disabilities, and people with mental disabilities in particular from living successfully in the community. As long as DMH continues to house its clients in disabled-only buildings, the agency perpetuates a level of stigma that they acknowledge adversely affects their clients' self-esteem and their ability to become and to be accepted as valued members of their communities. As one author-anthropologist described from what she learned by living with Madison clients of the Wisconsin Mental Health

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[13] T. Cook, "The Americans with Disabilities Act: The Move to Integration," 64 Temple Law Review, No. 2 (1991).

Department, being a full-time crazy person was an occupation that the system encouraged.[14]

Second, integration significantly improves the socialization of persons with disabilities with non-disabled peers. One of the most frequently cited rationales for segregating people with mental disabilities is that they behave inappropriately and therefore would be at risk -- and might place others at risk -- in an integrated setting. In addition to numerous studies showing that people with mental disabilities are no more likely to engage in criminal activity than non-disabled people, a substantial body of research also substantiates Justice Marshall's observation that excluding people with disabilities from community activities deprives them "of much of what makes for human freedom and fulfillment -- the ability to form bonds and take part in the life of the community."[15] Not surprisingly, once

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[14] Sue E. Estroff, Making It Crazy: An Ethnography of Psychiatric Clients in an American Community, Berkeley: University of California Press (1981).

[15] City of Cleburne, Texas v. Cleburne Living Center, Inc., 473 U.S. 432, 461 (1985) (Marshall, J., joined by Brennan and Blackmun, J.J.).

people with disabilities live in situations that permit them to form friendships with and to establish contact with non-disabled people in integrated settings such as libraries, supermarkets, and bowling alleys, their rates of inappropriate behavior decrease. Instead of learning behavior that is appropriate for segregated settings, they learn, as the rest of us do, what behavior is appropriate in integrated settings.[16]

Similarly, the peer interactions that are available in the community, and the variety of natural reinforcements and opportunities to test skills which communities provide make social, education, and employment skills training much more likely to succeed there than in segregated settings.[17] Fourth, integration improves the health, independence and affect of persons with disabilities and increases the likelihood that

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[16] T. Cook, "The Americans with Disabilities Act: The Move to Integration," supra note 13, at p. 451, nn. 388 and 389.

[17] Id. at 452.

they will live, work, and socialize in regular community settings.[18]

Given a choice, a non-disabled person will speak to the person accompanying someone riding in a wheelchair rather than to that person, even if she is the one asking directions, being treated by a physician, or making hotel reservations. People with mental disabilities, like people with physical disabilities, traditionally have been ignored and certainly not asked their opinions about treatment options. Nor have they been provided with meaningful choices about the most essential elements of their lives -- with whom they would like to live, where they would like to work, what they would like to study, and what supports are most effective for them. The Americans with Disabilities Act rejects these infantilizing approaches, and requires public service providers, such as Defendants in the instant case, to treat their clients with the deference and respect owed to autonomous human beings.

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[18] Id. at 442-56, passim.

Last year, the Center for Psychiatric Rehabilitation provided Defendants with the Final Report of the Massachusetts Survey of Client Preferences for Community Support Services.[19] The Center had conducted the survey under contract and in collaboration with the Department of Mental Health, and its final report is attached to this brief. Among other valuable findings, the Report demonstrates that people with severe and persistent mental illness are capable of living in the community, are capable of expressing their preferences as to housing and choice of treatments and services, and do try to take advantage of independent living situations whenever they appear to be available.

When asked whether they were satisfied with their living arrangements, the respondents stated a clear preference for living alone or with significant others; with less residential support but with support services made available in the community instead (in the same way that doctors,

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[19] Rogers, Walsh, Masotta, Danley, Massachusetts Survey of Client Preferences for Community Support Services: Final Report, Boston (August 1, 1991).

therapists and social workers are available to more traditional families); and a desire to move out of group homes and other disabled-only housing arrangements.[20] Contrary to another popular belief that homeless people with mental illness don't know how to or aren't capable of obtaining housing that is available to them, the respondents who were homeless listed different reasons for their inability to find homes. Either they found the programs were full, or that they didn't meet the program's eligibility criteria, or that not enough information was available about the programs.[21]

The study thus reinforces the findings upon which the Americans with Disabilities Act is based: that people with disabilities are capable of choosing programs and services that will best enhance their abilities to live in integrated settings; that service providers, like DMH, serves its clients interests best when it designs programs and delivers services to meet the needs and desires of its clients rather than forcing its

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[20] Id. at 52.

[21] Id. at 31.

clients to fit into existing programs; and that contracting with housing providers who refuse to accept people with mental illness and alcohol addiction results in perpetuating the homelessness and segregation of clients whom DMH is statutorily required to serve.

In fact, the depositions of DMH administrators reflect their acknowledgement that integrated housing is preferable to segregated, disabled-only housing. The fact that the depositions contradict statements made on behalf of DMH in its litigation documents reveals a common conundrum in mental health systems today: the desire of mental health professionals to integrate their clients into the community conflicting with a system that was built on different philosophies of care and different perceptions of society's and the patients' needs. Fortunately for both the system and for its clients, the ADA requires DMH to adopt practices that will yield integrated housing for all of its clients, and to begin doing so immediately.

The requirements that the ADA imposes on public services agencies are not new. They are a

reinforcement of the requirements imposed by Section 504 of the Rehabilitation Act of 1973.[22]

More than ten years ago, the District Court of New Hampshire applied Section 504 to the state institution for children and adults with mental retardation and required changes that are analogous to those requested in the instant litigation.[23] There, the defendants had failed to include profoundly retarded residents in education, training and recreation programs. The institution's administrators had concluded that people who were diagnosed as having "profound retardation" were incapable of benefiting from such programs. The Court applied Section 504 and found that the school was discriminating against these residents by denying them benefits and services based not on individual evaluations but on stereotypical assumptions. The Court required the defendants to provide "education and training services to the same extent as mildly retarded

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[22] 42 U.S.C. § 12134(b); 56 Fed. Reg. 35694 (July 26, 1991).

[23] Garrity v. Galen, 522 F. Supp. 171 (D.N.H. 1981).

residents, even though the teaching methods might be quite different."[24]

The ADA certainly requires no less of DMH than Section 504 required of the New Hampshire institution. If DMH's clients with a dual diagnosis of mental illness and alcohol addiction require specific services in order to benefit from integrated housing, DMH must provide it. It is no longer legal, if it ever was, for DMH to ignore the housing needs of a group of its clients, as the defendant in New Hampshire ignored the education needs of its "profoundly retarded" clients. Nor may DMH continue to provide segregated housing to the majority of its clients because "that's the way it's always been done" when professional research, client preferences and the civil rights laws require integrated housing.

For all of the reasons stated above, amicus curiae respectfully requests that the Court affirm the lower court's denial of summary judgment as to the Americans with Disabilities Act. The plaintiffs do state claims under the ADA and

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[24] Id. at 217.

should be permitted to present evidence to prove their claims.

Respectfully submitted,

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