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CLASH OF THE INTEGRATIONISTS: THE MISMATCH OF CIVIL RIGHTS IMPERATIVES IN SUPPORTIVE HOUSING FOR PEOPLE WITH DISABILITIES

HENRY KORMAN*

A northeastern state embarked on an ambitious planning effort to develop supportive housing opportunities for homeless people with serious mental illnesses in subsidized, scattered site, community-based apartments as an alternative to hospitalization and placement in halfway houses. The initiative brought together state mental health officials, state housing agencies, non-profit developers, homeless service providers, and civil rights advocates. The plan that emerged from the group would have combined state and federal housing funds to build housing for homeless people with mental illnesses, where services would be available on a voluntary basis to individual participants. The effort stalled and then stopped altogether when the U.S. Department of Housing and Urban Development enforced a rule that prohibits use of federal housing funds in developments that serve people with a single type of diagnosis.

I. INTRODUCTION

There exists a tension within the idea of disability rights. It coalesces around the questions of whether, when, and how an individual's characteristics as a person with disabilities should be factors in access to employment, housing, and public services. There is a day-to-day reality to these questions in any number of contexts. This article focuses on one: equal access to integrated housing opportunities for people with significant disabilities, including homeless people with disabilities, who choose to receive supportive services in community-based settings. In that context, there is a failure of two systems to function together. Supportive services are generally delivered through systems that make services available to people with disabilities based on their category of disability. Mainstream federal housing programs permit admissions and selection preferences under a broad, all-inclusive definition of disability, but

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they tend to prohibit programs that serve categories of people with disabilities. The clash in these two approaches often thwarts attempts to create integrated, community-based housing opportunities for meeting the needs of people with disabilities.

Advances in disability rights over the last four decades mark a far-reaching "paradigm shift" in how and where people with disabilities receive housing and supportive services.[1] Old models hid people with mental illnesses, people with physical disabilities, and people with mental retardation and other developmental disabilities in state psychiatric hospitals, nursing homes, state schools, and intermediate care facilities for the mentally retarded (ICF/MR). These places were often squalid, and by definition they were segregated and isolated from community life. The delivery of services in such settings was controlled by single purpose agencies with the narrow mission of serving people with a single type of disability.

Beginning in the 1970s, civil rights lawsuits improved living conditions, and in some cases succeeded in closing the worst of these places. When institutional care was replaced, it was with a "continuum of facilities"[2] including community residences, halfway houses, and other community-based facilities often characterized "as 'mini-institutions,' 'candy-coated hospitals,' and 'living room jails.'"[3] The continuum includes homeless shelters and transitional housing for homeless people who "tend to have disabling health and behavioral health problems."[4] In the continuum model, housing and services are "bundled" and delivered in a range of settings from most restrictive to least restrictive based on the extent and nature of an individual's disability. "To move from a more restrictive setting to a less restrictive

1. Michael Allen, *Waking Rip Van Winkle: Why Developments in the Last Twenty Years Should Teach the Mental Health System Not to Use Housing as a Tool of Coercion*, 21 BEHAV. SCI. & L. 503, 504, 521 (2003); Paul J. Carling, *Housing and Supports for Persons with Mental Illness: Emerging Approaches to Research and Practice*, 44 HOSP. & COMMUNITY PSYCHIATRY 439, 442 (1993) [hereinafter Carling, *Housing and Supports for Persons with Mental Illness*].

2. ANN O'HARA & STEVEN DAY, CENTER FOR HEALTH CARE STRATEGIES, INC., OLMSTEAD AND SUPPORTIVE HOUSING: A VISION FOR THE FUTURE 7 (2001), *available at* http://www.chcs.org/usr_doc/supportive_housing.pdf (last visited Mar. 3, 2007).

3. John V. Jacobi, *Federal Power, Segregation and Mental Disability*, 39 HOUS. L. REV. 1231, 1252 (2003) (citations omitted).

4. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. CTR. FOR MENTAL HEALTH SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVICES, BLUEPRINT FOR CHANGE: ENDING CHRONIC HOMELESSNESS FOR PERSONS WITH SERIOUS MENTAL ILLNESS AND/OR CO-OCCURRING SUBSTANCE ABUSE DISORDERS 3 (2003), *available at* http://download.ncadi.samhsa.gov/ken/pdf/SMA04-3870/SMA04-3870.pdf [hereinafter HHS, BLUEPRINT FOR CHANGE]; *see also* Ronnie Michelle Greenwood et al., *Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness*, 36 AM. J. COMMUNITY PSYCHOLOGY 223, 224 (2005) (describing "Continuum of Care" in provision of homeless services funded by U.S. Department of Housing and Urban Development).

setting. . .an individual must acquire more independent living skills and need fewer services."[5] Like large institutions, continuum-type facilities persist. And like those large institutions, housing and services are typically delivered through single purpose agencies and non-profit organizations that serve limited categories of people with disabilities.

In the slow evolution of the new paradigm over the last decade, the most recent model for provision of housing and services is "permanent supportive housing." There is no single definition of supportive housing. Indeed, some of the statutory housing programs that fund supportive housing define it to include continuum-type facilities.[6] For purposes of this discussion, the concept of supportive housing is used more precisely to describe an advance over institutional and quasi-institutional settings. "Common principles of supportive housing include" settings where housing is permanent, and not transitional.[7] Housing "must be 'unbundled' from supportive services and not made contingent on receipt of services. However, supportive services must be made available. . .if needed and desired. Supportive services must be flexible and individualized, rather than defined by a 'program.'"[8] Even with these shared principles, the "lack of a common definition . . . typifies segmented approaches that evolved as supported housing was developed for disparate groups." [9] In other words, supportive housing tends to serve categories of people with disabilities, just like institutions and continuum facilities.

The supportive housing model places a high premium on permanent housing. It recognizes that many people with disabilities are extremely poor.[10] Consequently, it is reliant on mainstream federal housing programs "to expand affordable housing opportunities for low-income people or people with

5. O'HARA & DAY, *supra* note 2; *see also* Greenwood et al., *supra* note 4.

6. *Compare, e.g.*, 42 U.S.C. § 8013(k)(1), (4) (2006) (Section 811 program of supportive housing for people with disabilities may include group homes and independent living facilities); 42 U.S.C. § 11384 (2006) (Supportive Housing Program for homeless people may include transitional housing, permanent housing, housing that meets the immediate or long term needs of homeless people, and single room occupancy housing); 42 U.S.C. § 12703(5) (2006) (supportive housing constructed with funds from HOME Investment Partnership program "combines structural features and services needed to enable persons with special needs to live with dignity and independence"); 71 Fed. Reg. 38882, 38883 (Jul. 10, 2006) (for purpose of disposition of surplus federal housing to assist homeless people, "permanent supportive housing means long-term, affordable, community-based housing that is linked to appropriate supportive health and social services . . . that enable homeless individuals and homeless families with disabilities to maintain housing").

7. O'HARA & DAY, *supra* note 2, at 8.

8. *Id.*

9. *Id*.

10. *Id*.

disabilities, including those who are homeless."[11] It is at this place where housing programs and supportive services programs intersect that there is a conflict within the new paradigm.

The source of this conflict is in a clash of integrationist ideals. State and federal providers of supportive services are motivated by the command of the Americans with Disabilities Act (ADA) as interpreted by the Supreme Court in *Olmstead v. L.C.*[12] States must maintain "a comprehensive, effectively working plan for" assuring that people with disabilities are offered the opportunity to live outside of institutions in the most appropriate "integrated setting" by means of "a waiting list that move[s] at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated . . . ."[13] Because *Olmstead* requires the deinstitutionalization of people isolated by diagnosis in places administered by agencies identified by diagnosis, its implementation is by necessity focused on category of disability. Restrictions in housing programs that prohibit preferences based on category of disability are also integrationist. Those limitations place a premium on equal treatment and equality of opportunity, and interpret preferences based on diagnosis as a form of exclusion and segregation. In the housing context, the integrationist ideal is one in which protected characteristics should not be a factor in the distribution of benefits and equality of opportunity is a function of choice in a market that ought to disregard disability.

Experience teaches that this clash of integrationist ideals can sometimes interfere with efforts to develop supportive housing for people with disabilities. Use of Project-Based Section 8 Housing Choice Vouchers to create supportive housing is the most recent example of such problems. Until rule changes were published in 2005, the Project-Based Voucher program was subject to general provisions that forbade any form of preferential admission based on category of disability.[14] Regulatory waivers by the U.S. Department of Housing and Urban Development (HUD) were necessary to construct Project-Based Voucher housing targeted at individuals receiving supportive services on a categorical basis. The process was lengthy, the outcome uncertain. The consequent delays and denials added significantly to project cost and undermined project feasibility.[15]

11. HHS, BLUEPRINT FOR CHANGE, *supra* note 4, at 52; *see also* O'HARA & DAY, *supra* note 2, at 10 ("people with significant disabilities- like other extremely low income groups- should have more access to government housing programs to make housing truly affordable. . .").

12. 527 U.S. 581 (1999).

13. *Id*. at 584, 585.

14. 24 C.F.R. § 982.207(b)(1) (2005) made applicable to Project Based Vouchers by 24 C.F.R. § 983.1(b)(1) (2005).

15. CONSORTIUM FOR CITIZENS WITH DISABILITIES AND TECHNICAL ASSISTANCE COLLABORATIVE, OPENING DOORS, THE SECTION 8 PROJECT-BASED VOUCHER PROGRAM: CREATING NEW HOUSING OPPORTUNITIES FOR PEOPLE WITH DISABILITIES 8 (2006). For

The conflict in civil rights principles raises several questions: What is it about the status of people with disabilities that makes supportive housing such a crucial resource? Why is it that category of disability is so central to the delivery of supportive services? What characteristics of housing programs cause the mismatch in principles? What civil rights considerations motivate the apparently different conceptions of the integrationist ideal? Is it possible to close the gap in thinking in order to promote access to housing opportunity for people with disabilities in a manner that honors an integrationist ideal? Is there evidence of a "newer paradigm" of supportive housing that suggests a trend towards the ideal?

The answers to these questions lie in a better understanding of the overarching civil rights principles that are common to systems of supportive services and affordable housing programs. The concept of supportive housing originated among people with disabilities, clinicians, and civil rights advocates concerned with individual dignity, personal choice, and autonomy. A true supportive housing model honors these themes. From this vantage, the apparent integrationist contradiction between programs that provide services and programs that provide housing is a false conflict. If in practical design and implementation, supportive housing programs adhere to principles of integration, it should not matter if the programs serve all people with disabilities or just some targeted group based on category of disability.

II. THE STATUS OF PEOPLE WITH DISABILITIES AND THE NEED FOR SUPPORTIVE SERVICES AND AFFORDABLE HOUSING

The most important factor affecting the status of people with disabilities is disability itself. Although it is often expressed in medical or functional terms, "disability" is a social construct and therefore is assigned different meanings in different contexts.[16] The 2000 United States Census uses a variety of definitions of disability, including sensory disability, physical disability, mental disability, self-care disability, "going-outside-the-home disability," and employment disability.[17] The ADA and other civil rights laws protecting people with disabilities like the Fair Housing Act (also known as Title VIII)

examples of approved waivers see 69 Fed. Reg. 47249, 47279 to 47283 (Aug. 4, 2004) (selection preferences for people with chronic persistent mental illness, people with developmental disabilities, and people with AIDS); 69 Fed. Reg. 62992, 63010 (Oct. 28, 2004) (homeless people with significant disabilities that interfere with their ability to find and maintain housing, including people with chronic persistent mental illness); 69 Fed. Reg. 64440, 64445 (Nov. 4, 2004); and 70 Fed. Reg. 2218, 2240 (Jan. 12, 2005) (people with HIV/AIDS).

16. Mark C. Weber, *Disability and the Law of Welfare: A Post-Integrationist Examination*, 200 U. ILL. L. REV. 889, 895 (2000).

17. U.S. CENSUS BUREAU, CENSUS 2000 SPECIAL REPORTS, DISABILITY AND AMERICAN FAMILIES: 2000 2 (2005) [hereinafter U.S. CENSUS BUREAU, DISABILITY AND AMERICAN FAMILIES].

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and Section 504 of the 1973 Rehabilitation Act (Section 504) define "disability" to include people with medical conditions that impair activities of daily living, people with a history of impairments who are not currently people with disabilities, and individuals perceived by others to be people with disabilities.[18] Laws that distribute public benefits based on disability, like supportive services and housing, typically define the qualifying features of disability only by the existence of a serious or significant impairment.[19] The range of definitions is a reflection of the social goal of the program.[20]

Any civil rights discussion about disability must recognize that disability is an individual experience. There are hundreds of conditions that affect different people in vastly different ways. The people protected by the outcome of *Olmstead* are people in institutions or at risk of institutionalization.[21] Supportive housing generally is targeted at people with serious and persistent

18. The ADA, Title VIII and Section 504 definitions of "disability" are virtually identical. For the ADA's definition see 42 U.S.C. § 12102(h) (2006). The Section 504 definition of disability is in 29 U.S.C. § 705(20)(B), § 794(a) (2006). The Title VIII definition of disability is codified at 42 U.S.C. § 3602(h) (2006). Title VIII actually uses the term "handicap person" to describe the class of people with disabilities protected by fair housing laws. *Id.* The terminology used here follows the ADA convention, recognizing that many people with disabilities find the term "handicap" objectionable because, like racial slurs, it is a word "overlaid with stereotypes, patronizing attitudes and other emotional connotations." 56 Fed. Reg. 35693, 35698 (Jul. 26, 1991) (to be codified at 28 C.F.R. § 36).

19. For example, an individual qualifies as a person with disabilities for federally funded medical assistance (Medicaid) and needs-based Supplemental Security Income (SSI) cash disability benefits if he or she is "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted. . .for a continuous period of. . .twelve months. . ." 42 U.S.C. § 1382c(a)(3)(A) (2006) (SSI benefits); 42 U.S.C. § 1396d(a)(v) (2006) (Medicaid available to persons with disabilities within the meaning of the SSI statute). Federal housing programs generally rely on a definition of disability under which a person qualifies if the individual has a disability meeting Social Security disability standards, has developmental disabilities, or has "a physical, mental or emotional impairment which (I) is expected to be of long-continued and indefinite duration, (II) substantially impedes his or her ability to live independently, and (III) is of such a nature that such ability could be improved by more suitable housing conditions." 42 U.S.C. § 1437a(b)(3)(E) (2006). Programs targeted at people experiencing chronic homelessness serve people "with a disabling condition," defined as "a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." 24 C.F.R. § 91.5 (2006). For a more complete discussion of the variety of definitions at work in different social benefits programs see Robert Silverstein, *Emerging Disability Policy Framework: A Guidepost for Analyzing Public Policy*, 85 IOWA L. REV. 1691, 1715 (2000).

20. *See supra* note 19.

21. *See* Olmstead v. L.C., 527 U.S. 581, 593 (1999) (plaintiffs are people confined to psychiatric units); Makin *ex rel*. Russell v. Hawaii, 114 F. Supp. 2d 1017, 1033-1034 (D. Haw. 1999) ("most integrated setting" mandate of ADA protects people living at home at risk of institutionalization).

disabilities who desire support with activities of daily living, or need assistance in order to overcome barriers to getting into and staying in housing.

Not all people with disabilities need or want to live in supportive settings. It is therefore important to bear in mind that the individuals who desire or qualify for supportive housing represent a subset of all people with disabilities. Those individuals who do desire supportive housing include frail elders, chronically homeless people, and people with significant disabilities. These are people with "specific functional limitations and long-term difficulty with functional or daily living activities."[22] They are often individuals who need "long-term supports and services in order to live as independently as possible."[23] People with significant physical disabilities require the removal of architectural barriers, and they may need assistive technology and adaptive equipment.[24] More than seven million people need personal care assistance with activities of daily living such as eating, getting in and out of bed or a chair, bathing, dressing or toileting.[25] Some people with serious mental illnesses need periodic assistance with money management, medication management, vocational support and skills training, socialization, housing search, and crisis support, especially to prevent re-hospitalization.[26] People with developmental disabilities such as mental retardation may require similar

22. U.S. CENSUS BUREAU, DISABILITY AND AMERICAN FAMILIES, *supra* note 17, at 3. "The term 'functional limitations' generally refers to people who have difficulty performing one of more functional activities, such as seeing, hearing, speaking, lifting, using stairs, or walking." *Id.* at 3 n.6.

23. O'HARA & DAY, *supra* note 2, at 7.

24. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES: A PRIMER 56 (2000), *available at* http://aspe.hhs.gov/daltcp/reports/primer.pdf (last visited Mar. 2, 2007) ("individuals with physical impairments benefit from home and vehicle modifications") [hereinafter HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES]; *see also* STEVEN LUTZKY, LISA MARIA B. ALECIH, JENNIFER DUFFY & CHRISTINA NEILL, THE LEWIN GROUP, REVIEW OF THE MEDICAID 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM LITERATURE AND PROGRAM DATA: FINAL REPORT 15-16 (2000), *available at* http://www.lewin.com/Lewin_Publications/Medicaid_and_S-CHIP/Publication-4.htm (last visited Mar. 2, 2007) (describing assistive technology and adaptive equipment).

25. Jae Kennedy & Mitchell P. LaPlante, *Disabilities Statistics Rehabilitation Research and Training Center, Institute for Health & Aging*, *in* A PROFILE OF ADULTS NEEDING ASSISTANCE WITH ACTIVITIES OF DAILY LIVING, 1991-1992 5 (1997); *see also* Andrew I. Batavia, *A Right to Personal Assistance Services: "Most Integrated Setting Appropriate" Requirements and the Independent Living Model of Long-Term Care*, 27 AM. J. L. & MED. 17 (2001) ("Sixteen percent of people over age sixty-five require assistance with their activities of daily living . . . [a]mong the working-age population (ages 18-64), the personal assistance rate rose by 35% during the 1980s to 2.7 % in 1993") (citations omitted).

26. Jessica Jonikas & Judith Cook, *Research in Psychosocial Rehabilitation*, *in* BEST PRACTICES IN PSYCHOSOCIAL REHABILITATION 63-64 (Ruth Hughes and Diane Weinstein, eds., International Association of Psychosocial Rehabilitation Services 2000); Carling, *supra* note 1, at 443-444.

services, and may also benefit from case management and habilitation services that are "designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings . . . ."[27]

People with disabilities are also significantly and disproportionately poor compared to their counterparts without disabilities. Of the 49.7 million individuals with disabilities in the United States, 8.7 million live in poverty.[28] That poverty rate of 17.6 % is two-thirds higher than the poverty rate for people without disabilities, 10.6 %.[29] While nearly eighty percent of individuals age sixteen to sixty-four are working, only sixty percent of working age people with disabilities are employed.[30] The poverty rate for individuals with disabilities of working age is double that of people without disabilities.[31]Sixty-one percent of families with a household member with disabilities receive Social Security benefits, needs-based Supplemental Security Income (SSI), or public assistance, compared to 17.8 % of families where there is no person with a disability.[32] The median income of families reporting full time earnings where the family includes a member with disabilities is nearly sixteen percent less than other families.[33]

Housing resources that serve all low-income people are scarce, and that scarcity is particularly burdensome for people with disabilities.[34] Each year HUD prepares a congressional report estimating the number of U.S. households with "worst case housing needs."[35] These families are renter

27. LUTZKY ET AL., *supra* note 24.

28. U.S. CENSUS BUREAU, CENSUS 2000 BRIEFS, DISABILITY STATUS: 2000 2, tbl.1 (numbers of people with disabilities), 10 (employment and poverty) (2003).

29. *Id*. at 10.

30. *Id*.

31. *Id*. at 2, tbl.1, 10.

32. U.S. CENSUS BUREAU, DISABILITY AND AMERICAN FAMILIES, *supra* note 17, at 6.

33. *Id*. at 8. Data on families excludes households that include people "who only reported difficulty in working;" that is, people who report only a work disability. *Id*. at 3. For the conditions of poverty faced by chronically homeless people see HHS, BLUEPRINT FOR CHANGE, *supra* note 4, at 23.

34. *See* HUD, OFFICE OF POLICY DEVELOPMENT AND RESEARCH, AFFORDABLE HOUSING NEEDS: A REPORT TO CONGRESS ON THE SIGNIFICANT NEED FOR HOUSING 41 (2005) [hereinafter HUD, AFFORDABLE HOUSING NEEDS] ("There are only 78.2 affordable units for every 100 extremely-low-income households. The ratio of available units is about half as great, at 44 units per 100 households, and even among these available units, only three-fourths are physically adequate."). For purposes of the report, "affordable" units include subsidized and other assisted housing, and unassisted units in the private market priced at affordable levels. *Id.* at 40. The lesser availability of affordable units results from the fact that many affordable units are occupied by households with higher incomes. *See* HUD, TRENDS IN WORST CASE NEEDS FOR HOUSING, 1978-1999: A REPORT TO CONGRESS ON WORST CASE HOUSING NEEDS 52 (2003).

35. *See* HUD, AFFORDABLE HOUSING NEEDS, *supra* note 34.

households without rental assistance or other housing subsidies, "very low incomes (below 50% of area median income- AMI) who pay more than half of their income for housing or live in severely substandard housing" or both.[36] HUD measures the rate of worst case housing need among very low-income people with disabilities at 36.4%.[37] The agency acknowledges that the annual worst case needs study significantly undercounts both the total number of very low-income renter households with disabilities, and the number of those disabled families with worst case housing needs.[38] Even with the low estimates, the rate of need among disabled households is higher than any other group whose needs are measured by the report, including families with children and elderly families.[39] When a group of disability rights advocates examined HUD data in 1996, they identified 1.7 million non-elderly households including people with disabilities with worst case needs, a number ten times the amount identified by HUD for the same time period.[40]

For the 4.1 million people with disabilities who rely on needs-based SSI payments, the measure of housing need is particularly troubling.[41] In twenty states, the fair market rent standard used by HUD to measure the cost of a modest one bedroom apartment for purposes of the Section 8 Housing Choice Voucher program exceeds the entire amount of an individual monthly SSI payment.[42] There is no state in the nation where the fair market rent is less than seventy one percent of monthly SSI benefits.[43]

36. *Id*. at 1.

37. *Id*. at 20.

38. *Id*. at 78-79.

39. *Id*. at 20. The worst case rate among elderly families is 34.5% and among families with children it is 29%. *Id*. at 19.

40. CONSORTIUM FOR CITIZENS WITH DISABILITIES AND TECHNICAL ASSISTANCE COLLABORATIVE, OPENING DOORS: RECOMMENDATIONS FOR A FEDERAL POLICY TO ADDRESS THE HOUSING NEEDS OF PEOPLE WITH DISABILITIES 11 (1996). Other government studies suggest that HUD seriously underestimates the numbers of very low-income non-elders with disabilities and consequently, the number of families including people with disabilities with worst case housing needs. *Compare* GENERAL ACCOUNTING OFFICE, PUBLIC HOUSING: IMPACT OF DESIGNATED PUBLIC HOUSING ON PERSONS WITH DISABILITIES 35, app. I, tbl.I.1 (1998) (2.1 million very low-income renter households including a person with disabilities), *with* HUD, AFFORDABLE HOUSING NEEDS, *supra* note 34, at 27 ("1.4 million very-low-income renter households have members with disabilities").

41. CONSORTIUM FOR CITIZENS WITH DISABILITIES HOUSING TASK FORCE AND TECHNICAL ASSISTANCE COLLABORATIVE, PRICED OUT IN 2004: THE HOUSING CRISIS FOR PEOPLE WITH DISABILITIES (2005).

42. *Id.*

43. *Id*. The HUD fair market rent, or FMR, is generally represented by the fortieth percentile rent based on "housing market-wide estimates of rents that provide opportunities to rent standard quality housing." 24 C.F.R. § 888.113(a) (2006). Thus, it is a rent level that is lower than even the median rent for a particular market area.

The confluence of poverty, high rent burdens, poor housing conditions, the decrease in the numbers of people living in institutions, and the need for supports that foster independent living lead to an unavoidable result. To accomplish the goal of integration that is the mandate of *Olmstead*, many people with disabilities require "publicly funded social programs which are necessary to enable transition from the segregated world of institutions and to facilitate full participation in civil life."[44]

III. SUPPORTIVE SERVICES AND THE IMPERATIVE TO DEINSTITUTIONALIZE

"Most people who require long-term care services receive their personal care under the 'informal support model,' in which uncompensated services are provided by family members and friends."[45] However, it is also true that after out-of-pocket personal expenditures, the largest source of funds for long-term care and community-based supportive services is the Medical Assistance or Medicaid program.[46]

Medicaid is a program where costs are shared roughly half and half between the states and the federal government. Each state adopts a Medicaid "state plan" that includes certain federally mandated services, plus additional optional services.[47] While some mandated services support independent living for people with disabilities, such as home health care, many of the services that are linked to supportive housing are optional, available only at the discretion of the participating state.[48]

Medicaid is hampered by an "institutional bias."[49] Frail elders and people with significant physical disabilities historically received and continue to receive Medicaid-funded care in nursing homes and rehabilitation facilities. Medicaid also pays for the costs of confining people with developmental disabilities to large institutions and ICF/MR. "Medicaid does not cover institutional costs for non-elderly adults with mental illness."[50] This circumstance dates to the inception of Medicaid, when Congress "feared that

44. Jacobi, *supra* note 3, at 1281.

45. Batavia, *supra* note 25, at 17.

46. *Id*. at 18 (citing Robyn I. Stone, *Long-term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century*, MILBANK MEM. FUND 16, 13 (2000)).

47. Sara Rosenbaum, Joel Teitelbaum, & Alexandra Stewart, *Olmstead v. L.C.: Implications for Medicaid and Other Publicly Funded Health Services*, 12 HEALTH MATRIX: J.L. & MED. 93, 124-31 (2002).

48. *See, e.g.*, HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 44 (describing home health services).

49. NAT'L COUNCIL ON DISABILITY, OLMSTEAD: RECLAIMING INSTITUTIONALIZED LIVES (Abridged Version) 34 (2003), *available at* http://www.ncd.gov/newsroom/publications/2003/pdf/reclaimabridged.pdf (last visited Mar. 2, 2007); *see also* LUTZKY ET AL., *supra* note 24, at 1.

50. LUTZKY ET AL., *supra* note 24, at 6.

the costs of covering" the thousands of individuals housed in state hospitals would overwhelm the program.[51] Amendments to the Medicaid statute now offer states "the option of Medicaid reimbursement for individuals under the age of twenty-two and over the age of sixty-four residing in psychiatric hospitals."[52] State funds continue to pay most of the costs of operating large state psychiatric institutions for non-elderly adults with mental illnesses.

The change to the continuum model of care did not end Medicaid's bias in favor of institutions. A "variety of models," including "halfway houses. . .family foster care, boarding homes. . .group residences," short term "apartments reserved for crisis intervention. . .[s]helters for homeless persons and transitional or permanent 'housing for the homeless' have become the latest in a series of quasi-institutional solutions to housing and support needs."[53] Both the institutional and the quasi-institutional models persist. Nearly a million people with disabilities remain in ICF/MR, psychiatric institutions, and board and care facilities.[54] Another 1.3 million people live in nursing homes, and of these, 10.9 % are under the age of sixty-five.[55] In many states nursing homes are the alternative to psychiatric hospitals for states hoping to shift to the Medicaid program the cost of institutionalizing non-elderly adults with mental illnesses. Even though federal rules require independent screening of admittees to avoid the practice, estimates are that as many as twenty percent of the individuals between the ages of twenty-two and sixty- four residing in nursing homes are people with a primary or secondary diagnosis of mental illness.[56]

As much as any one motivating factor, it was civil rights claims asserted by people with disabilities during the 1970s that began the paradigm shift to community-based services:

> These cases consistently concluded that civil rights of individuals with [mental retardation and developmental disabilities] in state institutions were being violated and that these individuals were being forced to live in inhumane

51. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., SCREENING FOR MENTAL ILLNESS IN NURSING FACILITY APPLICANTS: UNDERSTANDING FEDERAL REQUIREMENTS 5, n.4 (2002) [hereinafter SCREENING FOR MENTAL ILLNESS IN NURSING FACILITY APPLICANTS], *available at* http://download.ncadi.samhsa.gov/ken/pdf/SMA01-3543/CMHS2a.pdf (last visited Mar. 2, 2007).

52. *Id*. at 5, n.4.

53. Carling, *Housing and Supports for Persons with Mental Illness*, *supra* note 1, at 441.

54. NAT'L COUNCIL ON DISABILITY, *supra* note 49, at 11-18.

55. *Id*.

56. OFFICE OF THE INSPECTOR GENERAL, U.S. DEP'T OF HEALTH AND HUMAN SERVS., YOUNGER NURSING FACILITY RESIDENTS WITH MENTAL ILLNESS: AN UNIDENTIFIED POPULATION 9-10 (2001), *available at* http://oig.hhs.gov/oei/reports/oei-05-99-00700.pdf (last visited Mar. 2, 2007). For a detailed discussion of the screening requirements, see generally SCREENING FOR MENTAL ILLNESS IN NURSING FACILITY APPLICANTS, *supra* note 51.

> conditions where physical, emotional, and sexual abuse, and physical and medical neglect were the common experience.[57]

Some litigation involved claims for deinstitutionalization and community-based living opportunities, while other court decisions established a right to treatment, education and training, freedom from unjustified physical restraint, freedom from abuse and neglect, freedom from indefinite involuntary confinement, and the opportunity for a fair procedure to determine the need for confinement. Based on Fourteenth Amendment guarantees of equal protection, liberty, and due process, as well as Section 504 and similar laws, the cases anticipated the ADA-based claim in *Olmstead*.[58] While the courts endorsed the principle that people with disabilities were entitled to receive services in a "least restrictive alternative," they also held that Section 504 does not prohibit institutionalization.[59] The changes sparked by this litigation led to an indirect, but crucial result. "The reforms of institutional care became a factor in further deinstitutionalization because they increased institutional care costs (e.g. requiring more staff, etc.)."[60] Due to the high costs of institutional care, "combined with criticism of Medicaid's institutional bias, states and the Federal government began to look for ways to provide long-term care services in less restrictive, more cost-effective ways."[61]

The Medicaid-funded system of community based services that emerged from this background retains fundamental features of the institutional and quasi-institutional forms of medical assistance that preceded it: Medicaid continues in an institutional bias, and it continues to serve people by category of disability. For example, basic Medicaid program rules require states to

57. LUTZKY ET AL., *supra* note 24, at 4.

58. *See, e.g.*, Youngberg v. Romeo, 457 U.S. 357 (1982) (restraint, neglect and abuse); O'Connor v. Donaldson, 22 U.S. 563 (1975) (unconstitutional confinement); Jackson v. Indiana, 406 U.S. 715 (1972); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (D.C. N.Y. 1973) (fair process); Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Halderman v. Pennhurst State School & Hosp., 610 F. Supp. 1221 (D.C. Pa. 1985) (right to treatment).

59. *See, e.g.*, Ky. Ass'n for Retarded Citizens, Inc. v. Conn., 674 F.2d 582, 585 (6th Cir. 1982) (Section 504 may require placement of people with developmental disabilities in least restrictive alternative, but does not prohibit all forms of institutionalization; state may expend funds to improve staffing and conditions in institutions); Halderman v. Pennhurst State Sch. & Hosp., 612 F.2d 84, 87 (3d Cir. 1979), *rev'd on other grounds*, 465 U.S. 89 (1984) (Developmentally Disabled Assistance and Bill of Rights Act provides the right to least restrictive environment); Garrity v. Gallen, 522 F. Supp. 171, 213-15 (D.C.N.H. 1981) (Section 504 does not broadly compel deinstitutionalization; it does require individual service plans for individuals that may include independent living outside of institutions); *cf.* Halderman v. Pennhurst State School & Hosp., 610 F. Supp. 1221, 1227 (E.D. Pa. 1985) (Court approved class action settlement which compelled the closure of an institution).

60. LUTZKY ET AL., *supra* note 24, at 4.

61. HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 7-8.

provide an equal level of services to all qualified participants, without regard to diagnosis.[62] However, under the Home and Community-Based Care Services (HCBS) waiver program, states may apply to the Federal Centers for Medicare and Medicaid Services (CMS) for waiver of this "comparability" requirement to assist only those "individuals who, in the absence of home care, would require [an] institutional level [of] services and benefits."[63] The HCBS waiver program is intended to foster more integrated living situations for elders and people with disabilities through a "broad variety of services that may be provided as part of the program," including adult day care and health services, habilitation services, assistive technology and adaptive equipment, case management, personal care attendants, respite care, and vocational services.[64] States participating in the HCBS waiver program "may vary the benefits they offer by beneficiary sub-category," (that is, they may restrict aid to certain types of disabilities or to certain age groups of beneficiaries) including elders, people with physical disabilities, people with developmental disabilities, individuals with traumatic brain injury, and people who have AIDS.[65]

Because of the historical prohibition on use of Medicaid to pay the costs of confining non-elderly people in state psychiatric institutions, HCBS waivers often do not serve people with mental illnesses.[66] States may choose to make supportive services available to people with mental illnesses under provisions for optional Medicaid services like personal care assistance, targeted case management, clinic services, and psychiatric rehabilitation services. Like HCBS waivers, these options are exempt from the Medicaid comparability requirement, and many states elect to target optional services based on category of disability, including mental illness.[67] Chronically homeless people

62. Rosenbaum, *supra* note 47, at 128-29 (citing 42 C.F.R. § 440.230 (2006)); *see also* 42 U.S.C. § 1396a(a)(10)(B) (2006) (statutory "comparability" requirements).

63. Rosenbaum, *supra* note 47, at 129.

64. LUTZKY ET AL., *supra* note 24, at 16-17.

65. *Id*. at 2; *see also* ROSENBAUM, *supra* note 47, at 130; HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 49.

66. LUTZKY ET AL., *supra* note 24, at 6. Recent legislation has de-coupled some waiver services from eligibility standards requiring people with disabilities to show that they "would require a level of provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded" as a condition of qualifying for waiver services. *See* P.L. 109-171, § 6086 (Feb. 8, 2006), amending 42 U.S.C. §1396(n). By separating eligibility for waiver services from need for Medicaid-covered institutional care, it is possible that more states may seek HCBS waivers to serve people with mental illnesses.

67. *See generally* HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 60-67. For a detailed discussion of the provision of rehabilitation services to people with mental illnesses see BAZELON CENTER FOR MENTAL HEALTH LAW, RECOVERY IN THE COMMUNITY: FUNDING MENTAL HEALTH REHABILITATIVE APPROACHES UNDER MEDICAID (2001).

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may receive services offered through the substance abuse treatment system.[68] That system is also characterized by a history that begins with institutional forms of treatment and a paradigm shift to community-based options.[69] And, like other forms of supportive services, treatment for substance abuse is made available through funding streams that serve only people with substance abuse problems.[70]

Medicaid expenditures exert tremendous fiscal pressures on state and federal budgets. As a consequence, limitations on eligibility for community-based services are designed to control cost. For example, HCBS waivers are available only to those states that "demonstrate that on average, spending for those receiving waiver services would not exceed the average cost of those in institutions."[71] Other strategies for limiting cost include "placing caps on spending per recipient or limiting the number of participants," imposing limitations on program eligibility "by degree of impairment or financial need," and use of waiting lists.[72] They also rely on diagnosis-specific eligibility criteria to target "services to those most likely to be institutionalized" in facilities identified by category of disability.[73]

There is one last feature of supportive services systems that derives in part from the categorical organization of the old system of institutions, and in part from the integrationist mandate of civil rights laws. Supportive services are usually delivered not through a single agency, but through separate agencies and organizations that are identified by type of disability.[74] Under *Olmstead* the obligation to administer services in the most appropriate integrated setting means that state agencies must maintain a "comprehensive, effectively working plan for placing qualified persons with. . . disabilities in less restrictive settings, *and a waiting list that move[s] at a reasonable pace* not controlled by the State's endeavors to keep its institutions fully populated."[75] The responsibility to develop a *moving* waiting list in the face of scarce housing resources means the separate state agencies that maintain institutions serving categories of people with disabilities must control the community placements made available to their individual consumers. It is therefore

68. HHS, BLUEPRINT FOR CHANGE, *supra* note 4, at 5.

69. *Id*.; Paul J. Carling & Laurie Curtis, *Implementing Supported Housing: Current Trends and Future Directions*, NEW DIRECTIONS FOR MENTAL HEALTH SERVICES 81 (Summer 1997) [hereinafter Carling & Curtis, *Implementing Supported Housing*].

70. HHS, BLUEPRINT FOR CHANGE, *supra* note 4, at 19.

71. LUTZKY ET AL., *supra* note 24, at 3. The cost neutrality standard was recently eased in connection with certain types of waiver services. *See*, P.L. 109-171, §6086(a)(i)(1) (Feb. 8, 2006).

72. LUTZKY ET AL., *supra* note 24, at 30.

73. *Id*.

74. HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 148-52.

75. Olmstead v. L.C., 527 U.S. 581, 583 (1999) (emphasis added).

common within the supportive service system that housing placements are only available through agencies that demand control over the housing waiting list and the "pipeline" of individuals that enter and move through the waiting list. That imperative, though driven in part by the civil rights obligation to comply with *Olmstead*, competes with the integrationist notions at work in housing programs. It is a point of disconnect where the supportive services system and the system of affordable housing fail to work together.

IV. PEOPLE WITH DISABILITIES IN HOUSING PROGRAMS

Medicaid and other forms of supportive services pay for the service component of supportive housing. Service dollars do not pay for room, board, or rent.[76] To create supportive housing opportunities, it is therefore essential to find ways to assure that people with disabilities and chronically homeless people also have access to mainstream affordable housing programs.[77] Federal, state, and local funds may all serve as sources of financing for affordable housing.[78] As a practical matter, due to conditions of poverty, housing is often affordable to people with disabilities only when it receives capital funding from multiple state and federal sources, and rent subsidies, usually federal rent subsidies, to supplement very modest tenant rent contributions.[79] The federal housing resources available for these purposes are characterized by an inconsistent mix of policies that tend to limit or forbid preferences for people with specific categories of disability. At the same time, federal housing policy often excludes people from mainstream affordable housing opportunities based on their status as individuals with disabilities.

Some supportive housing is funded by programs administered through HUD's Office of Community Planning and Development (CPD). CPD provides capital and operating support for homeless programs established under the McKinney-Vento Homeless Assistance Act,[80] the program of

76. 42 U.S.C. § 1396n(c)(1) (2006) (no HCBS payment for room and board); *see also* HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 58-59 (Medicaid payments under HCBS not available for room and board), 71 (no Medicaid payment for residential costs of habilitation programs), 96 (Medicaid payment for assisted living services, but not cost of housing).

77. HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 97; HHS, BLUEPRINT FOR CHANGE, *supra* note 4, at 52-54.

78. HHS, BLUEPRINT FOR CHANGE, *supra* note 4, at 21-23.

79. O'HARA & DAY, *supra* note 2, at 19; *see also* Joseph Harkness, Sandra Newman, George Galster & James Reschovsky, *The Financial Viability of Housing for Mentally Ill Persons*, 15 HOUSING POLICY DEBATE 133, 139-40 (multiple capital subsidies), 153 (rental subsidies) (FannieMae Foundation, 2004).

79. HHS, BLUEPRINT FOR CHANGE, *supra* note 4, at 21-23.

80. P.L. 100-77 (Jul. 22, 1987), codified at 42 U.S.C. § 11301, *et seq*. (2006).

Housing Opportunities for People with AIDS (HOPWA),[81] and HOME Investment Partnerships (HOME) program.[82] It is within these programs that HUD policies display the greatest inconsistency. The statute governing HOPWA requires that the program serve only people with AIDS and related disorders.[83] The McKinney-Vento Shelter Plus Care program targets assistance to eligible "homeless person with disabilities (primarily persons who are seriously mentally ill, have chronic problems with alcohol, drugs, or both, or have acquired immunodeficiency syndrome and related diseases)."[84] HUD rules interpret the statute to say that providers may establish a preference for people within a single category of eligible homeless individuals, but may exclude other groups of homeless people with disabilities only when there is sufficient demand for the housing within the target population, and only when the other homeless people cannot benefit from the services offered by the provider.[85] Current rules in the Supportive Housing Program (SHP) also allow targeting of units to designated populations of people with disabilities.[86]

Housing financed with funds provided to state or local jurisdictions from the HOME Investment Partnerships (HOME) program may include "permanent housing for disabled homeless persons, transitional housing, and single room occupancy housing."[87] HOME funds may be used for both tenant-based rental assistance and capital funding for construction and rehabilitation.[88] Use of HOME funds is subject to federal consolidated planning requirements that mandate an assessment of community housing needs, including the needs of people with disabilities.[89] Consolidated planning standards instruct jurisdictions to review the needs of people who "may or may not require supportive housing (i.e., elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addiction, persons with HIV/AIDS and their families, and public housing residents)" and to devise and carry out strategies intended to meet those needs.[90]

Despite the statutory and regulatory standards that seem to favor HOME-funded supportive housing serving categories of people with disabilities,

81. AIDS Housing Opportunity Act, P.L. 101-625, § 851, *et seq.*, codified at 42 U.S.C. § 12901, *et seq.* (2006).

82. 42 U.S.C. § 12721, *et seq.* (2006).

83. 42 U.S.C. § 12901 (2006).

84. 42 U.S.C. § 11403g (2006).

85. 24 C.F.R. § 582.330(a) (2006).

86. 24 C.F.R. § 583.325(a).

87. 42 U.S.C. § 12742(a)(1).

88. *Id*.

89. *See* 42 U.S.C. § 12746(5) (2006) (HOME is subject to consolidated planning requirements for comprehensive housing affordability strategy); 42 U.S.C. § 12705(b)(1) and (i)(2) (consolidated plan must address housing needs of people with disabilities).

90. *See, e.g.*, 24 C.F.R. § 91.215(e) (2006) (with respect to local jurisdictions).

HUD's implementation of the program is equivocal. Rules governing the use of HOME for tenant-based rental assistance permit selection preferences "for a specific category of individuals with disabilities (e.g. persons with HIV/AIDS or chronic mental illness) if the specific category is identified in the participating jurisdiction's consolidated plan as having unmet need and the preference is needed to narrow the gap in benefits and services to such persons . . .[p]references cannot be administered in a manner that limits the opportunities of persons" based on federal civil rights laws.[91] There are no comparable regulations for capital use of HOME funds. Early guidance from 1997 indicates that while selection *preferences* may be offered to a category of people with disabilities in housing using HOME capital funds, *eligibility* cannot be limited to a category of people with disabilities.[92] Instead, "housing projects of five or more HOME-assisted units must be affirmatively marketed to all persons within the special needs group."[93] In addition, "[A] project may not be filled exclusively through referrals from a single social service agency."[94]

Later policy statements from 2001 emphasized the availability of HOME funds for "special needs housing," including "such traditional housing as single-family homes and apartments, as well as single room occupancy housing and group homes."[95] The 2001 policy showcased HOME projects that served discrete populations, such as people with chronic mental illnesses, frail elders, drug and alcohol dependent women, people with physical disabilities, people with mental retardation, and people with HIV/AIDS.[96] Still later, in 2005, HOME program fair housing guidelines said that in special needs housing for people with disabilities, "the housing must be marketed to all individuals with disabilities and cannot be restricted to persons with specific types of diagnoses or subclasses of persons with disabilities."[97]

Other housing programs display a similar range of sometimes contradictory policies. In the public housing, tenant-based Section 8 Housing Choice Voucher, and multifamily subsidized housing programs administered by HUD, agency regulations permit selection preferences that favor people with disabilities in general, but they explicitly forbid preferences that are

91. 24 C.F.R. § 92.209(c)(3).

92. *See* HOMEfires, Vol. 1, No. 4 (Oct. 30, 1997).

93. *Id*.

94. *Id*.

95. HUD OFFICE OF COMMUNITY PLANNING AND DEVELOPMENT, HUD-2001-18-CPD, SPECIAL NEEDS HOUSING AND THE HOME PROGRAM 1 (May 2001).

96. *Id.* at 25, 28 (mental illness), 26-27 (elders), 29 (chemically dependent women), 33 (physical and developmental disabilities), 37 (mental retardation), 35 (HIV/AIDS).

97. HUD OFFICE OF COMMUNITY PLANNING AND DEVELOPMENT, HUD-2005-10-CPD, FAIR HOUSING FOR HOME PROGRAM PARTICIPANTS: UNDERSTANDING THE BASICS 9 (May 2005).

targeted at people with a specific category of disability.[98] Other prohibitions apply in HUD programs where supportive services are part of the program design. The Section 811 program of Housing and Supportive Services for People with Disabilities (Section 811) links capital grants, project rental assistance contracts, and supportive services in housing serving people with "physical, mental, or emotional impairment[s]" and individuals with developmental disabilities.[99] Under program requirements, "[a]n Owner may, with the approval of [HUD], limit occupancy. . . to persons with disabilities who have similar disabilities and require a similar set of supportive services in a supportive housing environment. However, the Owner must permit occupancy by any qualified person with a disability who could benefit from the housing and/or services provided regardless of the person's disability."[100]

HUD's Project-Based Section 8 Housing Choice Voucher program adopts a mix of approaches. Public housing agencies (PHA) are permitted to "project-base" up to twenty percent of the PHA's Section 8 Housing Choice Vouchers by entering into contracts with private owners to attach vouchers to units.[101] In general, the percentage of assisted units in any building may not exceed twenty-five percent.[102] The twenty-five percent per building cap does not apply to dwelling units "specifically made available for households comprised of elderly families, disabled families, and families receiving supportive services," making it clear that the program is intended in part to provide supportive housing to people with disabilities.[103] Project-based voucher providers may not limit admission by category of disability.[104] Providers may limit eligibility to people "who need services offered at a particular project."[105] Like the Section 811 program, an owner may "advertise the project as offering services for a particular type of disability; however, the project must be open to all otherwise eligible persons with disabilities who may benefit from services provided in the project."[106] Preferences that base admission on establishing need for services are only permitted in order to serve individuals:

> (i) . . .with disabilities that significantly interfere with their ability to obtain and maintain themselves in housing; (ii) Who, without appropriate supportive

98. 24 C.F.R. § 5.655(c)(3) (2006) (multifamily subsidized housing); 24 C.F.R. §960.206(b)(3) (2006) (public housing); 24 C.F.R. §982.207(b)(3) (2006) (tenant-based Housing Choice Vouchers).

99. 42 U.S.C. § 8013(k)(2) (2006).

100. 24 C.F.R. § 891.410(c)(2) (2006); *see also* 42 U.S.C. § 8013(i)(2) (similar effect).

101. *See generally* 42 U.S.C. §1437f(o)(13) (2006).

102. 42 U.S.C. § 1437f(o)(13)(D)(ii) (2006).

103. *See* 24 C.F.R. § 983.251(d) (2006).

104. *Id.*

105. *Id*.

106. *Id*. at (d)(3).

services, will not be able to obtain or maintain themselves in housing; and (iii) For whom such services cannot be provided in a nonsegregated setting.[107]

The largest program providing capital funding for affordable housing is the Low Income Housing Tax Credit (LIHTC) program administered by the Internal Revenue Service (IRS).[108] Acting through state housing credit agencies, the program provides allocations of tax credits to housing developers that sell the credits to investors to provide capital funds for the construction or rehabilitation of rent restricted housing for low income households.[109] Supportive housing is a permissible use of tax credits.[110] Civil rights requirements in the LIHTC program are embodied in a rule under which dwelling units qualify for credits only if they are available "for use by the general public."[111] To meet this standard, tax credit units must be rented consistent with HUD non-discrimination rules, including the provisions of a HUD handbook governing multifamily subsidized housing programs.[112] In addition, they must not be constructed for the exclusive use of a limited class of people such as "a member of a social organization."[113]

In the single interpretive ruling addressing limitations based on type of disability, the IRS said that low rent units qualify for tax credits where, for example, they are part of a project for homeless individuals with a selection preference for people with alcohol and chemical dependencies.[114] The

107. *Id*. at (d)(1).

108. HUD, THE LOW-INCOME HOUSING TAX CREDIT PROGRAM: A NATIONAL SURVEY OF OWNERS 1 (Mar. 2000).

109. *See generally* 26 U.S.C. § 42 (2006).

110. *See, e.g.,* 26 U.S.C. § 42(c)(2) (properties with Section 8 moderate rehabilitation assistance are ineligible for credits, except for housing for homeless people); 26 U.S.C. § 42(c)(3)(B)(iii)(I) (transient housing not permitted use in tax credit program except for housing used exclusively to facilitate the transition of homeless individuals to independent living), § 42(c)(3)(B)(iii)(II) (to same effect, housing made available by government entities and non-profits to provide homeless individuals with temporary housing and supportive services designed to assist in locating and retaining permanent housing); 26 U.S.C. § 42(g)(2)(B) (services that "enable residents of a residential rental property to remain independent and avoid placement in a hospital, nursing home, or intermediate care facility for the mentally or physically handicapped"); 26 U.S.C. § 42(m)(1)(C)(v) (state qualified allocation plans for distribution of tax credits must include selection criteria for "tenant populations with special needs").

111. 26 C.F.R. § 1.42-9(a) (2006).

112. *Id.* The handbook referenced in the rule is HUD HANDBOOK NO. 4350.3, REV-1, OCCUPANCY REQUIREMENTS OF SUBSIDIZED MULTIFAMILY HOUSING PROGRAMS (May 2003) [hereinafter HUD, MULTIFAMILY OCCUPANCY HANDBOOK].

113. 26 C.F.R. § 1.42-9(b). The general public use rule also forbids housing "provided by an employer for its employees." 26 C.F.R. § 1.42-9(a). In addition, "any residential rental unit that is part of a hospital, nursing home, sanitarium, lifecare facility, trailer park, or intermediate care facility for the mentally and physically handicapped is not for use by the general public and is not eligible for credit under Section 42." 26 C.F.R. § 1.42-9(b).

114. I.R.S. Priv. Ltr. Rul. 98-14-006 (Apr. 3, 1998).

selection preference was permitted only because the units were also made available to all homeless applicants, without regard to disability.[115] The general public use rule's prohibition on limiting occupancy to members of a particular class of individuals also suggests that a unit will not qualify for tax credits if it is rented solely to consumers of a specific agency serving a particular category of disability, a policy comparable to the one at work in some HOME program guidance.[116]

Despite the ethic of "nonsegregation" articulated in agency regulations, in practice, HUD maintains policies that are designed to deliberately exclude people with disabilities from federal housing programs. Prior to 1992, apartments in HUD-administered "mixed-population" public housing and multifamily housing developments were required to rent to non-elderly people with disabilities and elders on an equal basis.[117] "The shift away from institutional to community-based mental health care, recent regulations that prohibit discrimination in housing, and the lack of affordable housing. . . all contributed to growing numbers of" people with disabilities living in mixed-population housing.[118]

Spurred on by concerns about "differences in values and lifestyle" as well as complaints about people with mental illnesses, Congress enacted laws that permit PHAs and owners of multifamily subsidized housing to limit and at times exclude non-elders with disabilities from assisted housing.[119] Estimates are that by 2001, the new policies resulted in a loss of access by people with disabilities to 68,500 previously available public housing units, and between 200,000 to 225,000 assisted multifamily units.[120] The estimates do not

115. *Id*. The IRS ruling ignored provisions of the MULTIFAMILY OCCUPANCY HANDBOOK permitting "preferences for persons with a specific type of disability" when "allowed in the controlling documents for the property." *See* HUD, MULTIFAMILY OCCUPANCY HANDBOOK, *supra* note 115, para. 4-6(C)(3). The reference in the handbook to controlling documents is meant to refer to contractual documents associated primarily with HUD's Section 202 Direct Loan Program.

116. *See* HOMEfires, Vol. 1, No. 4, *supra* note 95*; cf.* I.R.S. Priv. Ltr. Rul. 92-09-020 (1992) (units in transitional housing facility for homeless families are available for use by the general public for purposes of tax exempt bonds even where county social services agency is the sole source of referrals).

117. GOVERNMENT ACCOUNTING OFFICE, GAO/RCED-92-81, PUBLIC HOUSING: HOUSING PERSONS WITH MENTAL DISABILITIES WITH THE ELDERLY (Aug. 1992).

118. *Id*. at 3.

119. *See* P.L. 102-550 (Oct. 21, 1992), Title VI-C, § 622(a), enacting 42 U.S.C. § 1437e (2006) (PHAs may designate some or all of any public housing development solely for occupancy by elders, solely for occupancy by people with disabilities, or for mixed use); Title VI-D, § 641, *et seq.*, enacting 42 U.S.C. § 13601, *et seq.* (2006) (owners of multifamily subsidized housing may limit or exclude occupancy by non-elders with disabilities).

120. Consortium for Citizens with Disabilities and Technical Assistance Collaborative, OPENING DOORS, WHAT'S WRONG WITH THIS PICTURE? 5 (public housing), 15 (multifamily housing) (2001).

measure the level of exclusion from HUD-funded housing based on the actions of housing providers who disregard even the limited protections available to people with disabilities under these laws. There is compelling evidence that disability discrimination plays a significant role in additional limitations on access to mainstream affordable housing opportunities.[121] This combination of legally permitted exclusion and unlawful discrimination against people with disabilities stands in stark contrast to the desire to create "nonsegregated" housing opportunities embodied in federal housing policies.

V. COMPETING CONCEPTS OF INTEGRATION?

The federal trend towards forbidding occupancy standards based on category of disability is not necessarily reflected in state laws, particularly those laws that are focused on the command of *Olmstead* to provide community-based housing options outside of institutions. States use a variety of funding mechanisms to plan and provide for community-based housing for people with mental illnesses, people with mental retardation and related conditions, and people with chemical dependencies. Some of these sources of financing are linked directly to services provided under HCBS waivers, and therefore limit occupancy based on category of disability. Others result in housing that is limited to consumers of the services of particular mental health or homeless agencies.[122]

121. *See* HUD, OFFICE OF POLICY DEVELOPMENT AND RESEARCH, REPORT TO CONGRESS: ASSESSMENT OF THE LOSS OF HOUSING FOR NON-ELDERLY PEOPLE WITH DISABILITIES, FINAL REPORT 5-2 (2000) (managers of assisted multifamily housing "report illegal practices that discourage people with disabilities from applying for HUD-assisted housing even though the potential applicant is eligible under the property's occupancy policy"); *see also* Matyasovszky v. Housing Authority of the City of Bridgeport, 226 F.R.D. 35 (D. Conn. 2005) (certifying class action complaint alleging unlawful discrimination in exclusion of people with disabilities from public housing); Bailey v. Housing Authority of the City of Baltimore, JFM-02-CV-225 (Dec. 20, 2004); U.S. v. Housing Authority of the City of Baltimore, JFM-04-CV-03107(Dec. 20, 2004) (consent decree, discriminatory exclusion of people with disabilities from public housing), *available at* http://www.usdoj.gov/crt/housing/documents/habc3settle.pdf (last visited Mar. 2, 2007).

122. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 53260 (West 2006) ("supportive housing" is housing occupied by a "target population," defined as low-income adults with one or more disabilities, including mental illnesses, HIV or AIDS, substance abuse, people with developmental disabilities, and others); CONN. GEN. STAT. § 17a-485 (2006) (Community Mental Health Strategic Investment Fund for new and expanded clinical services and supportive housing for people with mental health needs); CONN. GEN. STAT. § 17b-337(a) (2006) (long term care plan for elders must include home and community-based services and supportive housing); ILL. COMP. STAT. Ch. 405, § 30/4.4 (2006) (savings from reduction in institutional services redirected to "create an array of residential and community-based support services to people with mental health needs and developmental disabilities"); MASS. SPEC. L. ch. S7, § 2 (West 1992) (Massachusetts Housing Finance Agency authorized to make loans for provision of community-based residences to people with disabilities); 2004 Mass. Acts ch. 290, line 4000-8200 (West

In an environment where it is almost always necessary to combine state and federal resources to develop supportive housing, it can be difficult to reconcile the targeted nature of state funding in service of *Olmstead* with HUD's competing prohibition on limiting occupancy to people with specific disabilities. HUD regulations prohibiting preferences based on category of disability are not themselves civil rights laws. They are "civil rights-related program requirements," intended to interpret civil rights statutes in the context of specific housing programs.[123] It is another curious feature of HUD housing programs that in contrast to civil rights-related program requirements, civil rights laws protecting people with disabilities do not preclude housing programs serving a category of people with disabilities so long as the programs serve integrative purposes.

Under HUD Fair Housing Act rules, for example, it is permissible to inquire about disability when necessary "to determine whether an applicant is qualified for a dwelling available only to persons with handicaps (sic) or to persons with a particular type of handicap" or "to determine whether an applicant for a dwelling is qualified for a priority available to persons with handicaps or to persons with a particular type of handicap."[124] It is, however, unlawful to assign "any person to a particular section of a community, neighborhood or development, or to a particular floor of a building" based on disability.[125]

2004) (funding for community-based housing for people with mental illnesses and mental retardation, including clients of state Departments of Mental Health and Mental Retardation); 2004 Mass. Acts ch. 290, line 4000-8201 (West 2004) (to same effect, for other people with disabilities at risk of institutionalization); MINN. STAT. § 252.50 (2003) (community-based housing for people with mental retardation or related conditions linking housing programs of state housing finance agency and HCBS waiver services); MO. REV. STAT. § 215.054 (2000) (Mental Health Trust Fund to establish community-based housing for clients of the Department of Mental Health who have a mental illness, developmental disabilities, or are chemically dependent); NEB. REV. STAT. § 68-1605 (2003) (Homeless Shelter Assistance Trust Fund to finance grants for projects that provide for "persons or families with special housing needs"); WASH. REV. CODE § 43.79.201 (1998) (funds appropriated for community-based housing for people with mental illnesses, developmental disabilities, or "youth who are blind, deaf or otherwise disabled"); WASH. REV. CODE § 82.14.400 (2000) (portion of sales and use tax for zoos, aquarium and wildlife preserves transferred to Department of Community, Trade, and Economic Development to maintain community-based housing for people with mental illnesses).

123. *See* 60 Fed. Reg. 14294 (Mar. 16, 1995) (civil rights-related program requirements (CRRPRs) "may be written into the statute or regulations governing the specific program at issue. CRRPRs may also be found within such sources as general civil rights statutes, HUD Notices of Funding Availability (NOFAs), and Mortgagee Letters. The subjects covered under CRRPRs include but are not limited to such topics as affirmative fair housing marketing, site and neighborhood standards, assurances or certifications of compliance with civil rights statutes, and monitoring recipient performance for compliance with civil rights requirements").

124. 24 C.F.R. § 100.202(c)(2), (3) (2006).

125. 24 C.F.R. § 100.70(c)(4) (2006).

Title VIII's balance between integration and recognition of disability is more fully developed in Section 504 and the ADA. Section 504 and ADA rules are modeled on similar rules that implement prohibitions against discrimination based on race, color, and ethnicity under Title VI of the Civil Rights Act of 1964, and discrimination based on gender under Title IX of the Education Amendments Act of 1972.[126] There is, however, a fundamental difference between principles of disability discrimination and the law of race and gender discrimination:

> The premise of both title VI and title IX is that there are no inherent differences or inequalities between the general public and the persons protected by these statutes and, therefore, there should be no differential treatment in the administration of Federal programs. The concept of section 504, on the other hand, is far more complex. Handicapped persons may require different treatment in order to be afforded equal access to federally assisted programs and activities, and identical treatment may, in fact, constitute discrimination. The problem of establishing general rules as to when different treatment is prohibited or required is compounded by the diversity of existing handicaps and the differing degree to which particular persons may be affected. Thus, under section 504, questions arise as to when different treatment of handicapped persons should be considered improper and when it should be required.[127]

Section 504 and ADA attempt to resolve these questions by recognizing that "different or special treatment" is permitted only "in order to assure equal opportunity."[128] HUD Section 504 rules and ADA Title II rules are explicit: different or separate services and benefits are permitted, and in some circumstances may be required when necessary to provide an "opportunity that is as effective as offered to others."[129] The statutory provisions of Title III of the ADA are identical.[130] Title III is applicable to supportive housing because it prohibits disability discrimination in places of public accommodation, including social service centers such as "substance abuse treatment centers,

126. *See* 41 Fed. Reg. 20295, 20296 (May 17, 1976) (to be codified at 45 C.F.R. pt. 84) (preamble to proposed Section 504 rules for Department of Health, Education and Welfare); 42 Fed. Reg. 22675, 22676 (May 4, 1977) (preamble to final HEW Section 504 rules); 43 Fed. Reg. 2131, 2132 (Jan.13, 1978) (preamble to HEW Section 504 coordination rules for federal agencies); 48 Fed. Reg. 20637, 20639 (May 6, 1983) (to be codified at 24 C.F.R. pt. 8) (preamble to proposed HUD Section 504 rules). Title VI is codified at 42 U.S.C. § 2000d (2006). Title IX is codified at 20 U.S.C. § 1681, *et seq.* (2006).

127. 41 Fed. Reg. 20296; 48 Fed. Reg. 20639.

128. 42 Fed. Reg. 22676.

129. 24 C.F.R. § 8. 4(b)(1)(iv) (HUD §504 rules); 28 C.F.R. § 35.130(b)(1)(iv) (ADA Title II regulations).

130. *See* 42 U.S.C. § 12182(b)(1)(iii) (separate programs for categories of people with disabilities are permitted when necessary to provide an "opportunity that is as effective as offered to others").

rape crisis centers, and halfway houses. . . residential facilities that provide social services, including homeless shelters, shelters for people seeking refuge from domestic violence, nursing homes, residential care facilities, and other facilities where persons may reside for varying lengths of time" while receiving supportive services.[131]

The ADA Title II regulation that is the foundation of *Olmstead* is an extension of these ideas. In promulgating the rule, the Department of Justice said that the Title II "most integrated setting" rules are founded on explicit Congressional "authority for separate programs in the specific requirements of title III of the Act."[132] HUD civil rights-related program requirements that forbid categorical preferences originate from a different vantage. They derive from a fair housing perspective that is more closely aligned to Title VI and Title IX: protected characteristics should, in the first instance, be neutral and invisible in the distribution of housing opportunities. There is considerable conflict within this point of view, especially because HUD and other federal agencies are obliged by law to "administer their programs and activities relating to housing and urban development. . . in a manner to affirmatively further the purposes of" fair housing.[133] The contradictory impulses are most evident in the context of race, where the courts have long struggled with the circumstances under which it is appropriate to make race-conscious decisions about preferences for admission in order to preserve or promote integrated patterns of residential living.[134]

The same tensions filtered into debates about HUD fair housing policies in the promulgation of Title VIII rules for the implementation of the Fair Housing Amendments Act of 1988, which added protections to the Fair Housing Act for

131. 42 U.S.C. § 12181(7)(K) (Title III definition of "public accommodation"); *see also* 56 Fed. Reg. 35544, 35551 (Jul. 26, 1991) (to be codified at 28 C.F.R. pt. 36) (discussing Title III definition of "public accommodation").

132. *See* 56 Fed. Reg. 35703, 35705 (Jul. 26, 1991). These principles also have a constitutional dimension. In applying Fourteenth Amendment concepts of equal protection to the rights of people with disabilities, the courts say that classifications based on disability are, unlike racial classifications, entitled to considerable deference because, among other reasons, "singling out the [individuals with disabilities] for special treatment reflects the real and undeniable differences between" them and people without disabilities, and among people with different disabilities. City of Cleburne, Texas v. Cleburne Living Center, Inc., 473 U.S. 432, 443, 444 (1985).

133. 42 U.S.C. § 3608(d) (2006).

134. *Cf.* Walker v. City of Mesquite, 169 F.3d 973, 987 (5th Cir. 1999) (rejecting selection of site for construction of housing in implementation of civil rights consent decree based on racial characteristics of neighborhood); U.S. v. Starrett City Assoc., 840 F.2d 1096, 1100-1101 (2d Cir. 1988) (rejecting selection practices intended to stabilize racial composition of housing development), *with* Raso v. Lago, 135 F.3d 11, 17 (1st Cir. 1998), *cert. denied*, 119 S.Ct. 44 (1998) (use of race conscious marketing targets to establish occupancy patterns in assisted housing is lawful for purposes of implementing civil right consent decree).

people with disabilities and families with children.[135] On the one hand, civil rights advocates "interpreted certain illustrations of conduct made unlawful in the proposed rule as prohibiting the use of governmentally approved programs designed to promote greater housing opportunities."[136] On the other hand, "a comment from an association representing persons involved in the sale and rental of dwellings urged that the proposed rule be revised to make it clear that such practices are prohibited by the Fair Housing Act."[137] Noting that in making changes to Title VIII, Congress debated and postponed action on proposals to outlaw "preferences in the provision of any dwelling based on race, color, religion, gender or national origin," HUD chose against addressing questions of affirmative action, determining "that it would not be appropriate to address the issue of pro-integration programs in this final rule."[138] To the extent that current HUD rules permit activities that account for protected characteristics, those activities are limited to imposing requirements on HUD-assisted multifamily owners "to identify any groups of persons who are not likely to be aware of the available housing and to undertake special marketing efforts designed to make such persons aware of the available housing and their ability to obtain it on a nondiscriminatory basis."[139]

The cautionary tensions inherent in allowing housing practices based on protected characteristics have a particular import for people with disabilities. Such practices often have the effect of excluding people with disfavored disabilities from mainstream housing opportunities. For example, longstanding provisions of agency Section 504 rules permit "[n]on-handicapped persons" to be "excluded from the benefits of a program" and allow the exclusion of a "specific class of individuals with handicaps," if the program "is limited by Federal statute or executive order to" people with disabilities, or a "class of individuals" with disabilities.[140] The regulations are intended to exempt such federal programs as the Section 202 program of

135. The Fair Housing Amendments Act of 1988 was passed as P.L. 100-430 (September 13, 1988). For provisions adding protections for families with children and people with disabilities, see, e.g., P.L. 100-430, §6(b)(2) (families with children) and §6(b)(1) (people with disabilities), enacting 42 U.S.C. §3604(a)-(e) (2006).

136. 54 Fed. Reg. 3232, 3234-3235 (Jan. 23, 1989) (to be codified at 24 C.F.R. pt. 100).

137. *Id.*

138. *Id*.

139. 54 Fed. Reg. 3235; *see also* 24 C.F.R. § 200.600, *et seq*; 24 C.F.R. § 108.1, *et seq* (affirmative fair housing marketing requirements for multifamily owners); 24 C.F.R. § 92.351 (to same effect, HOME program).

140. *See, e.g.*, 24 C.F.R. § 8.4(c)(1) (2006) (HUD Section 504 rules). The same standards are applicable to all federal agencies through the Section 504 coordinating regulations published by the U.S. Department of Justice. 28 C.F.R. § 41.51(c) (2006).

housing for elders and people with disabilities from the integrationist and equal opportunity mandates of Section 504.[141]

In the Section 202 program, HUD allows housing providers to select applicants from favored categories such as people with physical disabilities.[142] The policies decidedly do not operate to enhance equal opportunity. Rather, they operate for the explicit purpose of excluding people with mental illnesses and developmental disabilities from Section 202 units.[143] Policies like these have another discriminatory effect. They tend to concentrate people with disabilities in the group homes and halfway houses that are characteristic of continuum facilities. In the wake of implementing formal policies for excluding people with disabilities from Section 202 properties, HUD noted that barely 10% of the previously available units in the program remained available to people with disabilities.[144] Of those, 75% were located in group homes serving only "persons with chronic mental illness or developmental

141. *See* 53 Fed. Reg. 20216, 20220 (Jun. 2, 1988) (to be codified at 24 C.F.R. pt. 8) (promulgating interim Section 504 regulations for programs receiving HUD assistance) (exclusion of categories of people with disabilities "does not violate Section 504" when authorized by statute or executive order). The analogous provision under Title II of the ADA allows categorical exclusions only in limited circumstances, enabling public entities to "provide special benefits, beyond those required by the nondiscrimination requirements of [the ADA], that are limited to individuals with disabilities or a particular class of individuals with disabilities, without thereby incurring additional obligations to persons without disabilities or to other classes of individuals with disabilities." 56 Fed. Reg. 35693, 35705 (Jul. 26, 1991) (to be codified at 28 C.F.R. pt. 35) (discussing purpose of 28 C.F.R. § 35.130(c)). For another example of a statutory program designed to serve people within a single category of disability, see 42 U.S.C. § 12901, *et seq.* (2006) (Housing Opportunities for People with AIDS).

142. 53 Fed. Reg. 20220 (Jun. 2, 1988) (to be codified at 24 C.F.R. pt. 8); *see also* MULTIFAMILY OCCUPANCY Handbook, *supra* note 112, at para. 3-18(B)(2)(c)(3), (7) (10% of units in §202 properties for elders are set aside for any person with disabilities with mobility impairments; only elders qualify for remaining units and individuals with non-qualified disabilities who are not elders do not qualify). The exclusions imposed by these occupancy standards apply to properties developed under the Section 202 Direct Loan Program in effect from 1959 to 1990. *Id*. Statutory changes in 1990 separated housing for people with disabilities from the Section 202 program by creating two new programs; a new Section 202 program of housing and supportive services for elders, and a companion Section 811 program of housing and supportive services for people with disabilities. *See* P.L. 101-625, Title VIII, § 801(a) (Nov. 28, 1990), amending 12 U.S.C. § 1701q (§ 202) and at Title VIII, § 811, adding 42 U.S.C. § 8013 (§ 811). References in this section of the paper are to the pre-1990 version of the Section 202 program.

143. *See* Beckert v. Our Lady of Angels Apartments, Inc., 192 F.3d 601, 607 (6th Cir. 1999) (excluding person with mental illness); Knutzen v. Eben Ezer Lutheran Hous. Ctr., 815 F.2d 1343 (10th Cir. 1987) (excluding people with mental illnesses and developmental disabilities); Brecker v. Queens B'nai B'rith Housing Dev. Fund Co., Inc., 798 F.2d 52, 56 (2d Cir. 1986) (excluding applicant with "mild mental retardation"); Almonte v. Pierce, 666 F. Supp. 517 (S.D.N.Y. 1987) (limiting occupancy to "wheelchair users").

144. HUD NOTICE H 93-36 (Jun. 2, 1993).

disabilities."[145] There is a practical import to this sort of segregation. Fragmentation in housing and services by diagnosis often result in a denial of opportunities to individuals who can benefit from a particular program but are rejected because they are people with multiple disabilities, or because their disability does not precisely fit the category served in the program.[146]

Diagnosis-identified supportive housing implicates other important rights. Disability rights laws aim at ending discrimination based on "presumptions, patronizing attitudes, fears, and stereotypes about individuals with disabilities. Consistent with these standards, public entities are required to ensure that their actions are based on facts applicable to individuals," not group characteristics.[147] In housing where both units and services are dedicated to particular categories of people with disabilities served by particular agencies, "every person served represents an income stream" and "people with disabilities are reduced to commodities."[148] The concept of equal opportunity means that services are provided in the communities where people live so that an individual with disabilities has a choice of housing options that are not limited by diagnosis or need for support.[149] Linking supportive services to specific dwelling units limits that choice. It requires people with disabilities to live in segregated places they might not choose, outside of the communities with which they identify, and, at least in group home or congregate settings, with people they do not select as partners.[150] Rights of privacy, autonomy, and liberty protect the physical person against intrusion, assuring that an individual cannot be forced to receive medical or therapeutic treatment against consent and protecting "choices about and control over one's environment."[151] The idea of equal treatment means that people with disabilities are not subjected to different or unequal terms and conditions in their occupancy of housing.[152]

145. *Id*.

146. HHS, BLUEPRINT FOR CHANGE, *supra* note 4, at 4, 35, 98; HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 104, 145.

147. 56 Fed. Reg. 35705 (July 26, 1991) (to be codified at 28 C.F.R. pt. 35).

148. Allen, *supra* note 1, at 503.

149. 56 Fed. Reg. 35705; *see also* 24 C.F.R. § 8.4(b)(3); 28 C.F.R. § 35.130(b)(2) (existence of programs solely for people with disabilities cannot serve as basis for curtailing opportunity in housing, benefits, and services available to general public).

150. Carling & Curtis, *supra* note 69, at 81; *see also* Henry Korman, Diane Engster & Bonnie M. Milstein, *Housing as a Tool of Coercion*, *in* COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW 96 (Deborah L. Dennis & John Monahan eds., 1996) [hereinafter Korman et al., *Housing as a Tool of Coercion*] ("community-based residential treatment programs" represent places where people "live with others not of their own choosing. . .").

151. Carling, *Housing and Supports for Persons with Mental Illness*, *supra* note 1, at 442; *see also* Greenwood, *supra* note 4, at 225 (continuum approach to providing services to homeless people with disabilities "undermines consumers' autonomy").

152. 24 C.F.R. § 8.4(b)(1); 28 C.F.R. § 35.130(1).

These concepts are undermined where housing is contingent on acquiescence to a treatment plan,[153] or when the ability to retain possession of the housing is not protected by the rights of judicial process afforded to most tenants.[154]

Thus, there are compelling arguments against supportive housing programs that are segregated by disability, notwithstanding the fact that they are not explicitly prohibited by fair housing and civil rights laws. Nonetheless, the challenge remains. In an atmosphere of scarce housing and service resources, is it possible to develop affordable housing opportunities for people with disabilities that offer support with community-based living when they want the housing, where they want the housing, and on terms and conditions that do not result in different treatment?

VI. FOCUS ON THE PERSON AND THE PLACE

History proves that separating people with disabilities from the mainstream through segregation in diagnosis-specific settings can result in abuse, disempowerment, isolation and neglect. On the other hand, the earliest advocates of disability rights thought that the "Failure to make necessary distinctions among the varieties of. . . disability is common alike to popular and professional thought, with consequences often destructive to the effectiveness of social provisions intended for welfare and rehabilitation."[155] Martha Minnow, writing about how such "categorical approaches. . . undermine commitments to equality," argued that what matters is not disregard of difference, but rather, an emphasis on human relationships in which there is a "shared 'right' to be included and to participate in society-on terms that may

153. Korman et al., *Housing as a Tool of Coercion*, *supra* note 150, at 96; Michael Allen, *Separate and Unequal: The Struggle of Tenants with Mental Illness to Maintain Housing*, 30 CLEARINGHOUSE REV. 720, 725-727 (1996).

154. *See, e.g.*, Thomas v. Cohen, 453 F.3d 657, 660 (6th Cir. 2006) (occupants may be evicted by police from transitional homeless shelter without process of any kind); Cotton v. Alexian Bros. Bonaventure House, No. 02-C-7969, 2003 WL 22110501, at *6 (D. Ill. 2003) (right to occupy transitional housing for people with HIV/AIDS may be terminated by administrative proceeding without judicial process); Padilla v. Padula, 1994 WL 879788, at *1 (Mass. Super. Ct. 1994) (to same effect, transitional housing for homeless people); Angelo J. Melillo Ctr. for Mental Health v. Denise B., 777 N.Y.S.2d 830 (Dist. Ct. 2004) (subsidized provider of supportive housing may terminate license to occupy based on refusal to accept treatment); Helping Out People Everywhere v. Deich, 589 N.Y.S.2d 744 (S.D.N.Y. 1992) (termination of license agreement in emergency shelter); Burke v. Oxford House of Oregon Chapter Five, 103 P.3d 1184 (Or. Ct. App. 2004) (resident of halfway house for recovering addicts may be evicted with fifteen minutes notice); Sunrise Group Homes, Inc. v. Ferguson, 777 P.2d 553 (Wash. Ct. App. 1989) (defenses to eviction available to tenants under landlord-tenant act not available to resident of congregate living facility for people with developmental disabilities).

155. Jacobus Tenbroek & Floyd W. Matson, *The Disabled and the Law of Welfare*, 54 CAL. L. REV. 809, 811 (1966).

vary for each individual, but that may also entail special rights to make inclusion and participation possible."[156] Recognition of difference within a context of a human relationship results in practical but crucial legal outcomes, requiring, for example, reasonable individualized modifications in policies and procedures to ensure "effective and meaningful" access to jobs, education, housing and services, removal of structural barriers and construction of architecturally accessible facilities and buildings to assure that they are "usable to people with disabilities."[157]

Here is the practical dilemma: Supportive services programs are in the process of casting off old, discriminatory practices that isolate people with disabilities in segregated, institutional settings by category of disability. High levels of poverty, the absence of affordable housing, the needs of people with significant disabilities for support in independent living, the history of isolation, and the scarcity of funds to undo that history require supportive service providers to command housing and service resources following the old institutional patterns- by category of disability. Housing programs hold fast to the core fair housing ethic that protected characteristics should be neutral factors in the distribution of housing benefits.

With larger commitments of resources, it might be easier for supportive service programs to address the needs of people with disabilities without regard to diagnosis, and in a "single point of entry" system where one agency administers services for all people with disabilities, instead of multiple agencies identified by category of disability.[158] Housing programs face similar problems of scarce resources and suffer from competing impulses that operate to exclude people with disabilities from mainstream assisted housing based on the very characteristics that from a fair housing perspective ought to be disregarded. The clash of integrationist ideals from this perspective may be as much a conflict between civil rights theory and civil rights practice as anything else.

Perhaps the answer to the question of whether housing programs can truly work with supportive service programs lies in the basic insight of the *Olmstead* court that "unjustified institutional isolation of persons with disabilities is a form of discrimination . . . ."[159] The court's conclusion "reflects two evident judgments" about integration and people with disabilities:

156. Martha Minnow, *When Difference Has Its Home: Group Homes for the Mentally Retarded, Equal Protection and Legal Treatment of Difference*, 22 HARV. C.R.-C.L. L. REV. 111, 112-3, 189 (1987).

157. Silverstein, *supra* note 19, at 1723.

158. HHS, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES, *supra* note 24, at 149.

159. Olmstead v. L.C., 527 U.S. 581, 596 (1999).

> First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life . . . Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment . . . Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.[160]

This observation in *Olmstead* suggests the core of an answer to the dilemma posed by the disconnect between the provision of services on a categorical basis and the prohibition in housing programs on serving categories of people with disabilities. A system of housing and supportive services must first proceed with respect for and attention to the needs and desires of the individual person, not the imperatives of the service provider, nor the category of disability served by the provider. The design of the supportive housing must preserve and enhance human relationships, and nurture full and integrated participation in the "family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment"[161] that are the stuff of community life. Supportive housing cannot result in "dissimilar treatment;"[162] that is, it should look like the "options available to the general public," rights of occupancy should not be associated with contingencies that differ from those available to the general public, and it should not require people with disabilities to relinquish choice of location, type of housing, or control over treatment decisions.[163]

These are principles that shift the focus away from legalistic concerns to considerations about ethical boundaries and relationships, imposing "clearer responsibility on the consumer for success" while at the same time "dramatically changing the role of staff."[164] A successful cultural shift in this direction results in housing with features that conform to two integrationist frameworks; the framework that emerges from *Olmstead* and efforts to deinstitutionalize systems that serve people with disabilities, and the fair

160. *Id.*
161. *Id*.
162. *Id*.
163. Carling & Curtis, *Implementing Supported Housing*, *supra* note 69, at 91.
164. *Id.*; *see also* Allen, *supra* note 153, at 730 ("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. . .").

housing framework that avoids distribution of housing resources based on protected characteristics. This approach is outcome oriented. It is the needs and desires expressed by the individual, the features of the housing, and the conditions under which the housing is linked to supportive services that matter. Within such a cultural shift, it should not matter whether eligibility for admission is based on category of disability.

Operationally, a supportive housing system that marks the cultural shift would have the following features:

• *Supportive housing within a larger regime of meaningful choice.* Some people with significant disabilities choose structured, less integrated settings based on their individual desire for particular kinds and levels of support.[165] However, "people with psychiatric" and other "disabilities generally want the same kinds of housing that other citizens want."[166] They want independent, affordable apartments or houses, with voluntary access to support.[167]

The existence of programs that serve only people with disabilities, or only people with particular disabilities cannot be a reason to curtail the availability of housing otherwise available to the general public.[168] One measure of progress towards integration is the achievement of conditions where "individuals of similar income levels in the same housing market area have a like range of housing choices available to them regardless of their race, color, religion, sex, handicap, familial status or national origin."[169] This understanding of integration derives from the obligation to affirmatively further fair housing under the Fair Housing Act.[170] The responsibility to further fair housing is one that is also imposed through program statutes and agency regulations on virtually every recipient of federal housing funds, including recipients of HUD housing subsidies and capital advances, HOME funds, and Low-Income Housing Tax Credits.[171] The duty is fulfilled, in part,

165. O'HARA & DAY, *supra* note 2, at 8, 27; HUD, OFFICE OF POLICY DEVELOPMENT AND RESEARCH, PREDICTING STAYING IN OR LEAVING PERMANENT SUPPORTIVE HOUSING THAT SERVES HOMELESS PEOPLE WITH SERIOUS MENTAL ILLNESS 75 (2006) [hereinafter HUD, STAYING IN OR LEAVING].

166. Carling, *Housing and Supports for Persons with Mental Illness, supra* note 1, at 442.

167. Carling & Curtis, *Implementing Supported Housing supra* note 69, at 84.

168. 24 C.F.R. § 8.4(b)(3); 28 C.F.R. § 35.130(b)(2).

169. 24 C.F.R. § 200.610.

170. 42 U.S.C. § 3608(d); *see also* NAACP, Boston Chapter v. Sec'y of Hous. and Urban Dev., 817 F.2d 149, 155 (1st Cir. 1987) (the codification of a duty to further fair housing reflects the congressional desire "to fulfill. . . the goal of open, integrated residential housing patterns and to prevent the increase of segregation" and "to assist in ending discrimination and segregation to the point where the supply of genuinely open housing increases").

171. For a discussion of how the federal obligations devolve to the state and local level, see generally Henry Korman, *Underwriting for Fair Housing? Achieving Civil Rights Goals in Affordable Housing Programs*, 14 J. OF AFFORDABLE HOUSING AND COMMUNITY DEV. L. 292 (2005) [hereinafter Korman, *Underwriting for Fair Housing*].

through the utilization of "some institutionalized method whereby. . . [the agency] has before it the relevant racial and socio-economic information necessary for compliance with its duties."[172]

There are ready "institutionalized methods" available to supportive service and housing providers through which it is possible to assure that supportive housing generally, and supportive housing dedicated to people with one type of disability is part of a larger regime of available housing opportunity. Through the intervention of CMS, state supportive services agencies are familiar with the responsibility imposed by *Olmstead* to develop "a comprehensive, effectively working plan for placing qualified persons with. . .disabilities in less restrictive settings."[173] State housing credit agencies also have the obligation to further fair housing.[174] They can do so through the Qualified Allocation Plans that federal law requires for the distribution of Low-Income Housing Tax Credits.[175] PHAs receiving public housing subsidies and Section 8 Housing Choice Voucher funds, and state and local recipients of HUD community planning and development funds such as HOME, Community Development Block Grants, and McKinney-Vento homeless funding are obliged to develop comprehensive plans that include activities to further fair housing.[176] So far, few *Olmstead* "planning groups include representatives of state housing" agencies.[177] Nevertheless, HUD has significant approval, monitoring, and enforcement responsibilities in the adoption of jurisdictional housing plans.[178] That oversight can be exercised to assure that in the administration federal housing resources, people with disabilities have access to a broad range of housing opportunities, including supportive housing that

172. Shannon v. U.S. Dep't. of Hous. and Urban Dev., 436 F.2d 809, 821 (3d Cir. 1970).

173. *Olmstead* v. L.C., 527 U.S. 581, 583; *see also* ALEXANDRA STEWART, JOEL TEITELBAUM & SARA ROSENBAUM, IMPLEMENTING COMMUNITY INTEGRATION: A REVIEW OF STATE OLMSTEAD PLANS 3 (Center for Health Care Strategies, Inc., Working Paper No. CA 233-802) (2002), *available at* http://www.chcs.org/usr_doc/ImplementingIntegration.pdf (last visited Mar. 2, 2007) (describing guidance to state Medicaid directors after *Olmstead* decision).

174. *In re* Adoption of the 2003 Low Income Hous. Tax Credit Qualified Allocation Plan, 848 A.2d 1 (N.J. Super. Ct. App. Div. 2004); Oti Kaga, Inc. v. S.D. Hous. Dev. Auth., 342 F.3d 871 (8th Cir. 2003).

175. 26 U.S.C. § 42(m).

176. *See* 42 U.S.C. § 1437c-1(d)(15)(2005) (public housing); 42 U.S.C. § 5318(c)(3) (2005) (CDBG); 42 U.S.C. § 12705(b)(15) (2005) (HOME).

177. NAT'L COUNCIL ON DISABILITY, *supra* note 49, at 174.

178. *See, e.g.*, 24 C.F.R. § 8.56 (2006) (§ 504 investigations, monitoring and compliance); 24 C.F.R. § 91.215(l) (2006) (local strategic housing plan must describe activities to enhance coordination between public and assisted housing providers and private and governmental health, mental health, and service agencies); 24 C.F.R. § 91.315(l) (to same effect, state strategic plan); 24 C.F.R. § 91.315(m) (2006) (state plan must describe strategy to coordinate use of HUD funds with LIHTC); 24 C.F.R. § 91.500 (2006) (HUD review and approval of consolidated plans); 24 C.F.R. § 903.23, § 903.25 (2006) (approval and compliance monitoring of public housing agency plans).

serves people with categories of disabilities, as well as including other affordable housing available to the general public.

• *Necessity and efficacy in the link between housing and supportive services.* It is worth stating once again the civil rights conditions under which separate housing for people with disabilities is permissible: segregated settings are appropriate only when *necessary* to provide "qualified individuals with [disabilities] with housing aid, benefits, or services that are *as effective* as those provided to others."[179] Research indicates that "the effectiveness of transitional halfway houses in reducing recidivism, improving economic self-sufficiency, and improving community adjustment [is] 'highly suspect.'"[180] The relative lack of efficacy in bundled housing for people with disabilities is most evident in studies that compare HUD's Continuum of Care approach to providing services to chronically homeless people with an alternative approach known as Housing First.

The "Continuum of Care model graduates" homeless individuals "through a series of stages," including "emergency shelter, transitional housing, and then finally to supportive and/or permanent housing, but only if the individual complies with prescribed treatment through 'supportive services'. . .Failure to comply at any level or a relapse into using alcohol or drugs may incur a return to a more restrictive environment."[181] In contrast, the "Housing First program's first priority is to stabilize people in the short-term and help them get housed immediately."[182] The program "provides a [subsidized] apartment without any prerequisites for psychiatric treatment or sobriety. In addition to an apartment, consumers are offered treatment by the program's Assertive Community Treatment (ACT) team."[183] Comparing outcomes for participants in Continuum of Care programs with those of participants in a Housing First program, one study found that Housing First "participants experienced a decrease in psychiatric symptoms . . . and smaller proportions of time homeless" even though the participants also "reported lower service utilization."[184]

While some Housing First programs serve all homeless families as the target population, others are aimed exclusively at "those with mental health

179. 24 C.F.R. § 8. 4(b)(1)(iv); 28 C.F.R. § 35.130(b)(1)(iv) (emphasis added).

180. Carling, *Housing and Supports for Persons with Mental Illness, supra* note 1, at 441.

181. Greenwood et al., *supra* note 4, at 224.

182. NAT'L ALLIANCE TO END HOMELESSNESS, INC., HOUSING FIRST FOR FAMILIES: RESEARCH TO SUPPORT THE DEVELOPMENT OF A HOUSING FIRST FOR FAMILIES TRAINING CURRICULUM 3 (2004), *available at* http://www.endhomelessness.org/pub/HousingFirst Research.pdf (last visited Mar. 3, 2007).

183. Sam Tsemberis, Leyla Gulcur & Maria Nakae, *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis*, 94 AMERICAN J. OF PUB. HEALTH 651, 657 (2004).

184. Greenwood et al., *supra* note 4, at 224-225.

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and substance use issues."[185] Nevertheless, Housing First qualifies as a supportive housing program that is consistent with civil rights principles for at least three reasons. The characteristics of the housing are the same as the sort of housing available to the general public. Supportive services are voluntary. Finally, when participation is limited to people within a category of disability, that limitation is effective in reducing barriers to stable housing for people whose disabilities might otherwise prevent equal access.

• *Matching people to services; not disabilities to units.* Disability discrimination laws require that decisions about the distribution of housing and services must be "based on *facts applicable to individuals* and not on presumptions as to what a class of individuals with disabilities can or cannot do."[186] In practical terms, this principle means that applicants for supportive housing qualify for admission not because of their relationship to a diagnosis-identified service provider, but instead because they can benefit from the services offered in connection with the housing. They should not be refused admission because they are not clients of the service agency at the time of application and selection. This approach is the one taken in the 1997 HOME program guidance.[187] A related concept is that people with multiple disabilities must not be excluded because they have some other disability in combination with the disability for which the services are primarily designed.[188]

• *Services are separate from housing.* The Housing First model in which services are voluntary and follow the person to their home is also responsive to the ideas of privacy and autonomy. It is based on the research finding that

> . . .a *lack* of personal control and choice, rather than too much of it is associated with the experience of psychiatric symptoms. Models that make housing contingent on relinquishment of control over daily living practices and preferences actually erode an important tool for coping with the very circumstances they are intended to redress. Programs that are designed to *restore* choice and enhance perceptions of personal control may actually be more successful in the reduction of psychiatric symptoms. . . .[189]

This approach understands that "housing needs are separate from the needs for treatment." It aims for "a highly individualized set of service relationships with individual consumers living in various housing situations." It means that

185. NAT'L ALLIANCE TO END HOMELESSNESS, INC., *supra* note 182, at 23.

186. 56 Fed. Reg. 35693, 35703 (Jul. 26, 1991) (promulgating ADA Title II rules) (emphasis added).

187. *See* HOMEfires, *supra* note 95.

188. Chapa v. Adams, 168 F.3d 1036, 1039 (7th Cir. 1999); *see also* U.S. DEPARTMENT OF JUSTICE, AMERICANS WITH DISABILITIES ACT TITLE III TECHNICAL ASSISTANCE MANUAL 4-2200 (person with blindness may not be excluded from office of cancer specialist on account of visual impairment) (1993).

189. Greenwood et al., *supra* note 4, at 234 (emphasis in original).

services are voluntary, and that they are "flexible, portable," and available "on demand."[190]

• *Rights of occupancy are not diminished.* Closely associated with the concept that services should be voluntary is the idea that people with disabilities should not be subjected to different terms and conditions and lesser privileges of occupancy simply because their housing is also a place where they might receive services.[191] Housing linked to services often violates this principle by diminishing the possessory rights of program participants to the units they occupy through the use of license agreements that allow for summary termination of tenancy with little or no procedural protections.[192] Using mainstream housing resources in supportive housing protect these rights simply because rules in the HOME, Project-Based Voucher, LIHTC, and similar programs require the use of leases, guard against eviction except for good cause, and forbid "summary eviction," including summary eviction without process for "failure to comply with program requirements."[193] In any case, it ought to be a principle of supportive housing that the housing is permanent, and continued occupancy is based on standard landlord-tenant law,

190. Carling & Curtis, *Implementing Supported Housing*, *supra* note 69, at 81. There is a significant body of law addressing the civil rights circumstances under which treatment can be administered without consent to people found to be a danger to themselves or others, people who lack capacity to make treatment decisions, and even people simply deemed by service providers as individuals in need of aggressive treatment. *See, e.g.*, Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENVER U. L. REV. 1145 (1997). These issues overlap with discussions about the voluntary nature of supportive services in housing. A full treatment of how the two topics interact is beyond the scope of this paper. For a collection of articles discussing such matters, see COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW (Deborah L. Dennis and John Monahan eds., 1996).

191. 24 C.F.R. § 8.4(b)(1) (2006); 28 C.F.R. § 35.130(b)(1) (2006); *see also* Olmstead. V. L.C., 527 U.S. 581, 601 (1999) (unjustified isolation is discrimination because "persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice").

192. *See supra* note 154.

193. I.R.S. Priv. Ltr. Rul. 98-11-020 (Dec. 3, 1997) (no summary eviction in tax credit housing); *see also* 24 C.F.R. § 92.253(c) (2006) (HOME program requires leases; no termination of tenancy without good cause or judicial process); *id.* at § 983.256 (lease in Project-Based Voucher program); *id.* at § 983.257 (good cause eviction, Project-Based Vouchers); Rev. Rul. 2004-82, 2004-350 I.R.B. (good cause evictions in LIHTC program); ANTHONY S. FREEDMAN, NATIONAL COUNCIL OF STATE HOUSING CREDIT AGENCIES, ESSENTIAL GUIDE TO HOUSING CREDIT COMPLIANCE: A MANUAL TO ASSIST HOUSING CREDIT PROPERTY OWNERS, MANAGERS AND STATE AGENCIES IN UNDERSTANDING AND MEETING COMPLIANCE RESPONSIBILITIES 2-12, 5-13 (1997) (based on the legislative history, conventional practice for tax credit units requires an initial lease of no less than six months, with month-to-month rental agreements thereafter).

instead of an individual's qualifications as a participant in a program of supportive services.[194]

• *Site selection, concentration, and design.* Civil rights-related program requirements already impose some site selection and design criteria intended to promote fair housing goals. For example, it is common knowledge that most housing developed with state and federal funds must be sited, designed, and constructed in a manner consistent with uniform architectural standards that make them "usable and accessible" to people with mobility and sensory impairments.[195] Most mainstream housing programs prohibit the use of funds for medical and institutional facilities.[196] Criteria used by HUD in the competitive selection process for awarding Section 811 funds for the development of housing and supportive services for people with disabilities impose project size limits for independent living projects and group homes that are intended to avoid high concentrations of people with disabilities in one project, or on one site.[197] Rating factor points are awarded for project design and siting features that are shown to "meet the individual needs of the residents and will facilitate their integration into the surrounding community and promote their ability to live as independently as possible."[198]

In the context of race discrimination, it is recognized that design, choice of location, and the density and configuration of housing result in significant fair housing consequences. So, for example, high-rise elevator buildings for families with children are usually not eligible for HUD funding because of concerns about density.[199] HUD civil rights-related program requirements generally forbid site selection in areas with high concentrations of poverty and racial segregation, and require PHAs to adopt admissions practices that serve to deconcentrate poverty.[200] Assisted housing must also "promote greater

194. O'HARA & DAY, *supra* note 2, at 8; Allen, *supra* note 153, at 730.

195. 24 C.F.R. § 8.4(b)(5), §8.20, *et seq.* (2006) (Section 504 site selection and accessibility requirements); 28 C.F.R. § 35.150, *et seq.* (2006) (ADA Title II requirements); 28 C.F.R. § 36.211 (2006) (ADA Title III); *see also* 42 U.S.C. § 3604(f)(3)(C) (2006) (Title VIII accessibility requirements for new construction).

196. 24 C.F.R. § 92.2 (HOME definition of "housing" excludes nursing facilities); 24 C.F.R. § 983.53(a) (forbidding use of Project-Based Housing Choice Vouchers in medical or mental institutions, nursing homes, and facilities providing continuous psychiatric, medical, or nursing services); 26 C.F.R. § 1.42-9(b) (residential rental unit that is "part of a hospital, nursing home, sanitarium, lifecare facility, trailer park, or intermediate care facility for the mentally and physically handicapped is not for use by the general public and is not eligible for credit under section 42").

197. 72 Fed. Reg. 11683, 11725 (Mar. 13, 2007).

198. 72 Fed. Reg. 11729.

199. *See* 42 U.S.C. § 1437d(a) (2006) (public housing); § 1437f(c)(1) (2006) (Section 8).

200. *See* 24 C.F.R. § 983.57 (2006) (standards for deconcentration of poverty and site and neighborhood standards in Project-Based Housing Choice Voucher program); 24 C.F.R. § 903.2

choice of housing opportunities," and be accessible to amenities like "educational, commercial, and health facilities," public transportation and employment opportunities.[201]

Site and neighborhood standards that focus on poverty and race also apply to the HUD housing programs that provide sources of funds for supportive housing.[202] "Housing environmental factors, including extent of crimes and illicit drug activities in the building and at the neighborhood level" often influence the decision of homeless people with disabilities to stay in or leave supportive housing because of the effect such conditions have on "their chance of staying sober. . . and their capacity for managing stress, and consequently, their opportunity for staying in permanent housing."[203]

Supportive housing can benefit from lessons learned in the race context with more robust standards aimed at reducing isolation, preventing segregation, and avoiding differential treatment. Units scattered within a larger housing development, integrated by income and occupied by people with and without disabilities are preferred over facilities serving only people with disabilities.[204] High density housing with a large number of units in one facility serving only one category of disability must be avoided, except in the rare case where aggregating services and housing in this manner is necessary to achieve integration for people with very significant disabilities.[205] Housing should be built on sites that are part of vibrant communities, located near educational, commercial, and health facilities, public transportation and employment opportunities, away from crime, poverty, drugs, and racial segregation. Units should be designed as apartments and homes, not as beds in a congregate facility. Indeed, the highest and best integrative model for supportive housing may be the one that people without disabilities expect will apply to their own life situations: "scattered-site housing models with mobile supports which may, or may not, be provided in the person's home."[206]

- *Race and ethnicity*. Discrimination and segregation based on race and ethnicity have long plagued public and assisted housing programs, some of it caused by histories of deliberate segregation and deprivation of housing opportunity for people of color, and some of it the result of benign but

(2006) (deconcentration of poverty in public housing); 24 C.F.R. § 941.202 (2006) (site and neighborhood standards for public housing).

201. *Id*.

202. *See, e.g.*, 24 C.F.R. § 92.202 (2006) (HOME program); 24 C.F.R. § 891.125 (2006) (Section 811 and Section 202); 24 C.F.R. § 983.53 (2006) (Project-Based Housing Choice Vouchers).

203. HUD, STAYING IN OR LEAVING, *supra* note 165, at 75.

204. 24 C.F.R. § 100.70(c)(4).

205. O'HARA & DAY, *supra* note 2, at 10-11.

206. *Id.* at 8.

persistent neglect of racial considerations.[207] Questions of racial discrimination are largely absent from discussions of supportive housing programs. Nevertheless, there is growing evidence that race, ethnic background, and culture all play a role in preventing people of color and people whose first language is not English from gaining access to health care and services. There is a higher prevalence of poverty and disability among households of color than among white households.[208] There is also a substantially higher rate of poverty among disabled families of color compared to white disabled households.[209] Government studies document "the existence of striking disparities for minorities in mental health services. . . [r]acial and ethnic minorities have less access to mental health services than do whites. . . [t]hey are less likely to receive needed care. . . [w]hen they receive care, it is more likely to be poor in quality."[210] At least one study observed that characteristics "such as race or ethnicity, may influence the propensity to use" Medicaid HCBS waiver services.[211] As a result, some states serving high numbers of people of color with disabilities elect against community-based services and instead continue to limit choice to institutional forms of long term care.[212]

Of course, it is *Olmstead*, the ADA, and Section 504 that provide the civil rights impetus for the new paradigm that is supportive housing. These are civil rights authorities that guard against disability discrimination, not discrimination based on race or ethnicity. However, the *Olmstead* court's conclusion that institutional isolation is a form of disability discrimination is directly connected to antecedent cases in which it was understood that stigmatizing injury often caused by racial discrimination "is one of the most

207. For discussions of the deliberate construction of the modern American racial ghetto in connection with federal housing programs, see, e.g., Arnold R. Hirsch, *Searching for a "Sound Negro Policy": A Racial Agenda for the Housing Acts of 1949 and 1954*, 11 HOUSING POL'Y DEBATE 393 (2000); DOUGLAS R. MASSEY & NANCY A. DENTON, AMERICAN APARTHEID: SEGREGATION AND THE MAKING OF THE UNDERCLASS (1993). Even without evidence of deliberate discrimination, racial segregation remains a persistent feature of more contemporary programs like the Low-Income Tax Credit program. *See* Korman, *Underwriting for Fair Housing*, *supra* note 171, at 303.

208. U.S. CENSUS BUREAU, DISABILITY AND AMERICAN FAMILIES, *supra* note 17, at 13-14.

209. *Id*.

210. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, MENTAL HEALTH: CULTURE, RACE AND ETHNICITY – A SUPPLEMENT TO MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 3 (2001).

211. *See* Nancy A. Miller, Sarah Ramsland, Elizabeth Goldstein & Charlene Harrington, *Use of Medicaid 1915(c) Home and Community-Based Care Waivers to Reconfigure State Long-Term Care Systems*, 58 MED. CARE RESEARCH AND REVIEW 100, 104, 110-111 (2001).

212. *Id.* ("There was a negative relationship between the proportion of the population that was African American in a state and 1915(c) waiver expenditures.").

serious consequences of discriminatory government action."[213] The obligations to further fair housing, to affirmatively market to racial and ethnic minorities, and to refrain from racial discrimination embedded in the Fair Housing Act and related laws apply with full force to supportive housing. It is incumbent on supportive housing providers to attend to these issues.

VII. TOWARD A NEWER PARADIGM

The impediment to developing supportive housing represented by the conflict between service programs dedicated to categories of people with disabilities and housing programs forbidding such standards is a false contradiction. For affordable housing and supportive services programs alike, the "'new paradigm' of disability" is focused on "eliminating the attitudinal and institutional barriers that preclude persons with disabilities from participating fully in society's mainstream."[214] The issues of scarcity, poverty, and disability that make it necessary for people with disabilities to command the availability of housing and service resources are not about to vanish, and will require setting aside housing specifically for people with disabilities for the foreseeable future. Those issues and the imperatives of *Olmstead* are likely to force the continued practice of dedicating resources to people with specific disabilities. If supportive housing is located within a larger fabric of opportunity for people with disabilities in the same housing that is available to the general public, if the features of supportive housing resemble the apartments, homes, and rights of tenancy also available to the general public, and if access to and utilization of services is a function of individual needs, desires, and choice, then it should not matter whether eligibility for housing is identified by category of disability.

Systems of supportive services are in fact moving toward models that do not restrict eligibility based on category of disability, connection to institutions, or control of services by providers. Recent amendments to the Medicaid statute allow states to provide home and community-based services to elders and people with disabilities without need for a federal waiver, and without the necessity of proving that the provision of HCBS would be less costly than institutional care. Under the new law, people with disabilities would qualify for services based on an individualized assessment of need; services would be based on an individualized care plan, and states would have the option to provide "self-directed services" where the "services for the individual. . .are planned and purchased under the direction and control" of the participant.[215] The same legislation creates a Medicaid demonstration program

213. Olmstead v. L.C., 527 U.S. 581, 601 (1999) (quoting Allen v. Wright, 468 U.S. 737, 755 (1984)).

214. Silverstein, *supra* note 19, at 1695.

215. P.L. 109-171, Title VI §6086 (Feb. 8, 2000), amending 42 U.S.C. §1396(n).

in which individuals who would otherwise face institutionalization receive Medicaid-funded services "in the appropriate settings of their choice, including costs to transition from institutional settings to a qualified residence," such as a home or apartment, or a "community-based residential setting, in which no more than four unrelated persons reside."[216]

Affordable housing programs may also be moving toward more flexible standards that permit different models of supportive housing. The recent amendments to HUD's Project-Based Housing Choice Voucher regulations reflect this trend. Services may be provided at the site of the housing, or off-site, independent of the dwelling units. The new rules match people to services based on individual need by permitting supportive housing providers to offer selection preferences "to disabled families who need services offered at a particular project."[217] The rules work to preserve autonomy by mandating that "[d]isabled residents shall not be required to accept the particular services offered at the project."[218] They honor the concept of separate housing only when needed to achieve civil rights goals by limiting segregated settings to those circumstances where there is no other means to meet the housing needs of people with significant disabilities.[219] Perhaps the most important feature of the Project-Based Voucher program from a civil rights standpoint is the central role of individual choice and housing opportunity embedded in the program. After one year of occupancy in a project-based development, participants can request and receive a portable, tenant-based voucher in exchange for the project-based assistance. Once issued, the tenant-based voucher enables a participant to leave the supportive housing environment and rent a unit of their choosing in the private market.[220]

Even with these new standards of flexibility, the gap between housing programs and service programs is not yet completely closed. The Project-Based Voucher rule retains the prohibition on selection preferences for people with a category of disability.[221] The recent changes to the Medicaid statute still permit supportive service providers to limit access to community-based services to target populations based on type of disability.[222] Under these

216. *Id*. at §6071. The program is implemented as the Money Follows the Person Rebalancing Demonstration. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES, FUNDING OPPORTUNITY TITLE: MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION (Jul. 26, 2006), *available at* http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf (last visited Mar. 3, 2007).

217. 24 C.F.R. § 983.251(d) (2006).

218. *Id*.

219. *Id*.

220. 24 C.F.R. § 983.260 (2006).

221. 24 C.F.R. § 983.251(d) (2006).

222. P.L. 109-171, § 6086 and § 6087, *supra* note 66, enacting 42 U.S.C. §1396n(i)(1)(C)(ii) and §1396n(j)(1).

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circumstances, housing opportunities for people with disabilities, especially the people with significant disabilities that stand to benefit from *Olmstead*, will depend on the ability of people with disabilities to demand, and the concomitant ability of service and housing providers to respond by developing supportive housing with operational hallmarks that further civil rights in order to achieve true integration.

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