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Mental Health and Housing in Vermont: Challenges and Opportunities

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Vermont Legal Aid

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Introduction & Executive Summary

Legal problems involving housing were the largest area of concern raised by low-income Vermonters calling Vermont Legal Aid (VLA) and Legal Services Vermont (LSV) for help at the start of my Vermont Poverty Law Fellowship (VPLF) in the fall of 2018. Many were experiencing homelessness, were at risk of losing their housing, or were otherwise unable to access housing for reasons relating to their mental health challenges. Others found themselves unnecessarily confined in correctional institutions or psychiatric hospital settings because they lacked the housing deemed necessary for release. While VLA and LSV have long provided legal help with these kinds of problems, my fellowship was the first resource dedicated to examining and addressing the mental health and housing intersections arising program wide.

Following the approach of previous fellows, I began by consulting widely across service sectors and representing individuals on a variety of housing and benefits matters. I spent my first year diversifying my legal caseload, expanding stakeholder contacts, and building a longitudinal picture of the impact mental health has on sustaining affordable and accessible housing. Some clients I tracked through the range of legal problems they encountered over time. In my second year, I narrowed my casework and research to a few key areas where the fellowship could have a sustained impact. These included access to community mental health services as a key form of supportive housing, parity for mental disability accessibility in affordable housing, and equal access to long-term residential care.

I was planning to focus my final quarters on administrative advocacy to address these narrowed issues when COVID-19 arrived in Vermont. Thanks to the flexibility of the VPLF, I quickly pivoted and joined the VLA and Vermont Bar Association (VBA) COVID-19 committees. Through these groups, I identified a variety of advocacy projects to help ensure that people with mental health challenges have equal opportunities to stay home and stay safe during the pandemic, as required by Vermont's state of emergency declaration and plan for monitoring and responding to COVID-19. Amended and Restated Vermont Executive Order 01-20. Rather than detract from my mental health and housing focus, the pandemic shone a bright light on many longstanding barriers to accessing justice, housing, and services facing people with mental health challenges. COVID-19 has demonstrated unequivocally that housing is healthcare.

In four sections, this report synthesizes several of these barriers and proposes opportunities for change. First, it offers a snapshot of my casework, stakeholder consultations, community legal education work, and advocacy efforts. Second, it overviews select systems of care with a focus on community mental health. Third, it summarizes my observations of the barriers to accessing services, housing, and justice. Fourth and finally, it recommends opportunities to make housing not just more affordable but also more accessible and integrated for people with mental health challenges.

Fellowship Snapshot

- Offered legal services as counsel or co-counsel in over 50 cases across at least nine counties, plus dozens more case consultations with partners and colleagues.

- Consulted with representatives from over 50 stakeholder groups statewide, including from the mental health, housing and homelessness, criminal justice, hospital and transitional care, youth services, and elder services sectors.
- Delivered six fair housing trainings and many more informal presentations to legal and lay advocate audiences statewide, and then recorded a virtual training which the Vermont Care Partners made available to community mental health advocates statewide.
- Advocated to state administrators and members of the judiciary to promote equal access to COVID-19 protections for VLA and LSV's client communities.

Key Findings

Our systems could better serve precariously housed or unhoused individuals experiencing mental health challenges if we:

1. Focus on serving one population subset or addressing one advocacy initiative at a time. Advocates seem overwhelmed by the impulse to simultaneously address the magnitude of mental health and housing challenges intersecting with other factors that put and keep people in poverty. Focusing on one issue at a time, like promoting fair housing and access to services for newly housed individuals in motels, could help us build momentum through measurable progress on one issue at a time.
2. Redirect blame-placing energy toward forging more collaborative, interdisciplinary partnerships between the mental health and housing sectors. Both sectors are expending precious limited energy laying ultimate responsibility on the other, and could be redirecting that energy toward more collaboration to better meet the needs of the populations they serve.
3. Embrace an equitable allocation of resources that might see most of the capacity dedicated to serving the minority of individuals with the most acute, complex needs. Providers often grapple with whether to serve the few with the more complex needs or the many with less complex needs, but the needs of these groups do not need to be pitted against one another. Creating efficiencies and addressing challenges anywhere in the system will free up resources to better serve those with more acute, complex needs.
4. Take steps to ensure that disability accessibility includes mental health accessibility. Service and housing providers, as well as policymakers, exhibit a limited view of what is needed to make housing and services as equally accessible to people with mental disabilities as they are to people with other disabilities or no disabilities. Legal services advocates could champion parity for people with mental health disabilities.
5. Reallocate funding from institutional care settings toward more integrated, affordable community care settings. Housing and service accessibility are unfunded mandates, but the system has sufficient resources to meet the need—the system just needs to allocate its resources differently.
6. Increase accountability for community mental health benefits programs, centering oversight by psychiatric survivors. Legal advocates should align with self-advocates to promote accountability for the state's community mental health providers, as folks have

done so effectively for the state's affordable housing providers. There are no rights without remedies. What creates access to those remedies is access to representation.

Key Recommendations

I recommend that legal services advocates consider the following options when deciding next steps to address Vermont's intersecting mental health and housing challenges:

1. Incorporate mental accessibility into minimum standards for new construction and into rules for reasonable modifications and housing retention programs.
2. Increase oversight of community mental health benefits recipients' service entitlements and due process rights using existing accountability structures.
3. Expand community mental health system accountability through the promulgation of informal policies or formal rules.
4. Join partners like Vermont Care Partners, Disability Rights Vermont, and Vermont Psychiatric Survivors to lobby for the expansion of community mental health, peer services, and supportive housing.
5. Formalize lay advocate capacity building and technical assistance efforts.
6. Dedicate resources to pursuing administrative and judicial relief for conflicted case management and *Olmstead* violations.

Acknowledgements

I am profoundly grateful to my colleagues, clients, and community partners for sharing their expertise and ideas these past two years.

My fellowship hinged on the generosity of my VLA and LSV colleagues, who patiently mentored me and supported me on top of their tireless fight to advance the rights of our constituents. I am in awe of you. Thank you.

I am also deeply thankful for the Vermont Bar Foundation supporters who make this work possible. Thank you so much for the opportunity to serve as Poverty Law Fellow and for supporting access to justice for low-income Vermonters.

My fellowship ended during the 30th anniversary year of the Americans with Disabilities Act. 42 U.S.C. § 12101 et seq. It included the 20th anniversary of the landmark *Olmstead* decision affirming the rights of people with mental disabilities to live and receive services in the most community-integrated settings appropriate to their wants and needs. *Olmstead v. L.C.*, 527 U.S. 581 (1999). Decades later, Vermonters with disabilities are still experiencing unnecessary restraint because of lack of housing and insufficient mental health services. My hope is that this compendium builds institutional knowledge at VLA and LSV, so we can continue supporting efforts by disability rights communities to realize the spirit of *Olmstead* in Vermont.

The Fellowship

Two years later, I can still see the look on one client's face as her Community Action navigator gave her an *802 Quits* pamphlet, some sample-size toiletries, and a paternalistic speech about how fast food is delicious but cooking at home saves money. She was sitting between her two very young and privileged lawyers, my co-counsel and me. Her face conveyed humiliation but not surprise (much to my surprise). *This* is the level of dignity and privacy to which low-income Vermonters become accustomed.

The navigator was assessing our client's monthly income and budget to determine if she was eligible for state assistance with catching up on rent. She and her three children were facing imminent homelessness because she was being evicted from her subsidized apartment for nonpayment of rent. Her arrearage resulted from a complicated domino effect of mishaps that boil down to three issues: she has psychiatric disabilities, she is unable to work and has low Social Security income, and her housing provider repeatedly violated her fair housing rights—violations that would have been actionable if not for complicated evidentiary issues.

Our client wrung her hands with anxiety as she explained how challenging it is to transport her children to their respective schools each day. Let alone to visit the food shelf and Economic Services offices to make sure her family has what it needs. Not to mention finding time to see her personal health providers and psychiatric prescribers to make sure she has what she needs. Since the start of her eviction case, she could now add to her to-do list frequent court appearances, meetings with her attorneys, and visits to Community Action. Despite having psychiatric disabilities, she was not eligible for any case management services to help her navigate these systems.

She provided the navigator with the solicited assurances that now, while fighting her eviction as a single parent, she would quit her stress-related smoking and cut back on the convenience of fast food. Unfortunately, the humiliation unfolded in vain. My client's below-market rent ate up too much of her monthly income and she was denied the one-time investment of back rent. Months later, as she was evicted to homelessness, she expressed to us her concerns about her worsening mental health.

Hers was the first case of my fellowship. The first time I blurred the line dividing legal and lay advocacy. The first time I encountered mental health-related housing problems that had no apparent legal solution. The first time I warned a client that whatever legal help I *could* provide would not achieve a feeling of justice being served—but maybe, if we were lucky, would open up an avenue toward meeting one of my client's goals. This section reflects on my many other similar cases, as well as the stakeholders I consulted, the workshops I delivered, and the advocacy I helped advance.

Casework

In my first year, I was generally interested in legal issues that could affect a low-income person's housing situation if that person also had a mental health concern or disability. In my second year, I focused on cases that would allow me to study the impact that community mental

health services are having (or could or should be having) on stabilizing precarious housing situations. All told, I offered legal services as counsel or co-counsel on over 50 cases statewide. Clients came from Addison, Caledonia, Chittenden, Franklin, Orleans, Rutland, Washington, Windham, and Windsor counties. My youngest client was under 18 and my eldest was over 70. I worked with several clients who had multiple cases each.

Legal issues included subsidized and unsubsidized evictions, rental assistance terminations, fair housing claims to restore rental assistance, appeals of temporary and emergency housing denials, grievances and appeals of mental health service reductions or denials, discrimination complaints to the Vermont Human Rights Commission, and other fair housing legal issues. I also consulted on dozens of cases with community partners and VLA/LSV colleagues. Periodically, I volunteered as attorney-for-a-day at rent escrow and criminal record expungement clinics in Chittenden, Franklin, and Windsor counties. For clients for whom the clinic setting was inaccessible due to their mental disability, I offered expungement help from my office.

These efforts helped low-income individuals expunge records, preserve subsidies, avoid eviction, exit homelessness, restore access to services and benefits, and obtain reasonable accommodations. They allowed me to develop a broad sense of the variety of legal problems a person with mental disabilities might encounter in relation to their housing. For a sampling of cases I worked or consulted on, see **Appendix A.**

Consultations

I developed and later refined the scope of my casework and research in consultation with diverse stakeholders statewide, many on an ongoing basis, including:

- Directors or staff from all of the Department of Mental Health's designated agencies and several specialized service agencies;
- Staff from several area agencies on aging, shelter providers, homelessness prevention organizations, and community action agencies;
- Housing authorities, other nonprofit housing providers, and residential treatment and transitional housing providers;
- Self-advocates and disability rights organizations;
- Criminal justice and prisoner's rights advocates and a forensic evaluator;
- Several local and regional continua of care and housing retention task forces;
- Several state and local administrators and members of the Vermont Judiciary;
- My incredibly generous colleagues at VLA and LSV.

For a more comprehensive list of the stakeholders I consulted, see **Appendix B.**

Outreach

My work also included outreach and community legal education in a variety of forums, including the following activities:

- Led a brown bag lunch discussion with Justice Robinson, Justice Carroll, and staff attorneys and law clerks of the Supreme Court of Vermont.

- Supervised two law student Inns of Court fellows in their research of complex fair housing issues. This mentorship culminated with our creation of an ethics CLE, which the students and I co-presented with Chief Justice Reiber at the Inns of Court in Rutland.
- Guest lectured to the South Royalton Legal Clinic on access to justice for self-represented litigants during the COVID-19 pandemic.
- Presented at several Vermont Bar Association (VBA) meetings and conferences, as well as Justice Fest events in Rutland, Washington, and Chittenden counties.
- Published a review of my first year in the *Vermont Bar Journal*.
- Co-delivered trainings on supporting tenants with disabilities to the Howard Center, Northwestern Counseling & Support Services, and Washington County Mental Health Services CRT Teams. Recorded a virtual training made available to all designated mental health agencies statewide through Vermont Care Partners.
- Represented VLA at the University of Vermont Health Network's Community Leaders in Mental Health Luncheon 2019.
- Led a training on supporting tenants with disabilities at the Youth Services Bureau Summit.
- Tabled at several *Here to Help* clinics for people experiencing homelessness in Burlington.
- Delivered a plenary as well as a training session on supporting tenants with disabilities at the 2019 Guen Gifford Advocates Training.
- Volunteered as subject matter mentor and debate judge for two semesters of the SPEAK Solutions program at the Chittenden Regional Correctional Facility, during which participants debated the issue of whether Vermont should provide universal access to supportive housing upon reentry. I had the chance to hear from about 20 incarcerated women on what mental health and housing related challenges they are facing or have faced during reentry.

Advocacy

Finally, I had the opportunity to contribute to the work of several committees and to forge advocacy partnerships, including:

- The VBA COVID-19 Committee**.** As the Access to Justice Coalition representative, I monitor barriers to accessing remote justice and complete projects to advance court accessibility to low-income and self-represented litigants.
- The VLA/LSV COVID-19 Committee. Completed advocacy projects to ensure low-income Vermonters with disabilities had equal opportunities to "Stay Home, Stay Safe." Projects included authoring and co-authoring letters to the judiciary, legislature, and state administrators advocating for an eviction moratorium, for FEMA relief, and for measures to mitigate barriers to remotely accessing justice.
- The VLA Residential Care Home Discharge Workgroup. Monitored residential care home discharges, regulatory enforcement, and the *Olmstead* rights of residents with mental disabilities. Inputted into advocacy letters to the Vermont Department of Disabilities and Independent Living.
- The VLA/LSV Housing Task Force. Consulted with policy advocates on the fair housing and accessibility needs of individuals with psychiatric disabilities in emergency and

temporary housing during COVID-19. Submitted verbal and written comments to the Vermont Department of Housing and Community Development on Vermont's HUD Consolidated Plans for 2019-20 and 2020-24.

- The 2020 Community Mental Health Services Survey with Disability Rights Vermont. Collaboratively surveyed community mental health service recipients since the arrival of COVID-19 to assess consumer satisfaction.

These cases, consultations, outreach initiatives, and advocacy projects made for an impactful fellowship. They afforded me insight into the mental health system, which I share in the following section. They form the basis for the key findings and recommendations detailed later in this report. Ultimately, while I am proud of what my fellowship achieved, in **Appendix C** I acknowledge some limitations of the fellowship and this report.

The System

"The only client you'll ever have is the system," cautioned Robert Ostermeyer, Director of Franklin/Grand Isle Community Action at the Champlain Valley Office of Economic Opportunity (CVOEO). Now memorialized on a Post-It above my desk, Robert's maxim provides comfort when frustrations with systemic mental health and housing gaps run highest.

Ask any VLA or LSV housing advocate about my fellowship topic and, without missing a beat, they will begin detailing the myriad ways in which mental health challenges pervade every type of housing legal issue they work on. Likewise, any involuntary treatment docket attorney could detail the ways housing instability and homelessness exacerbate individuals' mental illness and increases the risk of involuntary treatment or institutional care. The same goes for clients already enrolled in scarcely available community mental health services.

We are struggling to connect clients to services that help stabilize housing and substantiate fair housing claims and defenses. We are also struggling to stop evictions and prevent homelessness for individuals who already receive some form of supportive services. We are spending considerable resources voicing frustrations about "the system," but are struggling to build institutional knowledge about it and take part in improving it. Most of all, we are struggling to hold Vermont's public mental health and housing systems accountable to the *Olmstead* promise—the right of people with disabilities to live and receive services in the most community-integrated settings appropriate to their wants and needs.[1]

This section introduces community mental health services from the perspective of an affordable housing advocate. It begins by overviewing the compounded barriers to accessing affordable and stable housing for low-income people with mental health challenges. It then examines community mental health case management, provided through the Community Rehabilitation and Treatment (CRT) program, as a primary source of Vermont's housing supports.

The Need

Low-income Vermonters face numerous barriers to accessing housing.[2] Nearly one-third of Vermont households are renters[3] in a state with one of the highest proportions of vacation homes in the country.[4] These renters are navigating the 13th least-affordable rental market in the country,[5]

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[1] 42 U.S.C. § 12101 et seq.; *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[2] For a general discussion, *see A Roadmap to End Homelessness in Vermont*, The Corporation for Supportive Housing Consulting LLC (2016), *available at* http://www.vtaffordablehousing.org/wp-content/uploads/2019/01/VT-Roadmap-to-End-Homelessness-Final-Report-2016.12.20.pdf#:~:text=Roadmap-,The%20Destination%3A%20Ending%20Homelessness,services%20to%20households%20experiencing%20homelessness.

[3] *See Out of Reach 2020: Vermont*, National Low Income Housing Coalition (2020), *available at* https://reports.nlihc.org/oor/vermont.

[4] *Vermont Housing Needs Assessment: 2020-2024*, Vermont Housing Finance Agency (February 2020) at 4, *available at* https://www.vhfa.org/documents/publications/vt_hna_2020_report.pdf.

[5] *See, e.g.*¸ *Affordability Rankings*, U.S. News, *available at* https://www.usnews.com/news/best-states/rankings/opportunity/affordability(accessed 12/23/2020).

with the fifth largest shortfall between wages and rents.[6] Vermont has an average rental vacancy rate of about 3.4 percent, a rate that is among the lowest in the nation and declines annually.[7] The annual income needed to afford one-bedroom housing at Vermont's fair market rate is $38,763.[8] However, the average renter household income is about $37,119.[9] About three-quarters of Vermont renters earn less than the median income.[10] About 36,000 or one-third of Vermont renters are rent-burdened, and about 18,000 spend more than half their income on housing.[11] It is no surprise that one in 44 renting households had an eviction filed against them in 2016, and that nonpayment of rent was the only issue in 70% of cases.[12] In these cases, the average arrearage at issue was only around $2,000 and three-quarters of filed cases resulted in an eviction (with even more resolving in a move out).[13] In 75% of cases, landlord-plaintiffs were represented by counsel and tenant-defendants were not.[14] These numbers do not account for the tenants who move out upon receiving a termination notice, unwittingly forgoing viable counterclaims and defenses.[15]

Federal and state subsidy programs mitigate the unaffordability of Vermont housing for a fortunate few.[16] The complex subsidy system is largely funded and regulated by the Federal Department of Housing and Urban Development (HUD), and generally comprises two types of programs—those targeting people exiting homelessness and those targeting low-income people in housing.[17] Subsidies typically attach to the person (which are tenant-based, like Housing Choice Vouchers or "Section 8") or the building (which are project-based) and are generally administered by public housing authorities (PHAs) and the Vermont Department of Children and Families

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[6] *Out of Reach 2020*, *supra* note 3.
[7] *Vermont Housing Needs Assessment*, *supra* note 4.
[8] *Out of Reach 2020*, *supra* note 3. This is calculated pursuant to the federal standard that individuals spend no more than 30% of income on housing in order to balance sustaining housing with sustaining other basic needs. *See, e.g.* https://www.census.gov/housing/census/publications/who-can-afford.pdf.
[9] *Out of Reach 2020*, *supra* note 3.
[10] *Vermont Housing Needs Assessment* at 43, *supra* note 4.
[11] *Id.* at 47 and 50.
[12] *Eviction in Vermont: A Closer Look*, Vermont Legal Aid (2019), *available at* https://www.vtlegalaid.org/sites/default/files/Eviction-Report-VLA-3.18.19-web.pdf.
[13] *Id.*
[14] *Id.*
[15] For recent analysis on the impact of evictions in Chittenden County, *see Why Vermont Legal Aid Supports Just Cause Reform*, Memorandum from HDLP to Burlington CDNR (July 14, 2020), *available at* https://www.burlingtonvt.gov/sites/default/files/Agendas/SupportingDocuments/FINAL%20Just%20Cause%20Eviction%20Burlington%20Memo.pdf.
[16] While approximately 36,000 or one third of Vermont renters are rent-burdened, only about 13,960 rental homes receive project-based public subsidies, including 1,190 Housing and Urban Development (HUD) Public Housing Program apartments in buildings managed by Public Housing Authorities (PHAs). In addition, about 5,460 low-income households receive tenant-based housing vouchers applicable toward market rent or subsidized units. About 7,550 subsidized apartments receive monthly rental assistance bringing residents' monthly rent to no more than 30% of their income. *Vermont Housing Needs Assessment*, *supra* note 4.
[17] *Report to the Vermont Legislature by the Specialized Housing Vouchers Working Group*, Agency of Human Services (November 15, 2019), *available at* https://legislature.vermont.gov/assets/Legislative-Reports/Specialized-Housing-Voucher-Report-FINAL.pdf.

(DCF).[18] Some affordable housing providers offer below-market rent in housing that is subsidized by federal and state tax credit programs.[19]

We lack sufficient subsidies to meet the needs of the one-third of Vermont renters who are rent burdened.[20] Furthermore, the subsidized rental vacancy rate is only about 0.8%,[21] and PHA waitlists for tenant- and project-based subsidy programs are typically so many years long that they are closed to new applicants. There is also an overall shortage of available housing stock in Vermont at which to use tenant-based vouchers, and that stock declines each year.[22] Further, along with a dearth of all-too-common habitability issues plaguing lower cost housing is a lack of resources needed to rehabilitate and renovate substandard housing.[23] Subsidy administrators cannot certify substandard housing for participation in HUD rental assistance programs, leaving otherwise subsidized renters without rental assistance, without housing, or both.[24] Renters who get evicted are mandatorily terminated from subsidy programs, knocking them to the back of waitlists. Relatively few landlords own most rental housing in Vermont's "urban" areas,[25] and in rural areas with little housing and limited anonymity, burning bridges with a landlord can prevent someone from becoming re-housed.

Mental health concerns[26] compound the barriers to getting and staying housed for numerous Vermonters. Under fair housing and anti-discrimination laws, a person's mental impairment (including a mental health concern) constitutes a disability if it substantially limits the person's performance of a major life activity, in turn defined broadly in the housing context as

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[18] *See Subsidized Housing/Subsidies*, Vermont's Legal Help Website, (accessed November 30, 2020), *available at* https://vtlawhelp.org/subsidized-housing. *See also Specialized Housing Vouchers*, *supra* note 14.
[19] *See, e.g., Housing Credit Program*, Vermont Housing Finance Agency (accessed November 30, 2020), *available at* https://www.vhfa.org/rentalhousing/developers.
[20] *Vermont Housing Needs Assessment*, *supra* note 4.
[21] *Id.* at 45.
[22] *Id.* at 51.
[23] *Id. see also Just Cause Reform*, *supra* note 15 ("Vermont Legal Aid's 2018 report *Renters at Risk: The Cost of Substandard Housing* concludes that fear of eviction is a significant factor that often prevents tenants from reporting housing health code violations")(citing *Renters at Risk: The Cost of Substandard Housing*, Vermont Legal Aid (2018), *available at* https://www.vtlegalaid.org/sites/default/files/Renters%20at%20Risk%20-%20The%20Cost%20of%20Substandard%20Housing.pdf (finding that substandard housing issues, like chronic bedbug infestations, can cause or exacerbate tenants' mental health concerns, at 13)).
[24] *Cost of Substandard Housing* at 31, *supra* note 23.
[25] *Who owns Burlington? The largest holdings are in the hands of the few*, VT Digger (November 3, 2019), *available at* https://vtdigger.org/2019/11/03/who-owns-burlington-the-largest-holdings-are-in-the-hands-of-a-few/.
[26] The Vermont Department of Mental Health (DMH) defines mental health as "a state of successful mental function and performance that results in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society." In contrast, it defines mental disorders as "health conditions that are characterized by alterations in thinking, mood or behavior associated with distress or impaired functioning. Mental disorders contribute to a host of problems, including disability, pain or death." Finally, it defines mental illness as a term referring "collectively to all diagnosable mental disorders. Symptoms of mental illness often lessen over time, and people can enjoy considerable improvement or full recovery." *Healthy Vermonters 2020: State Health Assessment Plan*, DMH at 21 (2020), *available at* https://www.healthvermont.gov/sites/default/files/documents/2016/11/Healthy%20Vermonters%202020%20Report.pdf.

anything the person does to use or enjoy their housing.[27] People with disabilities are eligible for fair housing and antidiscrimination protections, targeted subsidies and supports, and Social Security income to pay rent, but many individuals lack access to the services they need to help them access these programs and invoke their rights under the law.

Over 25,000 Vermonters live with serious mental illness, a rate of about four percent.[28] While Mental Health America ranks Vermont 12th nationally for adult mental health,[29] the Federal Substance Abuse and Mental Health Services Agency (SAMHSA) reports that Vermont has a higher annual average prevalence of suicidal ideation and serious mental illness than its regional counterparts and the nation.[30] Vermont also has one of the fastest growing suicide rates in the country, and about 80% of Vermonters living with a persisting serious mental illness also experience a substance use disorder.[31] One in seven Vermonters experience Adverse Childhood Experiences, and many also experience Adverse Family Experiences later in their youth, both highly correlated with future mental health concerns.[32] As 25% of Vermont's population will be 65 or older by 2030, additional care needs associated with chronic disease and disability will complicate the need for improved mental health supports.[33]

Almost half of adult Vermonters living with mental illness do not receive any services.[34] My clients in this position provided a variety of reasons. Many lack access to reliable transportation, time off work, technology, or case management support needed to access services. Many others lack a choice in providers and either do not want the services offered by the mental health agency in their area, maybe because of a bad past experience, or have burned bridges with the one available provider in their region beyond repair. Many lack access to the insurance needed to pay for care.[35] Without services and supports in place, renters with mental health concerns face a disparate risk of falling into arrears or incurring lease violations for behavior relating to their

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[27] 42 U.S.C. § 12102; 42 U.S.C. § 3602; 9 V.S.A. § 4503.

[28] National Alliance on Mental Illness Vermont Resources, *available at* https://namivt.org/nami-resources/. Serious mental illness (SMI) is defined as "adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the DSM-IV and has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities." *Behavioral Health Barometer 2017*, SAMHSA, Vol. 5 at 36 (2017), *available at* https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Vermont-BH-BarometerVolume5.pdf.

[29] *Vision 2030: A 10-Year Plan for an Integrated and Holistic System of Care*, DMH at 13-14 (January 29, 2020), *available at* https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/Vision_2030_FINAL.pdf.

[30] *Behavioral Health Barometer*, *supra* note 28.

[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] *Id.* Approximately 6,700 Vermonters receive adult outpatient services for episodic or lower acuity mental illness. *Department of Mental Health Scorecard*, DMH (2020), *available at* https://embed.resultsscorecard.com/Scorecard/Embed/9939 (accessed November 30, 2020). DMH reports no recent change to the 58% of Vermonters receiving any mental health treatment. *Id.* DMH also reports virtually no recent change to the rate of Vermonters receiving community mental health services, a rate of 37 per 1000 people. *Id.*

[35] For the majority of mental health services available to the thousands of low-income Vermonters who need them, Medicaid is key. However, even though 50% of all lifetime mental illness cases appear by age 14, and 75% of cases appear by age 24, about one third of Vermont's young adults is uninsured. *See* NAMI VT Resources, *supra* note 27.

mental health concerns or for reacting to triggering conditions endemic to Vermont's affordable housing stock. As a result, renters with mental health concerns face disparate risk of eviction for cause (for breach of lease), which comprises about 20% of all evictions in Vermont, as well as eviction for no cause through which landlords can evict a tenant (lease-compliant or not) without the burden of proving why.[36]

Renters with mental health concerns also risk eviction for nonpayment of rent, as Vermont tenants with disabilities who are unable to work represent a significant subset of rent-burdened households.[37] Over 25,000 Vermonters receive Social Security Disability Insurance (SSDI) income on account of having a disability, and over 14,000 Vermonters receive Social Security Insurance (SSI) income on account of having a disability, many of whom rely on these programs as their primary or only income to pay for housing.[38] Vermont has one of the highest rates of SSDI utilization in the country, including utilization by people with mental disabilities that is higher than the national average and overall utilization that is growing at a faster rate than the national average.[39] The average SSDI payment for eligible individuals is around $1,200 per month[40] and the average SSI payment is around $835 per month.[41] This means that even the higher-end dual SSI/SSDI earners earn up to around $24,000 per year,[42] far below the estimated $38,763 needed to afford one-bedroom housing at Vermont's fair market rate.[43] For Vermonters receiving only SSI, the average affordable rent would be $251 per month.[44] Fair market rent for a one-bedroom apartment in Vermont is $969 per month.[45]

Specialized subsidy programs target individuals with mental disabilities, as well as those who have experienced homelessness and/or who need wraparound supports to sustain affordable housing.[46] While impressive in design, these programs are insufficient to meet the growing need.

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[36] *Just Cause Reform* at 4, *supra* note 15 (citing *Eviction in Vermont*, *supra* note 12).
[37] Services and supports to help manage the daily budget are also sparsely available, as explored in the next subsection.
[38] *SSI Recipients by State and County, 2018*, Social Security Administration Office of Retirement and Disability Policy (2018), *available at* https://www.ssa.gov/policy/docs/statcomps/ssi_sc/2018/vt.html.
[39] *Number of Vermonters Receiving Disability Benefits Due to Mental Illness is Increasing*, Vermont Public Radio (October 30, 2017), *available at* https://www.vpr.org/post/number-vermonters-receiving-disability-benefits-due-mental-illness-increasing#stream/0.
[40] *See Out of Reach*, *supra* note 3.
[41] *Id.*
[42] *Social Security Disability Insurance Benefits & Supplemental Security Income*, National Alliance on Mental Illness (2015) (accessed November 30, 2020), *available at* https://www.nami.org/Your-Journey/Living-with-a-Mental-Health-Condition/Social-Security-Disability-Insurance-Benefits-Su.
[43] *See Out of Reach*, *supra* note 3. This is calculated pursuant to the federal standard that individuals spend no more than 30% of income on housing in order to balance sustaining housing with sustaining other basic needs. *See, e.g. Who Can Afford to Live in a Home?: A look at data from the 2006 American Community Survey*, Mary Schwartz and Ellen Wilson of the U.S. Census Bureau, *available at* https://www.census.gov/housing/census/publications/who-can-afford.pdf.
[44] *Out of Reach*, *supra* note 3.
[45] *Id.*
[46] *Specialized Housing Vouchers*, *supra* note 17. These programs include Permanent Supportive Housing (PSH) vouchers like Shelter Plus Care and Vermont Department of Mental Health (DMH) Subsidy Plus Care, Rapid Rehousing (RRH) vouchers, DCF Family Reunification Program vouchers, DCF emergency housing, DMH

Frustratingly, Vermont also underutilizes many of these specialized subsidies and has returned over $500,000 in specialized vouchers to HUD over the past three years.[47] Underutilization is attributed to the fact that much of Vermont's housing stock does not meet HUD habitability and affordability requirements, and because Vermont's service sector lacks sufficient capacity to provide the requisite supportive housing services.[48] That said, obtaining a sought-after specialized voucher does not guarantee long-term housing stability. As is true for non-specialized rental assistance programs, specialized voucher programs feature stringent program rules, eligibility bars for certain conviction histories, and years-long waitlists that conspire to leave many low-income renters with disabilities rent-burdened, without subsidies, and at risk of eviction.[49]

Eviction and foreclosure proceedings make up the majority of Vermont's Superior Court docket.[50] Cases are generally brought by represented, landholding parties who are suing generally unrepresented, low-income defendants for lack of money. *Id.* These folks facing eviction lack access to the income needed to keep up with market or even subsidized rent. Many also lack the income needed for transportation, family care, time off work, and technology required to fully participate in the legal proceedings against them. Those with disabilities lacked the supports and services they needed to help them obtain reasonable accommodations in their housing in the first place. In court, many also lack access to reasonable accommodations and interpreters needed for equal access to their proceedings. In general, many from VLA and LSV's client communities express fears of participating in legal proceedings for reasons related, but not limited, to class, race, and disability. The pivot to remote proceedings in light of the COVID-19 pandemic has exacerbated these barriers.[51]

These barriers to accessing justice factor into the resolution of most ejectment actions with an eviction or move out deal.[52] In other words, the majority of cases result in low-income tenants and tenants with disabilities moving out to homelessness—causing collateral harm to individuals and communities through associated job loss, educational disparities, health disparities, community instability, associated loss of community safety, and mental illness.[53] As sociologist

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Housing Support Fund assistance funded through the designated mental health agencies, and rental assistance available through the Federal Veteran's Administration (VA).

[47] *More than $500,000 in housing vouchers unused since 2017,* VT Digger (December 9, 2019), *available at* https://vtdigger.org/2019/12/09/more-than-500000-in-housing-vouchers-unused-since-2017/; *Vermont Housing Needs Assessment 2020*, *supra* note 4; *see also Vermont Housing Needs Assessment: Highlights*, Vermont Housing Finance Agency (February 2020), *available at* https://accd.vermont.gov/sites/accdnew/files/documents/Housing/Fact%20sheet%201%20Highlights.pdf.

[48] *Housing Needs Assessment Highlights*, *supra* note 46.

[49] The standard for termination is much higher than for non-specialized subsidy programs, but we continue to see my client base face termination for disability-related incidents.

[50] Statewide Legal Needs Assessment, *Legal Services Vermont and Vermont Legal Aid* (December 6, 2019), *available at* https://legalservicesvt.org/sites/default/files/2019-VERMONT-LEGAL-NEEDS-ASSESSMENT.pdf.

[51] For a discussion of barriers to accessing justice in courts, see *Appendix to Long Term Planning Committee: Ramp-Up Report*, Vermont Judiciary at 37 (May 13, 2020), *available at* https://www.vermontjudiciary.org/about-vermont-judiciary/blueprint-expansion-court-operations.

[52] *Eviction in Vermont*, *supra* note 12.

[53] *Why Eviction Matters*, Eviction Lab (accessed November 30, 2020), *available at* https://evictionlab.org/why-eviction-matters/#eviction-impact.

and *Eviction Lab* expert Mathew Desmond puts it, "The evidence strongly suggests that eviction is not just a condition of poverty, it is a cause of it."[54] In Vermont, homelessness puts people into "explosively" expensive emergency housing programs,[55] and puts people at risk of institutionalization in prisons and emergency departments—levying the highest possible human, social, and financial costs and putting people at risk of unnecessary institutionalization in violation of *Olmstead.*[56]

International best practice for ending the cycle of chronic homelessness has shifted from a 'housing readiness' to a 'housing first' approach, meaning that individuals should not have to demonstrate readiness by progressing through emergency and temporary shelter and services before having access to the one proven solution to chronic homelessness: housing.[57] Housing provides access the other services and supports people's need to achieve physical, mental, social, and economic health. As the COVID-19 pandemic has proven, housing *is* healthcare—the first and foremost contributor to health.[58] *Housing First* programs create immediate access to subsidized and permanent supportive housing.[59] They prioritize individual autonomy and scattered-site housing choice to maximize community integration.[60] They make available interdisciplinary home-based supports and services and offer flexibility on program and treatment compliance.[61]

Vermont is home to the first high fidelity rural *Housing First* program, meaning it closely adheres to *Housing First* best practice, delivered by Pathways Vermont.[62] Since 2010, over 200 of Pathways' clients have become stably and sustainably housed through *Housing First*, having previously experienced chronic homelessness, engagement with emergency services, and/or institutionalization in hospitals and prisons.[63] Through immediate access to affordable housing and interdisciplinary supports, Pathways clients enjoy an 85% housing retention rate.[64] Over eighty percent of Pathways' participants do not become incarcerated long-term again.[65] Program delivery costs on average $43 per day, in contrast to the approximately $58 daily for transitional housing, $92 daily for homelessness services, $98 daily for residential treatment, and $156 daily for

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[54] *Id.*
[55] *Roadmap to End Homelessness*, *supra* note 2.
[56] *See generally*, *Housing First*, Pathways Vermont (accessed November 30, 2020), *available at* https://www.pathwaysvermont.org/what-we-do/our-programs/housing-first/.
[57] *E.g.*, *Housing First*, National Alliance to End Homelessness (accessed November 30, 2020), *available at* https://endhomelessness.org/resource/housing-first/.
[58] *E.g.*, *Housing and Health Care: Working Together to Address COVID-19*, National Alliance to End Homelessness (April 24, 2020) (accessed November 30, 2020), *available at* https://endhomelessness.org/housing-and-health-care-working-together-to-address-covid-19/.
[59] *Housing First*, *supra* note 56.
[60] *Id.*
[61] *Id.*
[62] *Pathways Vermont Housing First*, *supra* note 55.
[63] *Id.*
[64] *Id.* Pathways staff have explained that by "retention" they mean that individuals maintain enrollment in subsidy programs and are in housing (if not in the first apartment the individuals moved into). Reportedly, about half of Pathways clients remain in their first apartment. Others move into a second, or sometimes third, apartment before stabilizing their tenancies and remaining in their units long term. In contrast, I have heard retention rates for housing readiness or compliance approaches reported at around 50%.
[65] *Id.*

incarceration.[66] Pathways Vermont is in the process of expanding its service area to all counties, while the Homeless Prevention Center offers a *Housing First*-like program in Rutland.[67]

For those lacking the acuity to be eligible for high fidelity *Housing First* services, 1:1 ratio home- and community-based (HCBS) case management runs a close second. SAMHSA defines case management as a range of services that support and assist individuals in developing skills necessary to access housing, medical and behavioral health, economic, social, educational, and other services essential for meeting basic human needs.[68] Case management links recipients experiencing (or at risk of experiencing) homelessness with community services, provides training in how to access those services, and monitors coordinated service delivery.[69] Case managers also help enrollees develop skills for independent living and connect enrollees with treatment as well as personal and professional support systems.[70]

In my casework, I observed the difference that meaningful access to case management can make in re-stabilizing access to housing through fair housing litigation. Fair housing claims to be reasonably accommodated often provide the best available strategy to re-stabilize, preserve, and promote more equal access to housing for precariously-housed individuals with mental disabilities.[71] The success of these claims generally turns on the evidence we can build in close partnership with clients' care providers. Many claims, like reasonable accommodation requests for another chance at program compliance, are nonstarters if clients cannot access care or the case management they might need to coordinate care, which is often the case. Ours is a system that sees demand for human health services exponentially outpacing supply. Thus, a threshold question we ask in a housing legal case for individuals with mental health challenges is what case management or similar resources are available to our clients so we can advance their fair housing claims for another chance at program or lease compliance.

Over the course of my casework and consultations, I maintained a list of the variety of case management or similar housing support services available to Vermonters experiencing mental health challenges, available at **Appendix C.** After researching and collaborating with many stakeholders from that list, my sense is that DMH's Community Rehabilitation and Treatment (CRT) program is one of the largest (if not the largest) providers of 1:1 HCBS case management relating to housing for Vermonters with mental disabilities.[72] CRT is not just one of or the largest resource, it is also one to which many rights attach for consumers as well as the general public.

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[66] *Id.*
[67] *See Services*, Homeless Prevention Center-HPC (accessed November 30, 2020), *available at* https://www.hpcvt.org/services.
[68] *Case Management*, SAMHSA (April 30, 2020) (accessed November 30, 2020), *available at* https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/case-management.
[69] *Id.*
[70] *Id.*
[71] 42 U.S.C. 3601 et. seq.; 9 V.S.A. § 4503.
[72] Second might be the Support and Services at Home (SASH) program, but SASH serves a broader client base than just individuals with mental health challenges. Further, engagement with SASH is legally risk since SASH is generally embedded with the housing provider organizations making engagement legally risky for precariously housed tenants whose case notes could be used against them during termination or eviction.

Despite those accountability measures, compared with other disability benefits programs, CRT receives limited oversight by advocates, and CRT consumers receive limited legal or lay advocacy support with resolving access.

For these reasons, I focused my fellowship on learning more about DMH's CRT program and its impact on housing for individuals with mental disabilities.

Community Rehabilitation and Treatment Framework

DMH bears responsibility for centralizing, overseeing, and delivering the state's mental health care services.[73] DMH must do so in a manner that is integrated, coordinated, flexible, comprehensive, holistic, and equally accessible.[74] As part of its mandate, DMH must "plan and coordinate the development of *community* services which are needed to assist … individuals with a mental condition or psychiatric disability to become as financially and socially independent as possible…"[75] Accordingly, DMH licenses, regulates, and supervises community health agency operations, monitoring institutional reports and investigating complaints as they may arise.[76]

Community health agencies include those public or private nonprofits that DMH designates to provide mental health services.[77] "Designated agencies" offer services to eligible individuals in their local catchment areas, and "specialized service agencies" offer services to specialized populations in select catchment areas.[78] Designated agencies determine the service needs of their catchment areas and establish local community services plans that are reviewed

[73] Mental health care includes "acts of diagnosis, treatment, evaluation or advice or any other acts permissible under the health care laws of Vermont, whether performed in an outpatient or institutional setting, and include alcohol and drug abuse treatment." 8 V.S.A. § 4089(b)(3).
[74] 18 V.S.A. § 7201(a)-(b).
[75] 18 V.S.A. § 7401(emphasis added).
[76] *Id.*
[77] 18 V.S.A. § 8907; Vermont Administrative Rules on Agency Designation (June 1, 2003), *available at* https://dail.vermont.gov/sites/dail/files//documents/administrative-rules-on-agency-designation.pdf. DMH's designated agencies and the counties they serve are as follows: Clara Martin Center ("CMC," Orange); Counseling Service of Addison County ("CSAC," Addison); Healthcare and Rehabilitation Services ("HCRS," Windsor, Windham); Howard Center ("Howard," Chittenden); Lamoille County Mental Health Services ("LCMHS," Lamoille); Northeast Kingdom Human Services ("NKHS," Orleans, Essex, Caledonia); Rutland Mental Health Services ("RMHS," Rutland); United Counseling Service of Bennington County ("UCS," Bennington); Washington County Mental Health Services ("WCMHS," Washington). Designated agencies also provide developmental disability services pursuant DAIL designation and regulation. *See generally* 18 V.S.A. § 8721 et seq.; Regulations Implementing the Developmental Disabilities Act of 1995 (October 1, 2017).

For individuals accessing care through their designated agency, people who are dually diagnosed and service-eligible could receive services from either the MH or DS side of their local agency, depending on primary diagnosis and clinical need. DMH also designates Pathways (statewide) and Northeastern Family Institute (statewide) to provide specialized services to adults experiencing chronic homelessness and serious mental illness, and youth experiencing mental illness, respectively. *See* DMH's website for more information, at https://mentalhealth.vermont.gov/individuals-and-families/designated-and-specialized-service-agencies. All designated and specialized service agencies but Pathways Vermont collaborate through Vermont Care Partners (VCP), a member-based network and lobbying body for the community mental health and developmental disabilities services systems. Vermont Care Partners' information is available at https://vermontcarepartners.org/.
[78] *Id.*

annually.[79] In addition to federal funding, including from Medicaid and SAMHSA, DMH may allocate state funds to the agencies if their local system of care plans demonstrate reasonable costs per service.[80] Although it delegates service delivery to its designated and specialized agencies, DMH must ensure that individuals "can receive information, referral, and assistance in obtaining those community services which they need and to which they are lawfully entitled."[81] To this end, DMH has not exercised its authority under 18 V.S.A. § 7401(2) to promulgate rules guiding the delivery of community mental health services.[82] Instead, DMH guides the community mental health service continuum through a series of manuals and policy documents, which are available online in alphabetical order.[83]

The most intensive adult HCBS offered by the DMH continuum is Community Rehabilitation and Treatment (CRT), a service established by the *DMH Mental Health Provider Manual* (September 1, 2020)("DMH Manual").[84] CRT aims to provide comprehensive, multi-disciplinary services and treatment for adults with "severe mental illness" to help them "remain integrated in their local communities in social, *housing*, school and work settings based on their preferences, while *building strategies* to live more interdependent and satisfying lives."[85] Designated and specialized service agency providers deliver CRT through coordinated efforts by a case manager, therapists, psychiatrists, nurses and other specialists.[86] These providers offer access to an array of services including clinical assessment, service planning, service coordination, community supports, therapies, primary care, and emergency services.[87] Agencies may offer additional optional services such as supported employment, education supports, and additional housing and home supports.[88]

People seeking CRT become eligible when they meet all three of the diagnosis, treatment, and functionality criteria. First, people need at least one qualifying diagnosis under the Diagnostic and Statistical Manual (DSM)-V of either schizophrenia, or other psychotic disorders,

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[79] 18 V.S.A. § 8908. Plans are or should be publicly available on the website of each individual agency, linked on VCP's site.
[80] 18 V.S.A. § 8910.
[81] 18 V.S.A. § 7401(15).
[82] DMH has promulgated rules in only three areas: (1) the 2003 Administrative Rules on Agency Designation, promulgated by the legacy Department of Developmental and Mental Health Services; (2) its 2017 rules on Emergency Involuntary Procedures; and (3) its 1999 rules on Nonemergency Involuntary Psychiatric Mediations. *Available at* https://mentalhealth.vermont.gov/policy-and-legislative-resources/rules
[83] *Available at* https://mentalhealth.vermont.gov/reports-forms-and-manuals/manuals.
[84] *Available at* https://mentalhealth.vermont.gov/sites/mhnew/files/documents/MH_Provider_Manual_9.1.20rev.pdf.
[85] DMH Manual at 18 (emphasis added).
[86] *Id.* In practice, not all agencies refer to their CRT team by that name, and team and position names vary from agency to agency. CRT case managers might be called case managers, community support workers, intensive community support workers, or similar. CRT teams generally comprise a director, management-level staff, case manager positions, non-case manager support positions, administrative support, and a housing specialist. Non-case manager staff can assist case managers with providing clients with transportation, shopping assistance, medication delivery, and Social Security Administration representative payee services.
[87] *Id.*
[88] *Id.*

or seriously debilitating mood disorders.[89] Second, people need the requisite recent treatment history of either (i) recent, long, or recurring periods of inpatient or residential care, or (ii) participation in any "mental health program or treatment modality" with no evidence of improvement, or (iii) being under a court order of non-hospitalization (an order of involuntary community-based mental health treatment).[90] Third, people need to show that they are functionally impaired in either social, occupational, or self-care skills because of their qualifying DSM-V diagnosis.[91] CRT directors have discretion to enroll individuals in CRT who *almost* meet criteria and who demonstrate a clinical need on a provisional basis for up to six months before making a final determination of eligibility.[92]

In practice, I have observed that designated agencies apply the CRT eligibility criteria narrowly and inconsistently for individuals who apply to receive services. Several agencies seem to require applicants to have already experienced institutional care, as well as the kinds of dysfunctionality that gives rise to housing instability, before offering them CRT. For example, although the treatment criterion can be met in a number of different ways, I have observed designated agencies denying CRT for individuals because they lacked recent inpatient treatment at a psychiatric hospital. I have also encountered designated agency providers who refused to assist with making intra-office referrals for CRT for the same reason. As a result, my VLA colleagues and I have watched individuals in psychiatric crisis slide toward CRT eligibility as they cycle through emergency department visits. When I am at a loss for where to direct individuals, their community advocates, or their families for further case management support in the interim, I have sought cold comfort in the fact that the individual will soon be able to

[89] The list of qualifying diagnoses includes: schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, unspecified schizophrenia spectrum and other psychotic disorders, major depressive disorder, bipolar I or II disorder and other specified bipolar and related disorders, panic disorder, agoraphobia, obsessive-compulsive disorder, including hoarding disorder, other specified obsessive compulsive and related disorders, and unspecified obsessive-compulsive and related disorders, and borderline personality disorder. DMH Manual at 18.
[90] Although the treatment criterion includes very broad language, I have observed that agencies apply it very narrowly during CRT intake. Moreover, non-CRT agency staff routinely voice the common misconception that individuals need to have multiple, recent episodes of inpatient treatment in order to meet this criterion. That is incorrect. The criterion can be met by showing any one of the following: "Continuous inpatient psychiatric treatment with a duration of at least sixty days," or "Three or more episodes of inpatient psychiatric treatment and/or a community-based crisis bed program during the last twelve month," or "Six months of continuous residence or three or more episodes of residence in one or more of the following during the last twelve months: residential program, community care home, living situation with paid person providing primary supervision and care;" or "Participation in a mental health program or treatment modality with no evidence of improvement," or "The individual is on a court Order of Non-Hospitalization." DMH Manual at 18. It bears mentioning that I worked with very few individuals receiving involuntary CRT through an order of non-hospitalization so this report presents information from the perspective of someone pursuing services voluntarily.
[91] This is met through "demonstrated evidence" of experiencing at least two of the following for at least six months within the last year: receiving public benefits because of experiencing mental illness, like SSI/SSDI or Medicaid, or displaying "maladaptive, dangerous, and impulsive behaviors," or lacking community supports and social systems, or requiring assistance in survival and life skills. DMH Manual at 19. This criterion is very broad. My clients' housing instability and the issues giving rise to that instability has been sufficient to meet this criterion.
[92] DMH Manual at 20.

demonstrate to designated agencies' satisfaction that they are mentally ill 'enough' to receive CRT.

If an individual is eligible for CRT, they are entitled to the benefits of that program as of right. This means that the state must extend insurance coverage to those who need it to cover the healthcare costs associated with CRT and agencies can only terminate individuals from CRT in extremely limited circumstances.[93] If an individual relocates to another designated agency's catchment area, agencies must facilitate a warm transfer of the individual's case.[94] Also, since CRT is a Medicaid-supported HCBS entitlement, Medicaid rules apply including the federal HCBS Rules, the state Health Benefits and Eligibility and Enrollment Rules (HBEE), and Health Care Administrative Rules (HCAR).[95] I understand that Medicaid rules extend to all CRT recipients, including those who may lack Medicaid and instead receive coverage from other state health insurance. Most importantly, this means that Medicaid notice, grievance, and appeals rights extend to all CRT participants.[96] However, in my experience and in the experience of

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[93] *Id.* at 15 and 21.

[94] *Id.* at 22.

[95] *E.g.*, Center for Medicare and Medicaid Services (CMS) 1915(c) Final Regulation CMS-2249-F/CMS-2296-F, available at https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html; Vermont Agency of Human Services HBEE and HCAR, *available at* https://humanservices.vermont.gov/rules-policies/health-care-rules. The incredibly complex world of Medicaid eluded me—one practitioner warned me early on that many advocates spend decades learning the landscape. In my two years, I did not make significant progress researching and understanding Medicaid in balance with my other priorities. For others taking up mental health and housing work in the future, it would be worthwhile to dig deeper into the Medicaid-related contours of CRT and learn what additional protections and advocacy opportunities Medicaid might afford CRT recipients.

[96] 42 C.F.R. Part 438, Subpart F. The DMH Manual incorporates by reference the federal and state Medicaid rules referenced at *supra* note 94, as well as the DVHA Clinical Criteria, the Medicaid Fee for Services Manual, and the Global Commitment to Health Medicaid Grievances and Appeals Technical Assistance Manual, among other guidance.

This means that CRT recipients or their representatives have the right to grieve any matter that is not an adverse benefit determination, orally or in writing. Complainants have the right to receive swift written acknowledgement within five days, a merits review and final written disposition within 90 days. Adverse benefit determinations involve substantive limitations, reductions, suspensions or denials of services, and can be appealed orally or in writing within 60 days from the date of notice. Appellants have the right to a written acknowledgement from their designated agency within five days, as well as the right to be heard by their designated agency's internal review person (an independent Medicaid Program Appeals Reviewer as designated by DMH). At the internal review meeting, appellants have the right to have representation and the right to present evidence, testimony, and legal and factual arguments. Reviewers are obligated to investigate to obtain "any necessary information" and then issue detailed written notice of a decision within 30 days (with the possibility of extension to up to 44 days). Appellants who receive an adverse appeal resolution have a right to a state Fair Hearing before the Human Services Board. For this reason, CRT providers must notify DMH of any appeal of a CRT action and provide all relevant correspondence and information that was considered in the internal review and adverse resolution. DMH offers technical assistance to internal reviewers at the designated agencies. Global Commitment to Health Medicaid Grievances and Appeals Technical Assistance Manual at 11, *available at* https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/GA_Manual-2017.pdf.

As for other quality assurance measures, designated agencies may fill staff and case manager positions with any candidates that they see fit in their discretion, and licensing for case management is not required. DMH Manual at 30. For those receiving CRT services from licensed professionals, mental health professional licensing and misconduct proceedings are directed by the relevant professional board or the head of Vermont Office of Professional Regulation. The bar for what constitutes MHP misconduct is very high. 3 V.S.A. § 129a. Failure to get

colleagues, these rights are under-exercised and several CRT teams I interacted with appeared unfamiliar with the process.[97] DRVT offers legal assistance with grievances and appeals and has offered to provide VLA with technical assistance and training for advocates interested in taking up this work.

Community Rehabilitation and Treatment and Housing

Last month, a fair housing and public accommodation discrimination case I filed and then litigated for two years settled favorably. The settlement secured damages for my client ("Cary" in **Appendix A**), as well as significant training, monitoring, and policy changes for my client's former housing provider. For most of the litigation, my client was cycling through housing instability and homelessness flowing from the impact of the initial incidence of discrimination. Throughout that time, she did not feel she was getting the support she needed from CRT to re-stabilize her housing situation. Then staff turned over…again. This was my client's second time switching case managers in about two years. Naturally, my client was concerned about yet another upset to her services and care plan. However, my client got lucky. The new case manager was different. He had personal lived experience with mental health challenges, as well as ten years working in the mental health field. The client-CRT relationship transformed. They began care planning to set accessible housing goals, and prioritizing meaningful action steps to meet those goals. They began reviewing progress together in honest and productive ways. Ultimately, my client moved into permanent supportive housing. Her mental and physical health continues to improve. She credits her relationship with her experienced, peer advocate case manager as making all the difference. This is the impact CRT can have on clients' housing.

Housing supports and services are entrenched throughout the design and delivery of CRT. By design, CRT recipients are entitled to clinical assessment services, which factor recipients' functionality in housing into individualized care planning.[98] Housing and home supports can be incorporated into individualized CRT care planning.[99] CRT recipients experiencing crisis but not needing hospital level care are entitled to designated agency crisis bed utilization, emergency and temporary housing search support, and in-facility crisis care.[100] CRT

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informed consent is unprofessional misconduct and potentially malpractice. 18 V.S.A. § 1852. There is no board governing the social work profession in Vermont, but there is a Board for Allied Mental Health Practitioners governing other clinical mental counselors and unlicensed or uncertified practitioners of psychotherapy. See Vermont Secretary of State, *available at* https://sos.vermont.gov/allied-mental-health/.

[97] I understand from colleagues at DRVT that the filing of an appeal stays an adverse benefit determination. For cases where broken down service relationships seem to be playing a role in a client's unstable housing situation, I see the CRT grievances and appeals process as a potentially powerful legal tool for repairing relationships enough to substantiate a reasonable accommodation request for a second chance at housing compliance. Most of my service access cases resolved very informally in conference with my client and their CRT team.

[98] DMH Manual at 23.

[99] Housing and home supports are defined as "Mental Health services and supports based on the clinical needs of individuals in and around their residences. This may include support to a person in his or her own home; a family home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement)." DMH Manual at 108.

[100] DMH Manual at 29.

recipients stepping down from inpatient care are eligible for residential treatment.[101] Finally, for CRT recipients waiting for HUD or other rental assistance are eligible to receive DMH's Housing Support Fund (HSF)—the HSF offers temporary and ongoing rental assistance, security deposits and other set-up costs, small loans and other one-time assistance, and hospital prevention or step-down assistance.[102]

As for service delivery, I had the opportunity to hear from clients, colleagues, partners, and the CRT case managers I built relationships with through casework and trainings I delivered on fair housing. My impression is that housing-related activities are a cornerstone of the services CRT offers clients. I have observed case managers providing clients with an array of housing supports, such as help with housing search, leasing up, rental assistance applications, and certification contracts. Services have also included liaising with housing providers and managing inspections, problem-solving neighbor and landlord conflicts, and supporting clients to connect with and access other service providers. Of course, these housing supports are in addition to the many other transportation, budget planning, medication management, referrals and other services CRT case managers provide.

At the system level, CRT providers partner with housing providers in local and regional HUD continua of care. CRT also co-locates with subsidized housing to provide on-site access to case management supports. CRT programs also staff temporary and rapid rehousing projects and provide services at designated agencies' various forms of emergency, temporary, long-term, and permanent housing. When I had the chance to present to CRT directors at their periodic Vermont Care Partners network meeting, they indicated agreement that housing supports are a central aspect of their work. One CRT director agreed that CRT was likely the largest provider of in-home housing supports in the state, given the housing services that CRT provides in practice and the thousands of Vermonters enrolled in CRT. Part of my fellowship work was collaborating closely with CRT teams to build case manager capacity to work smarter, not harder, by shifting housing support capacity away from future housing search toward preventative housing stabilization.[103]

When CRT is working well, CRT is playing a critical and creative role in helping to make clients' housing more accessible, and by extension more sustainable to them. I got to know several case managers, in addition to the case manager for "Cary" discussed above, who were doing really creative reasonable accommodations advocacy for their clients to proactively stabilize those clients' tenancies. Typically, the case managers who had been in the role the longest and those with lived experience seemed most comfortable with requesting and attending reasonable accommodations meetings with housing providers. They seemed to situate their clients' housing as central to mental health, and to help clients plan for care accordingly. They seemed skilled at broadening their clients' understanding of the universe of what is possible and

[101] Residential treatment is defined as "Intensive mental health treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and skill building to support community living, but not provided in institutions for mental disease (IMD). Treatment may include the use of approved peer supported and peer run alternatives." *Id.*

[102] DMH Manual at 135-136. Housing Support Funds have minimal program rules that set out who is prioritized for funding as well as reporting requirements, but do not extend notice or due process rights to recipients.

[103] An example training I co-delivered (albeit in a less engaging, digital format without normal audience participation) is available at https://youtu.be/7NSmJrfm698.

then using tools like motivational interviewing to help clients develop service and care plans designed to meet their housing goals.

However, more often, when CRT is buckling under the pressure of low staff wages, high caseloads, high turnover, and widespread vacancies, CRT is missing opportunities to build client meaningful relationships and to case plan for sustained community integration—not just by obtaining but also maintaining the housing CRT recipients need to avoid unnecessary institutionalization.[104] All told, there appears to be a disconnection between *Olmstead's* mandate for integrated setting services, DMH's vision for integrating housing supports into mental health system reform, the volume of CRT housing supports already incorporated into the DMH Manual, and the consistency of housing supports that CRT currently offers in practice.[105] CRT in practice embraces housing as healthcare. However, the quality and quantity of housing-relevant services provided by CRT varies widely. The variation seems less connected to clients' wants and needs, and more attributable to resourcing and capacity issues like case manager training, caseloads, and retention.

Community Rehabilitation and Treatment Utilization

Before COVID-19 changed the fellowship's direction, I analyzed the readily available DMH reports on CRT utilization and did not see the volume of housing supports I know CRT provides reflected in the data.[106]

CRT comprises about 15% of the services that DMH provides, reaching about 2,700 Vermonters each year. This rate has remained steady since the 1990s, with a brief expansion to around 3,000-3,500 recipients in the 2000s. There has been an overall decline in the number of new CRT enrollees since 2008, with about 60-90 people enrolling every quarter from 2019-2020. About half of all CRT recipients were admitted to CRT eleven or more years ago. Almost half of CRT enrollees are between 50 and 64 years old. The next highest represented age group are 30- to 49-year-olds, who comprise about one-quarter of enrollees.

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[104] For an overview of the impact under-resourcing has on agencies' staffing and service capacity, *see 3% Factsheet 2020*, Vermont Care Partners (accessed November 30, 2020), *available at* https://vermontcarepartners.org/wp-content/uploads/2020/02/3-percent-2020-fact-sheet-1.pdf.

[105] *See generally Vermont 2020: Reforming Vermont's Mental Health System, Report to the Legislature on the Implementation of Act 79* (January 15, 2020), *available at* https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/Leg/2020-ACT_79_REPORT_011520_FINAL_Corrected.pdf.; *See also* Act 82, *An act relating to examining mental health care and care coordination* (2017), *available at* https://legislature.vermont.gov/Documents/2018/Docs/ACTS/ACT082/ACT082%20As%20Enacted.pdf (recognizing that "[i]ssues related to hospital discharge include inadequate staffing in community programs, insufficient community programs, and an *inadequate supply of housing*" s1(5)(emphasis added), that "*housing… must be considered part of this work* as well" s1(16)(emphasis added), and that "*stable* housing" must be considered during action planning as part of the care spectrum fulfilling *Olmstead*'s promise s3(A)(1)(D))(emphasis added)).

[106] Unless otherwise indicated, this section draws on data from the DMH Scorecard, *available at* https://embed.resultsscorecard.com/Scorecard/Embed/9939. I last analyzed FY18 CRT statistical data, before the FY19 information was available.

According to one survey of about 900 enrollees, more than half earned less than $10,000 income annually, and about 90% earned less than $20,000 income annually. About 50% had Medicare insurance, about 75% had Medicaid insurance, and Vermont extended Medicaid-equivalent coverage to the other 25% (reported out as "Other State Insurance"). About half of those polled had a diagnosis of schizophrenia or schizoaffective disorder or non-mood psychotic disorder. Almost half had a diagnosis of a mood disorder. Almost one-third had a diagnosis of anxiety and other nonpsychotic disorders.[107] Personality and behavioral disorders were diagnosed in 18% of those polled. About one-third had a dually diagnosed substance use disorder. Of the individuals polled, DMH reports that only about 1% have been dually diagnosed with an intellectual or developmental disability.

In recent years, there has been a slight increase in the number of inpatient days for CRT recipients, from 2,545 days in 2016 to 3,522 days in 2018. In one recent survey of 1,705 enrollees, about 25% reportedly access crisis services and about 13% experience stays in a crisis bed setting (spending an average of 22 nights in a crisis bed in total). The proportion of CRT recipients who receive post-inpatient contact from CRT within the first week of discharge has remained level at about 82%.

As for the array of overlapping services being provided through CRT, definitions can be found under each DMH Manual subheading.[108] Of the 1,705 CRT recipients polled in one survey, almost half were receiving services to address daily living and social problems, with about 22% receiving clinical assessment and about 17% receiving day services. Over 90% were receiving service coordination and community supports. However, only about 35% were receiving individual or group therapy overall, with therapy rates varying widely from agency to agency, but about 82% were being psychiatrically medicated.[109] At the Howard Center, which serves the largest number of CRT clients, only 7% of recipients are enrolled in therapy while over 80% receive assistance with managing their medication. As for housing and home supports, only 9% were getting "housing services" (about 245 people, presumably through residential treatment) and those receiving such services did so for an average of 222 days per year. Three designated agencies report providing no housing or home supports through residential treatment, and no agency offered residential treatment to more than 20% of their enrollees.[110] In FY18,

[107] I am mindful of the harm caused by focusing on or reducing individuals to specific diagnoses. I include this information here because fair housing advocacy turns on the specific contours of how clients experience their disabilities and what rules, practices, or structures would need to change to make clients' housing more accessible.
[108] DMH Manual from 23. Many services are available to all Global Commitment to Health recipients, but many others are available only to CRT recipients.
[109] For a compelling investigation of the lack of supporting evidence for our ever-increasing reliance on psychotropic drugs, and the causal relationship between long-term drug use and chronic mental disability, see the works of journalist Robert Whittaker and his fellow writers at *Mad in America* (https://www.madinamerica.com/). See, e.g., Whitaker, R. (2010). *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York: Random House, Inc.; Whitaker, R. (2002). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Cambridge, MA: Perseus Pub.
[110] As for optional CRT services, employment can provide an important sense of identity, self-esteem, routine, and financial security for individuals. Supported employment services has been shown to be an effective modality for reducing high unemployment rates for people with severe mental illness (SMI) and for overall recovery. In Vermont, the rate of employment for CRT recipients has remained steady at around 20-25%, and supported employment through CRT is only available at select designated agencies.

agencies discharged 135 people from CRT, or 5% of all enrollees. Of the individuals whose services agencies terminated, providers reported that for 55% their mental health status was "unchanged."

Community Rehabilitation and Treatment in Contrast

Over the course of my consultations and casework, I heard two opinions repeated about CRT. One was that designated agencies provide better housing supports through the developmental disability service (DS) continuum than the mental health service (MHS) continuum, either because of better resources or better regulations or both. The other was that *Housing First* provider Pathways Vermont seems to play fast and loose with move out deals, and is not above pursuing eviction for cause (evictions for alleged violations of lease provisions or subsidy program rules), but the overall quality of their housing supports seem to eclipse those provided by designated agencies' CRT. I endeavored to investigate: What is so different?

Regarding the DS continuum, the Department of Aging and Independent Living (DAIL) has exercised its statutory authority to promulgate regulations that incorporate due process measures set out by federal and state Medicaid rules.[111] I asked VLA's Disability Law Project (DLP) whether the consumer protections introduced by the DS rules have yielded overall system improvements, noting that the DLP helped draft and, later, revise them. DLP attorneys shared their impression that clearer definitions and due process protections have improved system accountability overall. Now that advocates were citing to agency regulations as opposed to lesser authority, agencies seemed more responsive to grievances and appeals. Over time, it became less necessary for advocates to exhaust all available strategies and appeal cases up to the Human Services Board, since agencies were coming to the table to resolve service issues through informal review.

I certainly encountered varying levels of responsiveness when citing DMH manual provisions to designated agencies and wondered whether agencies would respond more consistently to formal rules. In addition to differing weight of authority, the biggest differences I see between having regulations in the DS system and informal guidance in the MHS system are that the DS regulations include an explicit statement of nondiscrimination, as well as a concise definitions section setting clearer service expectations up front (including housing supports).[112]

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[111] 18 V.S.A. § 8721; Regulations Implementing the Developmental Disabilities Act of 1996 (October 1, 2017), *available at* https://ddsd.vermont.gov/resources/statutes-regulations. I will not attempt to describe specific contours of the DS continuum and instead leave that in the expert hands of the Disability Law Project (DLP).

[112] The DS regulations provide for many home and housing supports that I have observed CRT providing my clients to some extent, or which my client wished CRT could provide. The need for these kinds of MHS is there and regulations could address inconsistency (for better or for worse). First, the DS regulations provide for "community supports" in the form of teaching and assistance in daily living skills, participating in the community, and building healthy relationships from a living setting of the client's choice that promotes inclusion in line with the client's care plan and the Medicaid HCBS rules. *Id.* at Part 1 Section 1.10, *supra* note 106. Further, the DS regulations provide for "home supports" which include services to maintain home health and safety, obtain reasonable modifications, promote independence, support to acquire life skills, and up to 24/7 support as agreed. *Id.* at Part 1 Section 1.23. These are expansive home-based services grounded in the *Olmstead* integration mandate and affirmed by the HCBS rules on patient-centered service planning. In my experience, they crop up in CRT delivery, but not as consistently

Both systems are equally subject to Medicaid rules on process, so I would not anticipate that DMH rulemaking on CRT grievances and appeals would substantively help clients unless the rules shorten designated agency response times.

I asked the DS and MHS directors at Vermont Care Partners (VCP) why they thought one system had regulations and the other did not, and whether that indicated a lack of parity between DS and MHS. I learned that even though the same designated and specialized service agencies and the same lobbying agency champion the DS and MHS continua, the question could be comparing apples and oranges. VCP gave me the impression that the systems, the clients they reach, and the services they provide might be too different to compare. Most notably, the overwhelming majority of CRT recipients live in fully independent settings, while the overwhelming majority of DS recipients do not. Accordingly, DS services focus more on assistance with activities of daily living. DS case management and health care are part, but not all, of the equation.

VCP did not report the same level of systemic improvement that DLP reported since the implementation of DS regulations, but I note that consumer protections carry onerous costs for the member agencies whose interests VCP represents. VCP did not credit weight of authority with creating any lack of parity between DS and MHS, instead pointing to evidence suggesting that governments have always allocated resources inequitably between these systems since the movement for deinstitutionalization.[113] Governments and the public were slower to recognize

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or comprehensively as the explicit, regulatory service entitlements for DS. VCP leaders had a different take, finding that the regulations don't go as far on housing supports as I interpreted.

[113] Since Vermont began closing state-run institutions in the latter half of the 20th century, community-based and step-down services have never been equitably funded to meet the growing need. *See, e.g.*, DMH report to the legislature 2017, *available at* https://legislature.vermont.gov/Documents/2018/WorkGroups/House%20Health%20Care/Mental%20Health/W~Melissa%20Bailey~History%20of%20Vermont's%20Public%20Mental%20Health%20System~1-31-2017.pdf Today, seven hospitals host inpatient psychiatric beds statewide, including for those receiving voluntary and involuntary treatment as well as "forensic bed" defendants diverted from the criminal legal system for lacking competence to stand trial. In fact, there are more locked inpatient beds than when the Vermont State Hospital was open. *See* Act 79 Legislative Reports by DMH, *available at* https://mentalhealth.vermont.gov/policy-and-legislative-resources/legislative-reports-and-budgets. Moreover, the Vermont Department of Corrections, like all corrections systems nationwide, is the largest mental health institution in the state, institutionalizing more people with mental illness than the actual mental health system serves. *See Messages and Talking Points*, NAMI Vermont (accessed November 30, 2020), *available at* https://docs.google.com/document/d/1rpt6NyMJ0sUZTEYAY1Sh0ZeEPPrUMzgIVrYvoAR6kZI/edit.

Before COVID-19, the number of institutional beds in Vermont was set to grow. In 2019, pursuant to a directive by the Green Mountain Care Board (GMCB), the UVM Health Network (UVMHN) was preparing to spend over $20mil of surplus revenue to construct at least 25 new locked psychiatric beds in Vermont. The cost of operationalizing the beds would be exponentially higher. *See* https://gmcboard.vermont.gov/sites/gmcb/files/IP%20Psych%20Bed%20Capacity%20VT%20GMCB%2011-26-18%20%281%29.pdf. The strain on the UVMHN created by the pandemic put the GMCB's directive on hold, giving disability rights communities a new opportunity to advocate that the GMCB direct further investment in community rather than hospital-level care. *See* https://vtdigger.org/2020/05/01/uvm-health-network-projects-152-million-loss-this-year-due-to-covid-19/.

mental health disability rights as a galvanized civil rights issue and allocate equitable resources.[114]

Regarding the success of Pathways Vermont's model and potential learnings for CRT, again we might be comparing apples and oranges. First, Pathways is not a mental health organization that provides housing supports. It is a housing organization licensed by DMH to provide mental health services, including supportive housing and CRT. Second, Pathways delivers housing and mental health services through two structurally distinct teams. The housing team specializes in cultivating housing provider relationships and advocating within the rental assistance, emergency housing, and fair housing frameworks. Housing team leaders display a mastery of program rules and reasonable accommodations advocacy that I would be fortunate to emulate. The mental health team coordinates care for Pathways clients, apparently unencumbered by concerns about landlord relationships. In contrast, designated agencies embed housing specialists within CRT teams who assist clients to pursue rental and other housing assistance and do housing search.[115] Third, as a specialized service agency, Pathways can restrict its *Housing First* intake to maintain low caseload caps and increase the likelihood of

[114] One explanation could be that because many people with developmental disabilities live in settings supported by family and community members, these relationships reinforced the size and cohesion of the network of individuals advocating with governments for DS resources and civil rights.

[115] A recurring concern for advocates is the housing conflict of interest built into these service models. I have observed CRT providers struggling to advocate for clients' best interests (to remain housed) while also maintaining relationships with clients' landlords who house or might house other clients. In very rare cases, I have also observed Pathways-as-landlord actively evicting a client while remaining that client's mental health service provider. On balance, I encountered fewer conflicts of interest in housing for my clients engaged with Pathways services. The Pathways housing team seems clear in its mission to hear out and hold both client and landlord priorities and concerns, and to advance client interests to the extent possible in balance with duties to other clients. In short, the housing team has to think of the group. The mental health team, on the other hand, can focus solely on the individual. These teams working together seem to navigate conflicts better than the CRT model of having the same team consider the interests of individuals and the group.

For example, I had a dual eviction/Shelter Plus Care subsidy termination case where the Pathways mental health team was advocating zealously to advance their client's goal of saving the current tenancy as well as the subsidy ("Earl" in **Appendix A**). Meanwhile, the Pathways housing team respectfully declined to sponsor what would be the client's second move out/second chance reasonable accommodation in two years. Pathways' housing team did not think a second chance reasonable accommodation plus more supports would be reasonably likely to address the recurring program violations at issue. To receive Pathways services, clients have to be willing to accept Pathways into their housing at least once a week, and this client was not. Even though it was confusing for my client and me to receive mixed messages from within the same agency, I appreciated that there was some division of interests here among the two Pathways teams. Maintaining the client's present tenancy and preventing the client's homelessness was unequivocally the mental health case manager's goal. The mental health team seemed to think that with a little convincing (by me), the housing team might get back on board.

In this way, the housing team's role of mediating between clients' and landlords' interests seems inherently conflicted. However, dedicating capacity to managing landlord relationships (by someone who is not the client's mental health case manager) might be a key reason why Pathways is arguably more successful at helping tenants with disabilities and poor rental histories to sustain more individually tailored, scattered site, community integrated housing. Housing conflicts of interest appear mitigated when the advocate for the group and the advocate for the individual are different people. That said, I do not know what it's like from a client's point of view to have the singular organization of Pathways say both "yes" and "no" to continued supportive housing—bifurcation that is made even more complicated in cases where Pathways assumes the role of landlord, as well.

service uptake.[116] Designated agencies, on the other hand, must offer CRT services to all area constituents who are eligible, which causes caseloads to swell to unmanageable limits. Structural differences might make these organizations too fundamentally different to compare, and I do not necessarily aim to turn CRT into *Housing First* and detract from what makes Pathways "special" as a specialized service agency. However, it is clear from studying Pathways' model that a greater investment of state resources in CRT, at a minimum, could help lower caseloads and increase training capacity for improved mental health and housing service delivery. After two years of collaboration and partnership with CRT providers, I am convinced that this state benefits program plays a critical role in recipients' access to housing, and that there are opportunities within reach to make that role more effective.

[116] Pathways maintains high fidelity caseload caps of around 1 staff person per 17 clients. Pathways serves clients in teams rather than by 1:1 assignment, so many clients work with several Pathways providers at a time. To be eligible for intake, clients must be willing to welcome Pathways staff into their homes at least once weekly and must have a specialized housing voucher for people experiencing chronic homelessness and serious mental illness (which clients can apply for an obtain through a centralized resource allocation process called Coordinated Entry, undertaken by regional HUD continua of care).

Key Findings

I first received my fellowship topic as a puzzle that might have some solution. In one corner, nonprofit and private landlords and residential care providers alike are discriminatorily denying housing to folks with disabilities with virtual impunity. In another corner, psychiatric hospitals and corrections facilities are needlessly institutionalizing people otherwise eligible for reentry because they lack housing or "adequate" housing required for release. Throughout, individuals who need services or subsidies may not yet have experienced "enough" homelessness or mental health crisis to have become eligible. Many who have access to the limited available supports and subsidies are nevertheless experiencing housing instability and unwittingly forgoing fair housing legal remedies. Individuals with disabilities who do assert their legal claims face tremendous barriers to accessing justice in judicial and administrative proceedings. After surveying this puzzle from edge to edge, I was welcome to recommend solutions—bearing in mind the resource limitations already straining the state budget.

Of course, I could not solve the puzzle of mental health-related housing instability in my two short years. Bona fide experts have been working on these issues for decades and many low-income Vermonters with disabilities still lack accessible, sustainable housing. Instead, I studied where facets of our mental health, housing, and legal systems are fitting together—or rather, where they are *not* fitting together. This section summarizes my observations about "the problem" of mental health and housing in Vermont.

1. The 'Everything the Light Touches' Problem

Mental health-related housing challenges arise everywhere—in homes, condos, housing authorities, treatment facilities, motels, shelters, encampments, nursing homes, hospitals, prisons, courts, federal and state benefits offices, schools, child protection systems, healthcare settings, and beyond. The same housing or service providers who align with tenants with disabilities in one sphere are perpetuating discrimination in another sphere. The universe of issues and corresponding legal frameworks is remarkably vast. As the fellowship progressed and increasingly diverse stakeholders reached out for consultations, it felt like everything that the light touches could become relevant for inquiry and investigation.

The volume of need for systemic reforms overwhelms and distracts us from devoting resources to improving any one mental health or housing issue. Over two years, I heard many of the same conversations repeated among many of the same people, and we often struggled to maintain focus on one subset of problems and possible solutions. Many conversations dedicated to addressing a specific subset of issues were met with questions about what this focus would mean for individuals impacted by the countless other issues.

For example, I recommended that we focus on identified legal avenues to challenge barriers to accessing quality community mental health case management. I did so because the program seems to account for a large proportion of the state's available housing supports, because it is subject to a robust legal framework including underutilized due process rights, and because the program appears to receive limited oversight by advocates and the state. I was frequently met with questions like: What about individuals who receive different services or fewer services or no

services at all? What about individuals who decline services? I agree that focusing on this particular issue would allocate resources to the exclusion of working on other issues. However, many issues I learned about, like how systems overfund psychiatric hospital beds and underfund community-based services, are deeper-rooted resource problems that I would not likely address using legal strategies within a two-year fellowship. Many others, like re-housing people experiencing mental health-related homelessness, or barriers to accessing Social Security disability income, are already receiving considerable oversight by legal and lay advocates.

I wonder what more narrowly focused advocacy could achieve in this arena. For example, what might have been my impact if I focused my two years exclusively on assessing the state's *Olmstead* liability for underfunding community mental health and integrated housing, and building pressure from the Statewide Independent Living Counsel and the Department of Justice? I observe that advocates and providers spend a lot of capacity, in addition to my fellowship resources, rehashing and reacting to the volume of mental health-related housing problems, rather than responding to specific issues with targeted solutions. In a universe with limited resources, we would better serve precariously housed individuals with mental health challenges if we allowed ourselves to focus on addressing one subset of issues at a time.

2. The 'Chicken or the Egg' Problem

Besides feeling overwhelmed by the sheer breadth of problems arising at the intersection of mental health and housing, service providers are also preoccupied by the question over who initially or ultimately bears responsibility for improving mental health-related housing instability. Throughout my two years of consultations, housing and shelter providers often faulted the under-resourced mental health system with providing inadequate housing stabilization supports. Mental health agencies frequently faulted the housing system with failing to make housing and shelters accessible, affordable, habitable, and sustainable for individuals with mental disabilities. Housing is the job of housing providers, and mental health is the job of mental health providers.

All of this is true. However, it is also true that mission-based housing providers are imposing lease addendums on tenants at risk of eviction or termination that prescribe detailed mental health and substance use disorder treatment plans. It is true that mental health case managers are doing the lion's share of precariously housed tenants' subsidy recertification, landlord relationship management, lease addendum and move out negotiations, and housing search. The degree to which DMH oversees a variety of housing services reflects the international best practice of providing accessible and supportive housing *first* as the most foundational element of healthcare. Likewise, the ways in which housing providers are embedding SASH and housing retention specialists in their workforces reflects how integral disability services are to stabilizing tenancies and preventing homelessness.

The false 'mental health or housing as the primary issue' dichotomy distracts us from realizing the concerted solutions that stakeholders have already identified. Mental health and housing are equally integral to the "three-legged stool" approach to ending homelessness in Vermont: constructing housing, offering subsidies, and providing supportive services for

tenants.[117] Mental health and housing providers already collaborate through regional and statewide continua of care (CoCs) to coordinate services and resources and administer HUD programs to end homelessness. They co-locate in project-based subsidized housing to provide in-home mental health case management and eviction prevention. Housing providers roll up their sleeves in an effort to support tenants with hoarding disorders to declutter,[118] and mental health agencies provide temporary and ongoing housing to individuals in crisis or at risk of hospitalization. While I understand when mental health agencies identify that they are in the business of providing healthcare not housing, I also observe mental health agencies doing a lot of housing work and vice versa. Pointing fingers at the sector "most" responsible for "the problem" pits partners against one another, creates silos, and detracts from the excellent concerted progress both sectors are making.

At VLA, the robust Housing Task Force (HTF) has forged productive partnerships with housing and homelessness providers through the CoCs and beyond, even though those providers are often opposing parties in litigation. The HTF lacks similar relationships with the mental health system. I wonder if that makes it easier to place blame with the mental health system and miss opportunities to harness resources for our clients. Legal advocates and service providers alike would better serve tenants with mental disabilities if we redirected energy we spend assigning fault toward forging more collaborative, interdisciplinary partnerships.

3. The 25/75 "Problem"

Advocates have closely monitored government administration of COVID-19 relief for fear that agencies will once again leave behind the individuals with the highest need. What we have seen is relief pouring in at unprecedented volumes to assist the individuals who had the farthest to fall during the pandemic through no fault of their own, including the so-called newly poor (or, more brazenly, the "deserving poor"). Meanwhile, a giant question mark has loomed over how to meet the pandemic needs of the individuals who have always lived on the margins—the individuals who experience chronic homelessness, those who experience chronic mental health challenges and substance use disorders, those who are unbanked, undocumented, or who are otherwise not eligible for IRS-administered rebates.

Vermont's homelessness service providers collaborated to offer temporary housing to every single person who wanted it, without exception or exclusion. Heroically, the sector succeeded in giving *everyone* the opportunity to stay home and stay safe. However, as the pandemic wore on, motels started pursuing lockouts and DCF eventually resumed terminations for program violations including those related to individuals' disabilities. Now as before, Vermont lacked sufficient services to support these newly housed individuals to retain their housing pursuant *Housing First* best practice. Vermont also lacked permanent housing solutions for these

[117] *See Vermont Roadmap to End Homelessness*, *supra* note 1.

[118] It is worth noting that while assisted declutters are well intended they are also misguided. Forced decluttering is among the most harmful responses to hoarding disorders. Research shows that in response to a forced declutter, an individual can re-accumulate in one year what previously took years to accumulate. For best practices on supporting individuals experiencing hoarding disorders, or for help with connecting with your regional Hoarding Task Force, contact David O'Leary, M.A. LLC, 145 Pine Haven Shores Rd. Suite 2091, Shelburne, VT 05482, Tel: (802) 391 6680.

individuals, who risk mass eviction back to homelessness once pandemic resources expire. Providers and policymakers find themselves playing the same old zero-sum game: Deciding whether to allocate finite COVID resources toward providing housing for the many, or housing plus services for the few.

A clinical hoarding specialist offered me some helpful framing on this issue of equitable resource allocation. I told him that my CRT case manager contacts reported no change to how they are allocating their time during the pandemic. Case managers are still dedicating about 75% of their capacity toward meeting the needs of only 25% of their clients. They are still meeting the needs of the remaining majority of clients with about one quarter of their time, but that work has been made more efficient and accessible thanks to the increase in telehealth. My colleague shared with me that this 25/75 distribution is not a problem that he and his colleagues struggle to solve but a reality that they plan for and embrace. Meeting the needs of the small proportion of clients with the highest acuity will always command the majority of our time and capacity. The challenge is to meet this need, not by distributing our resources equally but by distributing our resources equitably.

I raised the critique that telehealth has made services more efficient and accessible for only some people and has left out many with the most complex needs. He posited that sometimes more efficiently and accessibly serving the majority of our clients with lower acuity is the best we can do to free up the resources necessary to better serve the minority of our clients with higher acuity. In other words, sometimes serving the 75% better is the best we can do to free up resources for the 25%.

This resonated for me. My fellowship focused on problem solving for that minority of clients with the highest care needs. Coming up short so often felt defeating. Representation on a for-cause eviction case can require hundreds of hours. Even limited representation on a for-cause eviction requires dozens of hours—services I offered to the exclusion of building a higher volume caseload comprising a wider variety of matters. After two years, I found that for-cause eviction practice was becoming *more* resource intensive as I identified new strategies to reasonably accommodate clients in the course of my legal representation, and new strategies to assist clients with pursuing the increased treatment plans they would need to substantiate a second chance reasonable accommodation request. The point was that higher acuity clients, like the for-cause evictions they face, might always command the majority of our time and capacity.

We cannot stall over the many immovable aspects of Vermont's intersecting mental health and housing challenges, for better or for worse.[119] We also cannot risk discriminating by declining to take these resource-intensive cases on. We will certainly struggle to identify ways to better serve the minority of individuals with the most complex care needs, and to find the funding necessary to implement the improved service modalities we manage to identify. Meanwhile, we will better serve tenants with mental disabilities if we promote an equitable

[119] For example, individuals have the freedom and autonomy to choose whether to engage in treatment. Appropriate investment in housing and services requires resources we lack. The federal government sets the rules defining subsidy eligibility so they are outside of Vermont's control. Improving CRT program does nothing to improve outcomes for those receiving adult outpatient services or no services at all.

distribution of resources and remain open to improving the moveable aspects of our system that we *can* influence. If systems are at a loss for how to better serve the 25%, but have identified ways to better serve the 75%, they should pursue those opportunities.

4. The Inaccessibility Problem

My housed clients often experienced difficult relationships with their landlords and neighbors. Clients struggled to monitor and tolerate disability-related behaviors in old, dense, and sometimes segregated apartment settings. These landlord and neighbor tensions and triggers, and systemic barriers to mitigating those tensions and triggers with reasonable accommodations and modifications, were often the root cause of the events precipitating my clients' eviction for cause. In other words, my clients' disability-related behavior may not have precipitated lease violations but for the triggering effect that landlord and neighbor tensions had on my client.

Clients with fair housing and ADA rights to reasonable accommodations of their disabilities, which could mitigate landlord or neighbor tensions and make their tenancies more viable, often did not invoke those rights until they were already facing adverse action and maybe have posed a 'direct threat' to the health and safety of their neighbors. Clients with subsidized housing often chose to release colorable fair housing counterclaims and instead move out with hopes of preserving their rental history and rental assistance. Every move lowered clients' of securing their next apartment. Extremely high rents, low vacancy rates, and substandard quality already made their housing search virtually impossible. Commonly, my subsidized for-cause eviction cases involved a move out plus a reasonable accommodation request for more time just to find a new place that was arguably affordable and available to my client—not to mention in a setting that was more accessible by design than the current place my client was being evicted from.

Numerous eviction defense clients and their case managers expressed that they would have never would have selected their current apartment to begin with, had they had a meaningful choice. Not just because the current apartment was unaffordable, or unserved by public transportation, or isolated from services, or that it was owed and managed by individuals who seem wholly unaware of their fair housing rights and obligations. All of that is true, which my tenants and service providers took as a given. Also, because the low-cost layout of most high-density apartment buildings featuring centralized hallways, thin walls, and noisy floors appears inaccessible by design for people with certain mental disabilities.

Many clients and their family members and service providers have described their ideal *next* apartment to me. It would include features like a separate entrance, windows that do not face the street, distanced mailboxes, thicker or sound absorbing building materials, and green space to garden or spend time with a support animal. What they are describing are minimum accessibility standards for individuals whose mental disabilities make noisy, crowded, dense settings ripe with neighbor interactions and triggers that impact on accessibility. What these folks are describing is privacy but not isolation. What they are describing is accessibility parity in the new housing we build, and parity in how we fund reasonable modifications of existing housing. Tenants with mental disabilities will have more equal access to housing—to integrated housing

as guaranteed by *Olmstead*—if we create more inclusive minimum mental accessibility standards for new construction and more inclusive criteria for how nonprofits administer state and local resources earmarked for reasonable modifications.

5. The Unfunded Mandate Problem

When confronted with habitability claims for providing substandard housing or fair housing claims for providing inaccessible housing, landlords often circle around the same defense. They cannot afford to meet their obligations, and ultimately they are vindicated in shirking their obligations because my clients are bad actors who violate their leases. Similarly, several mental health system leaders and mission-based housing providers lamented that meeting clients' disability and fair housing rights makes the whole system prohibitively expensive. One leader even admonished my accessibility advocacy as causing more harm than good, and suggested that disability rights advocates pull back on ADA and fair housing litigation. Stakeholders from every corner have suggested that holding providers accountable to basic standards habitability, accessibility, and community integration creates disincentives to providing housing and incentivizes providers to take existing units and long-term care beds offline. In a resource-constrained universe, isn't having more but worse units preferred to having fewer, standard units?

Housing availability is not mutually exclusive with housing habitability, accessibility, and community integration. Charity is not solidarity. There are enough resources to meet the need. The system is just spending those resources elsewhere—on the costs of the eviction machine, emergency response, emergency care, emergency housing, untreated chronic illness, untreated mental illness, untreated substance use disorders, law enforcement, and corrections. States exacerbated cycles of homelessness, hospitalization, and incarceration by closing state-run psychiatric institutions without shifting adequate resources toward community-based psychiatric supports, a process many refer to as "transinstitutionalization." States continue to concentrate funds at the institutional, crisis end of the housing and service spectrum, which is constraining resources at the front end, resources needed to make housing sustainable to begin with in terms of affordability, accessibility, and surrounding supports.[120] Individuals risk cycles of homelessness, hospitalization, and incarceration as a result. *Housing First* data indicates that we can mitigate the higher costs associated with transinstitutionalization by shifting funds toward lower cost community-based housing and higher quality preventative services.[121]

In our current structure, fair housing, ADA, and mental health service rights feel more like unfunded mandates than legal entitlements. Community integration requires housing choice, but in Vermont housing options are severely limited. Supportive housing and mental health services are available but only for relatively few. Agencies struggle to retain and train staff and maintain the sustainable caseloads needed to provide individual clients with quality services. Consumers struggle to navigate intake, referrals, Housing Opportunity Program and Community Action processes, and to make informed choices about mental health treatment plans as they

[120] *See supra* note 113.
[121] *See supra* note 55.

relate to housing. Service providers are not set up to champion their clients' fair housing rights to be reasonably accommodated in their housing and other services. Legal service providers are not funded to meet the need for help with seeking remedies.

We have an *Olmstead* problem in the form of overfunding institutional settings and underfunding disability rights mandates in both the housing and service sectors. Vermont would better serve tenants with mental disabilities if we redirected resources spent on emergency and crisis care toward meeting individuals' FHA, ADA, and mental health service needs to promote stable housing.

6. The Accountability Problem

Reading DMH's CRT consumer satisfaction reports and reviewing data on low rates of homelessness for some CRT teams paints a positive picture of community mental health that is difficult to square with the countless complaints my VLA colleagues and I receive from clients and partners about the quantity and quality of available services. In fact, when DRVT and I rolled out an independent CRT consumer survey in the summer of 2020, several community partners from around the state reached out to ask that the survey extend to partner providers, who have a lot of constructive feedback to share.[122] Despite our targeted outreach, very few consumers chose to participate. This tracks with how few consumers exercise their rights to be heard on formal grievances, appeals, or complaints before the Human Services Board or Human Rights Commission. The picture looks very different in the long-term care and housing arenas, where lay and legal advocates help bring visibility and accountability to otherwise complicated, onerous, and inaccessible systems.

Even in the long-term care and housing arenas, overt mental disability discrimination, discriminatory exclusion, and differential treatment and impact are difficult to police and prove. The severity of the cases we do encounter, and the structural ableism we see across the board, raises serious concerns about what we are not hearing. Are we not hearing about more mental disability discrimination because it isn't happening, or because people aren't complaining, or because people don't know they can complain? Are we not hearing about more consumer dissatisfaction because subpar or inaccessible services aren't a problem, or because people aren't complaining, or because people don't know they can complain? Worse, are complaints being lodged, but then mishandled or ignored?

Some cases I encountered suggest that the answer is yes. One of my highest acuity clients facing an immediate risk of homelessness was summarily denied CRT after a mere telephonic intake, and was almost denied again during his intake appeal when the assessment nurse failed to inquire into the client's housing functionality besides a simple exchange of "How's your housing situation?" "Good" ("Adam" in **Appendix A**). Another client's substance use disorder counselor refused to make an internal referral over to CRT intake until I corrected the counselor's complete misunderstanding of the CRT eligibility criteria. A colleague got a call from their client's crisis service provider asking whether VLA had ideas on how that provider could make an internal

[122] I was very aware of this following months of fellowship consultations, and as a constituent advocacy organization, DRVT was committed to hearing directly from consumers in the first instance.

referral to their own CRT intake specialist colleagues. How are CRT applicants, the individuals with the highest acuity, fairing when no lay or legal advocate is available?

My aim is not to single out the accountability problems in the mental health system.[123] My aim is to draw attention to the disparate level of accountability we see between the mental health system and the other systems my fellowship population encounters, like housing and long-term care. These systems can be impenetrable for low-income individuals with disabilities who lack access to lay advocates or counsel. Fundamental inaccessibility makes it all too easy for systems to overlook the civil rights of people with psychiatric disabilities. Maybe this fundamental inaccessibility would not have been the case had system architects respected the demand by disability rights advocates for "nothing about us, without us." We need to make all of these systems increasingly accountable to constituents with mental health challenges—not only through due process considerations, but also through lay or legal advocate capacity to make those processes more accessible. Strategic planning on accountability should center participation from psychiatric survivors.

[123] For example, legal services organizations, the self-anointed watchdogs, are rarely subject to the kind of ADA scrutiny and accountability to which we subject the other systems that serve our clients. Sometimes I fear that, like others, our inability to take a client's case due to constrained resources is actually an abdication of our obligation and responsibility to reasonably accommodate that client's disabilities.

Key Recommendations

This report examined several seemingly incongruous pieces of the mental health and housing puzzle. These challenges bring opportunities, some of which I had hoped to pursue before the arrival of COVID-19, and others which would have always required new and focused resources of their own. This final section lays out, in no particular order, several strategies that could help address mental health system issues influencing Vermont's housing challenges and vice versa.[124]

1. Promote mental accessibility in rules for new construction and housing assistance

VLA should consider advocating for minimum mental accessibility standards for the construction of new housing, as well as revisions to the DCF Housing Opportunity Program (HOP) and DMH Housing Support Fund (HSF) program rules to extend financial assistance for mental accessibility-related housing costs.

VLA's HDLP has already begun incorporating mental accessibility for new construction into its administrative advocacy for universal design, for example in the HUD Consolidated Planning and VHFA Qualified Allocation Planning arenas. As for next steps, per HDLP's suggestion, VLA could advocate for a statewide client and provider survey on what expanded mental accessibility housing standards should include. VLA could collaborate with stakeholders like Vermont Psychiatric Survivors, Vermont Care Partners, and DRVT to vet this evidence and build administrative awareness and support for the refined list of accessibility measures. Disability rights advocates who have advanced existing accessibility standards could advise on strategies to lobby the state and legislature to get expanded standards over the line.[125] In my cursory review, I did not uncover a federal basis for mental accessibility standards in new construction. However, I did encounter several innovations in mental accessibility in housing.[126] These example models, in addition to Vermont DMH's own tiny house pilot,[127] could help start a conversation about building out more diverse and accessible affordable housing options for low-income Vermonters with mental health challenges.

To address the inaccessibility of existing housing, Vermont could expand the housing assistance and homelessness prevention programs it already administers, such as DCF's HOP or CRT's HSF, to cover reasonable accommodations and modifications for mental health

[124] I leave the many opportunities for housing, healthcare, and long-term care systems advocacy in the expert hands of the relevant VLA projects and task forces already dedicated to advancing those issues.
[125] Lynne Cleveland Vitzthum, Director of Developmental Disability Services, and Dillon Burns, Director of Mental Health Services, at Vermont Care Partners expressed interest in these ideas and a willingness to help strategize on advocacy.
[126] *See, for example, Operation Tiny Home in Oregon, available at* https://www.operationtinyhome.org/; *Implementing Tiny Homes as Permanent Supportive Housing: Early Lessons from Housing First Village in Bozeman, Montana*, Metropolitan Housing and Communities Policy Center (August 2020), *available at* https://www.urban.org/sites/default/files/publication/102715/implementing-tiny-homes-as-permanent-supportive-housing.pdf. *But see Tiny Houses—Not a Big Enough Solution*, Miles Howard for Shelterforce (January 10, 2020)(accessed November 30, 2020), *available at* https://shelterforce.org/2020/01/10/tiny-houses-not-a-big-enough-solution/.
[127] DMH's Housing Director, Brian Smith, is the contact point: brian.smith@vermont.gov; 802-241-0116.

accessibility in housing.[128] Reasonable accommodations (RAs) and modifications (RMs) are not just accessibility measures—they are housing stability and homelessness prevention measures. They are also difficult to pay for using limited disability or state benefit income. In most situations, a housing provider must allow a tenant RAs/RMs in their unit, but does not have to pay for them.[129] Individuals needing RAs/RMs to make housing more mentally accessible to them have a hard time finding the resources for even low-cost, one-time investments.

Looking first to DMH resources, my clients have benefitted from security deposit assistance, moving costs, storage costs, furniture set up, and even ongoing rental assistance through the CRT's HSF. However, I have never encountered or heart about a CRT client whose case manager had pursued HSF (or any funds, for that matter), to purchase reasonable soundproofing measures, like sound-absorbing curtains or floor underlayment, to neutralize their client's experience of noise sensitivity or the impact their client's noise makes on others. One CRT housing specialist shared that they had never thought about sound mitigation as an accessibility measure, or even a housing preservation measure, before. I explained that sound mitigation is among the more common remediation measures that fair housing legal advocates can propose to address or prevent violations relating to noise and neighbor conflict. DMH programs like CRT seem like the right programs to be leading advocacy on RAs and RMs that stabilize housing, prevent homelessness, and, ultimately, prevent institutionalization. HSF funds for CRT seem like the right resource to close the needs gap for tenants with mental health disabilities in Vermont.

Another great resource for RAs and RMs could be the housing programs that DCF administers, like HOP. As part of its permissible uses, HOP can fund homelessness prevention through grants for back rent or security deposits for tenants is under legal threat of eviction or termination. HOP program rules, like any housing program rules, can be reasonably changed to accommodate beneficiaries with disabilities. In that vein, I heard about a HOP provider that grants reasonable accommodations in the form of changes to program rules to allow for security deposit/moving assistance for individuals moving out due to physical inaccessibility even if they are not facing eviction or termination. I consulted with a client, "Frank," who was denied access to the same reasonable rule change because his move out was related to mental inaccessibility, not physical (see **Appendix A**). The HOP provider reportedly told Frank and Frank's case manager that if Frank's disability had been a physical one, then the provider could have covered Frank's moving costs without issue. This is differential treatment in housing on account of disability and is illegally discriminatory. While Frank decided not to pursue remedies, his situation raised two concerns—one about the accessibility of the HOP program, and the other about the HOP program missing opportunities to realize its goal as a homelessness prevention program.

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[128] *See Joint Statement of HUD and DOJ: Reasonable Modifications Under the Fair Housing Act* (March 5, 2008), *available at* https://www.hud.gov/sites/documents/reasonable_modifications_mar08.pdf; *Joint Statement of HUD and DOJ: Reasonable Accommodations Under the Fair Housing Act* (May 17, 2004), *available at* https://www.justice.gov/sites/default/files/crt/legacy/2010/12/14/joint_statement_ra.pdf. For respective program information, see https://dcf.vermont.gov/sites/dcf/files/OEO/Docs/HOP-AR-2020.pdf and DMH Manual at 135.

[129] *Id.*

Existing state programs, like HOP and HSF, could be making relatively low-cost, life-changing investments in making housing more sustainable and accessible for low-income people with mental disabilities.

2. Increase mental health system oversight utilizing existing accountability structures

VLA should also consider monitoring existing mental health system accountability structures. When the pandemic arrived and paused business as usual, I was preparing to make an information request of DMH contacts[130] and, failing that, a Public Records Request.[131] My biggest questions were: (1) To what extent is DMH maintaining oversight of the DAs and holding agencies accountable to the service entitlements and due process rights of their clients; (2) To what extent are mental health benefits recipients exercising and enjoying their rights to accessible due process; and (3) To what extent is DMH maintaining oversight of its many housing programs and services?

The pandemic necessitated a change in my focus, but my questions remain. At the time of writing, only DRVT devotes legal advocacy capacity to monitoring individual community mental health issues in Vermont. DRVT advocates are stretched thin liaising with Vermont Care Partners on systemic issues and troubleshooting individuals' service complaints, in addition to their other P&A responsibilities to monitor issues like voter access, psychiatric hospitalization, and *Olmstead* implementation. Maybe VLA could lend capacity to holding DMH and its designated agencies accountable to the data they should be collecting and reporting to consumers and the public.

Where data is lacking, VLA could advocate with the agencies to help them meet their obligations, as VLA's Residential Care Home Discharge Working Group was considering in response to reports of discriminatory long-term care discharges around the state. VLA can also

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[130] Suggested contacts include: the DMH Grievances and Appeals Manager (TBD); the DMH Data Analysts (Sheila Leno, Cindy Chornyak, Christopher Donnelly, and David Horton whose general inbox is ahs.dmhpip@vermont.gov); the DMH Housing Director, who administers the Housing Support Fund and the Subsidy Plus Care Program among other housing initiatives (Brian Smith, brian.smith@vermont.gov); the DMH Legal Unit (Kim Velk, AAG, kim.velk@vermont.gov. I was pointed to Kim by Matt Viens, AAG.); DMH Deputy Commissioner (Mourning Fox, tel: 241-0130); and former DMH Director of Policy Selina Hickman (selina.hickman@vermont.gov).

[131] To help frame my request, I considered what data the state should be collecting and analyzing for program accountability:

- Funding agreements between DMH and the DAs.
- DA's local community services plans, which DMH must find "reasonable." *See* 18 V.S.A. 8908, 8910.
- Mental health grievances and appeals data required by Medicaid rules and managed by DVHA.
- Human Services Board decisions on mental health grievances and appeals.
- DAs' logs of the requests for CRT they have received and their approvals, denials, appeals, redeterminations, and terminations. DAs are required to maintain such logs for the most recent four years and make them available to DMH upon request.
- Recent reports on the DMH Housing Support Funds and on Subsidy Plus Care terminations.
- Recent DA monthly service reports to DMH.
- DAs' recent Quality Assurance and Utilization Reviews as required by the DMH Provider Manual.
- DA's recent DMH Minimum Standards Chart Review and Agency Review as required by the DMH Provider Manual.
- Recent CRT Housing Support Fund reports to AHS.
- Recent community mental health audit reports pursuant the DMH and DAIL join Audit Guide for Community Mental Health Centers (March 26, 2009).

consider strategies to fill in missing datasets, as it did with the *Eviction in Vermont* and *Kicked Out* reports.[132] One option is to collaborate with the investigative journalists who produced the joint Seven Days and VPR series, *Worse for Care*, who are skilled at and interested in requesting and synthesizing data to build public awareness on key mental health and housing gaps.[133]

Clearer data on issues, and clarity around data gaps, could bolster our ability to do informal advocacy with DMH, with the AAGs representing DMH, with the VHRC in its oversight of public accommodations discrimination, as well as federal bodies like CMS in its oversight of Medicaid programs and the DOJ in its civil enforcement of state *Olmstead* violations. Partners in this arena could include the Vermont Psychiatric Survivors, DRVT, Vermont Care Partners,[134] the DMH 10 Year Planning Think Tank,[135] the DMH Mental Health Block Grant Planning Council and the Adult Mental Health State Program Standing Committee,[136] and the State Independent Living Council.[137]

Far be it for me to lay out how VLA might progress through the stages of informal and formal data gathering and advocacy. VLA wrote the playbook and spent two years teaching me everything I know. VLA resources are also eternally overextended addressing legal problems for which there are no other advocates available to assist. Here, I propose data gathering because for two years I observed how intensively mental health challenges bear on every other challenge a low-income person might need legal help with. I am convinced that greater oversight of mental health services could improve outcomes in the other areas on which VLA closely focuses, especially housing.

3. Create new mental health system accountability structures

VLA should also consider building new accountability mechanisms into the community mental health legal and regulatory framework. This strategy could include requesting rulemaking pursuant to the Vermont Administrative Procedure Act for DMH's housing or service programs, or revising the DMH Mental Health Provider Manual to clarify minimum housing service standards and disability rights competency.[138]

As for rulemaking, the idea of requesting rules for DMH's CRT, HSF, or Subsidy Plus Care (SPC) programs came up early in the fellowship. These programs are large state benefits programs available to thousands of individuals who have only the most complex mental health and

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[132] *Available at* https://www.vtlegalaid.org/sites/default/files/Eviction-Report-VLA-3.18.19-web.pdf and https://vtbarfoundation.org/wp-content/uploads/2016/06/Kicked-Out-School-Discipline-Report.pdf.

[133] Andrea Suozzo, Seven Days Data Editor, and Colin Flanders, Seven Days Political Reporter, are particularly open to hearing pitches about what mental health and housing data should be pursued and what mental health-related housing stories should be told. They can be reached at, respectively https://www.sevendaysvt.com/author/andrea-suozzo and https://www.sevendaysvt.com/author/colin-flanders.

[134] Contact Dillon Burns at Dillon@vermontcarepartners.org and see https://vermontcarepartners.org/directory/name/dillon-burns/.

[135] https://mentalhealth.vermont.gov/about-us/department-initiatives/10-year-planning-process-mental-health-think-tank.

[136] https://mentalhealth.vermont.gov/about-us/boards-and-committees.

[137] https://governor.vermont.gov/boards_and_commissions/independent_living.

[138] Pursuant 3 V.S.A. § 800 et seq.

housing needs. They comprise the majority of DMH's housing services. From a consumer advocate point of view, these resources are too critical, and the risk of unfair program administration is too high, to have anything but the utmost accountability and due process in place. After road testing rulemaking ideas with mental health and housing stakeholders, and studying the comparable developmental disability regulations and their origins, I am in two minds. I am not convinced that rulemaking for CRT is the path of least resistance toward improving access to housing supports for people with mental disabilities. I am more convinced that rulemaking for the HSF and, especially, the SPC would establish much needed process for programs serving those with the most critical of critical care needs (those at the most immediate risk of homelessness and psychiatric institutionalization).

As discussed, CRT is already subject to Medicaid rules for grievances and appeals. Unless DMH regulations would speed up the grievance and appeal response times that Medicaid imposes on DAs and DMH, I see no immediate benefit to reiterating the grievances and appeals process in new DMH regulations. Furthermore, the community mental health system, including CRT, is already undergoing dramatic reforms.[139] It might be prudent to plug into and assess existing reform efforts first, rather than requesting rulemaking for CRT right out of the gate. Finally, rulemaking might not serve to clarify service entitlements or definitions if those program aspects are not "rules" under VAPA.[140]

As for the HSF and SPC programs, for every example I encountered of how program flexibility yields positive outcomes for beneficiaries, I also encountered an example of the serious consequences of facing termination without the opportunity to be heard. In part, the HSF functions

[139] The first major change is that DMH is implementing system-wide payment reform. *Act 79 Report 2020*, *supra* note 100; *see also* DMH Mental Health Provider Manual at 12. Agencies are now billing to one bundled case rate, rather than fee-for-service billing, funded through DMH, DVHA, and DCF. *Id.* Payment reform is designed to encourage service flexibility, integration, and holistic care, and to promote a cultural shift from volume-focused to outcomes-focused service provision. *Id.* Consequently, agency leaders have relayed that they are consumed with overhauling data tracking, reporting, and training for all staff. The whole system is also shifting away from thinking of CRT as separate and apart, and is working to better integrate CRT into the service continuum. The second major change is that AHS is in the early stages of bringing pertinent areas of Vermont's system of care into compliance with the final CMS regulations on home- and community-based services ("HCBS"). 79 FR 2947. The CMS rule is designed to ensure the delivery of person-centered and person-driven care in the most integrated settings appropriate to individuals' wants and needs. *See e.g.,* https://dvha.vermont.gov/global-commitment-to-health/conflict-of-interest-home-and-community-based-services. A key measure is the requirement that case management is provided in manner that is free of conflicts of interest, meaning that an individual's provider of Medicaid-funded HCBS, like CRT, cannot be the same entity as the one providing the individual with case management and person-centered service planning. Although the rule passed in 2014, AHS is in a stakeholder engagement and early assessment phase, beginning with the developmental disabilities service sector. *Id.* The impact of conflict-free case management on CRT is yet to be seen.

[140] VAPA defines a "rule" as an "agency statement of general applicability which implements, interprets, or prescribes law or policy." *Id.* § 801(b)(9). The Supreme Court of Vermont in *Parker v. Gorczyk*, 173 Vt. 477, 479 (2001) explained, "the APA does not concern itself with daily individual decisions of the Commissioner, except as they are related to rules of general applicability. To the extent that the Commissioner promulgates new policies of general applicability, they are subject to the rulemaking procedure. The APA goes no further." Even a practice that is generally applicable to a class of individuals is a rule subject to VAPA procedures.

as a DA-administered bridging subsidy for CRT enrollees pursuing other forms of rental assistance.[141] Neither DMH nor the DAs owe participants *any* formal notice or process to terminate HSF assistance. I had several clients prioritized by the HSF eligibility criteria whose DAs nevertheless terminated HSF rental assistance around the time of their housing legal cases, the time when financial flexibility to move to a new unit and avoid homelessness is most critical. On the other hand, the SPC termination process is more developed, but program administration lacks clarity and transparency. DMH subcontracts with VSHA to administer the SPC, and that contract incorporates the HUD Shelter Plus Care program's eligibility and termination rules. However, based on the few SPC cases I encountered, it appears that DMH retains ultimate decision-making power over terminations and second chance reasonable accommodation requests, even when VSHA is the entity administering the program, and even when VSHA administers termination proceedings outside of the presence of DMH. (see "Hannah" in **Appendix A**). I would support rulemaking for these programs. Several community advocates I consulted would support rulemaking, as well.

Short of proposing DMH rulemaking, VLA could advocate for revisions to the DMH Mental Health Provider Manual to clarify minimum housing service entitlements and disability rights competency.

As for housing entitlements, DMH should codify its commitment to supporting housing as a form of mental healthcare. Housing services, resources, and interventions appear everywhere in the mental health system. The Manual and Vision 2030 consistently present stable housing as central to mental health and community integration.[142] DMH administers housing programs like the HSF and SPC. DAs and SSAs administer crisis beds, transitional housing, and even permanent housing. Case managers and agency staff provide clients with critical housing search and stabilization supports. In sum, the system recognizes that accessible and affordable housing is central to providing person-centered mental health services in the most integrated, least restrictive setting. DMH should clarify housing service entitlements by incorporating into the Manual clearer housing service definitions and minimum case manager housing service standards.

As for disability rights competency, DMH should set minimum training standards or other measures to ensure basic disability rights competency among DA and SSA staff. In my experience collaborating on cases and delivering trainings, case managers' familiarity with their clients' fair housing and ADA rights varied *widely*—let alone their comfort level with helping clients to assert their rights to be reasonably accommodated in their housing and all of their services. DMH should

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[141] *See* DMH Mental Health Provider Manual Attachment I, *available at* https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/MH_Provider_Manual.pdf. The HSF could also be used to fund reasonable modifications to mentally inaccessible units, but I did not encounter a single CRT client whose DA would assist with providing one-time reasonable modification costs to make units more accessible and to justify a second chance reasonable accommodation to stop an eviction. *Id.* at 136.

[142] *See, e.g.*, DMH Mental Health Provider Manual, which includes in the CRT statement of purpose a charge to "help people remain integrated in their communities in . . . housing," at 18, *available at* https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/MH_Provider_Manual.pdf. *See also* Vision 2030, affirming that public mental health requires interventions like "stable housing," at 21, "affordable housing" at 25, "safe housing" at 26, *available at* https://mentalhealth.vermont.gov/sites/mhnew/files/doc_library/Vision_2030_FINAL.pdf.

improve the Manual or issue other agency guidance to ensure that the agencies entrusted with providing case management for clients with mental health disabilities have a fundamental understanding of those clients' disability rights.

Mental health provider colleagues have warned that no matter how small the change, every new definition or training requirement imposes tremendous implementation, monitoring, and reporting costs on the already resource-strapped agencies. VLA would likely be met with concerted pushback on expansions to provider obligations and consumer entitlements, given the immense resource constraints bearing down on the system. However, the Manual is iterative. It is subject to regular review as the system undergoes radical payment reform. Now might be the right time to request a seat at the table and bring a consumer advocate's perspective to policy review.

4. Partner with mental health sector members to lobby for more resources

VLA should also consider lending housing-related testimony to lobbying efforts by the Vermont Care Partners to increase funding for community mental health, including through raising provider wages and reimbursement caps.[143] Much like our relationship with the Vermont Affordable Housing Coalition (VAHC), there are certainly shared interests with VCP and opportunities for complementary advocacy, even though both VAHC and VCP represent the interests of entities that often become our clients' opposing parties in litigation. Broadening the coalition of stakeholders working together to expand access to permanent supportive housing will only serve to carry our voices further. VLA also has a unique perspective to bring to lobbying efforts by VCP. VLA has stories to share about the costs of underfunding mental health services on housing and homelessness—as well as stories, like some of mine, of the benefits to housing when mental health services are working well.

There might also be ways to adapt ambitious lobbying efforts to make them more feasible and palatable for the legislature. For example, this summer DRVT and I developed a community mental health survey to verify anecdotal reports from clients, case managers, and designated agency leaders that the switch to telehealth has yielded some unexpected benefits.[144] While the survey received less than optimal participation, DRVT was able to glean some interesting data about the emerging and continuing needs of CRT recipients during COVID-19.[145] While telehealth is not accessible to all and, accordingly, should not be the only method of service delivery, expanding its availability might increase efficiencies for the system overall that could free up resources for those with the most complex needs. Seeking state investment in relatively lower cost

[143] *E.g.*, *3% Factsheet*, *supra* note 76.

[144] For individuals who have access to technology, we heard that telehealth meant less cross-county commuting, more appointment timeliness, and, for some, more comfort with trying new treatment modalities like group therapy, wellness activities, and support groups. From case managers, we heard that telehealth meant less cross-county commuting, more phone time available per client, and more frequent contacts. Several case managers described feeling more available to help clients troubleshoot housing problems more frequently, which seemed to be having a de-escalating effect. No one reported that telehealth was perfect, or that it should replace in-person services completely, or that it is accessible to all. In fact, for every example of someone who felt they were being served better since the pandemic there was a counter-example. At least there were folks at all levels (clients, case managers, designated agency leaders) who agreed that, for some people, telehealth is a more efficient and accessible treatment modality that should remain on offer in a post-pandemic world.

[145] A brief report out from DRVT is forthcoming.

modalities, like telehealth case management for those who can access and benefit from it, could improve overall efficiency without depleting the state's coiffures. Even if these efforts do not yield immediate resource allocations, DRVT has made the point that the more notice advocates give the legislature about Vermont's integrated service deficiencies, the stronger our arguments become that Vermont is abdicating its responsibilities with respect to *Olmstead.*

5. Formalize lay advocate capacity building and technical assistance efforts.

VLA should also seek resources to continue building fair housing and ADA advocacy capacity in CRT and the community sector, which are best placed to help individuals request reasonable accommodations early and often. Over my two years, colleagues and I trained several CRT teams and community advocate groups on stabilizing housing through reasonable accommodations. These trainings helped develop advocates' basic competency on their clients' disability and fair housing rights. They demystified housing legal processes and fortified good working relationships between case managers and attorneys.[146] They fostered space for creative brainstorming and interdisciplinary learning. Importantly, they introduced me to exponentially more case managers than I could otherwise meet in two years working individual cases, relationships I cultivated for ongoing know your rights, outreach, and consultation, as well as warm referral pathways. These impacts should increase individuals' access to competent disability rights advocacy and stable housing, scaling VLA's impact beyond the individual clients we represent.

VLA should continue investigating resources to support capacity building and partnership with CRT providers. One option is to establish a mental health Medical-Legal Partnership embedded at a select designated agency(s). Another option, of particular interest to VCP, is to embed a fair housing and ADA attorney in the VCP network, similar to the embedded staff attorney offering limited legal assistance to clients at the Vermont Network to End Domestic Violence (Vermont Network).[147] VCP suggests that having buy-in from the DMH Commissioner would be instrumental to securing SAMHSA or other federal or state funds for this purpose.

6. Pursue administrative and judicial relief for conflicted case management and *Olmstead* violations.

Finally, VLA should continue to advance claims for relief and reform in the various available judicial and administrative forums with regards to conflicted case management and *Olmstead* violations.

First, VLA should monitor progress with Vermont's implementation of the HCBS rules for conflict-free case management in CRT.[148] Implementation could address many of the mental health and housing conflicts of interest discussed in this report, and could even give rise to a new,

[146] Mental health service providers have cited fears of being swept into clients' lengthy and complicated legal proceedings, as well as fears of facing provider liability for its own missteps, as barriers to calling VLA for help. Community legal education is a productive, effective way to break these barriers down.
[147] *See* Vermont Network at https://vtnetwork.org/the-network/network-staff/alex-bottinelli-2/#:~:text=Staff%20Attorney%2C%20Legal%20Assistance%20for%20Victims%20Clinic&text=Breanna%20graduated%20magna%20cum%20laude,Center%20for%20Applied%20Human%20Rights.
[148] *HCBS Rules*, *supra* note 94.

independent case management entity—perhaps one akin to the Vermont Ombudsman Project in the long-term care sector.[149] Where Vermont falls short of its obligations, VLA could consider further state administrative advocacy through informal channels, or could escalate formal advocacy to CMS.

Second, VLA should continue to raise *Olmstead* claims in housing, disability, and discrimination litigation. It should consider coalition building with skilled civil enforcement partners, like the DOJ, to hold Vermont accountable to its *Olmstead* obligations and push state resources toward permanent supportive housing and community mental health. Seasoned advocates flagged *Olmstead* litigation early into my fellowship as a potential fellowship focus and powerful tool for addressing intersecting housing and mental health injustices. I quickly learned that bringing an *Olmstead* impact suit could be its own fellowship project from end to end. It could take two years to develop competence on relevant case theories and accompanying Section 504 claims; to identify appropriate plaintiffs, defendants, expert witnesses, and litigation partners to offer technical expertise; and finally, to begin litigating a case. The fellowship is structured to support federal impact litigation of this level of complexity.[150] However, I was able to utilize *Olmstead* in the course of litigating individual discrimination claims and defenses against administrators of public housing and healthcare programs. In partnership with housing and long-term care facility colleagues, I was able to develop a base-level understanding of the contours of *Olmstead* should future VLA advocates identify capacity to take up this work.

People with mental disabilities are entitled to receive services in the most integrated settings appropriate to their needs, and unnecessary restriction is unlawful discrimination.[151] An individual with disabilities has a right of action against any public entity (or service or program made available by a public entity) that violates the individual's integration rights, as long as the individual meets essential program or service eligibility requirements.[152] Aggrieved individuals can submit administrative or judicial complaints.[153] If litigating in court, individuals should explore asserting commonly related claims.[154] The federal government centralizes common *Olmstead* applications, emerging trends, and enforcement advice from the DOJ, as well as recent decisions organized by issue.[155] 'At risk of institutionalization' claims would be most relevant to

[149] Nancy Breiden of the Disability Law Project is a good point of contact, as the DLP is monitoring HCBS rules implementation in the developmental disabilities service sector.
[150] By design, fellows spend the first year expanding legal services intake and stakeholder consultations before refocusing in the second year on discreet areas where the fellowship can have a sustained impact.
[151] *Olmstead v. L.C.*, 527 US 581 (1991)(citing 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d)).
[152]28 CFR 35.102; 28 CFR 35.104. A Protection and Advocacy (P&A) organization, like DRVT, also has standing on behalf of constituents if they meet constitutional requirements for associational standing. *Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289 (E.D.N.Y. 2009).
[153] The Federal Department of Health and Human Services (DHHS) and HUD will hear administrative complaints, and the DOJ will accept and refer cases to the appropriate agency. 8 CFR 35.190. In Vermont, individuals can complain before the Vermont Human Rights Commission.
[154] *Olmstead* claims are often brought alongside claims under Section 504 of the Rehabilitation Act, the Fair Housing Action, the Due Process Clause of the 14th Amendment, the Affordable Care Act, 42 U.S.C. § 1983, state law claims, and contract claims.
[155] *Olmstead Cases by Issues*, ADA.gov (accessed November 30, 2020), *available at* https://www.ada.gov/olmstead/olmstead_cases_by_issue.htm#persons-at-risk.

the intersections of community mental health and housing issues in Vermont.[156] *Olmstead* remedies have included dramatic system reforms like the mandated pursuit of Medicaid HCBS waivers to fund community-based supportive housing, case management, and peer-provided services.[157]

The existence of a state *Olmstead* plan, like the one Vermont submitted to the legislature in 2006, or a facially robust community mental health system, like Vermont has, is not a defense unless it "comprehensively and effectively addresses the needless segregation of the group at issue in the case."[158] For example:

> On paper, Mississippi has a mental health system with an array of appropriate community-based services. In practice, however, the mental health system is hospital-centered and has major gaps in its community care. The result is a system that excludes adults with SMI from full integration into the communities in which they live and work, in violation of the Americans with Disabilities Act (ADA). At its heart, this case is about how Mississippi can best help the thousands of Melody Worshams who call our State home. The State generally understands the urgency of these needs, and it understands its obligations under federal law. It is moving toward fulfilling those obligations. The main question at trial was, has it moved fast enough to find itself in compliance with the ADA? The United States Department of Justice has presented compelling evidence that the answer to that question is "no." Mississippi's current mental health system—the system in effect, not the system Mississippi might create by 2029—falls short of the requirements established by law.

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[156] *See U.S. v Mississippi* (S.D. Miss 2016)(citing *Steimel v. Wernert*, 823 F.3d 902, 911–13 (7th Cir. 2016); *Davis v. Shah*, 821 F.3d 231, 263 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d 307, 321–22 (4th Cir. 2013); *M.R. v. Dreyfus*, 663 F.3d 1100, 1116 (9th Cir. 2011), amended by 697 F.3d 706 (9th Cir. 2012); *Fisher v. Oklahoma Health Care Authority*, 335 F.3d at 1181; *Steward v. Abbott*, 189 F. Supp. 3d 620, 633 (W.D. Tex. 2016); *Pitts v. Greenstein*, No. 10-635-JJB-SR, 2011 WL 1897552, at *3 (M.D. La. May 18, 2011); *Disability Advocates Inc. v. Paterson*, 653 F. Supp. 2d at 187–88 (finding violation of ADA and Rehabilitation Act where approximately 4,300 individuals with SMI were "residing in, or at risk of entry into" segregated settings), *vacated sub nom*. *Disability Advocates Inc. v. Paterson II*, 675 F.3d at 162 (finding that original plaintiff lacked organizational standing but the U.S. could bring such a suit).

[157] *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and* Olmstead v. L.C. (accessed November 30, 2020), *available at* https://www.ada.gov/olmstead/q&a_olmstead.htm#:~:text=Olmstead%20remedies%20should%20include%2C%20depending,support%20services%2C%20and%20supported%20employment.

[158] *Id*. The DOJ continues, "Any plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in *Olmstead*, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future." I have heard criticism from the Governor's State Independent Living Council on the lack of detail, specificity, timelines, and resources in Vermont's outdated *Olmstead* plan.

U.S. v. Mississippi (S.D. Miss 2016). Since the Mississippi decision came down in September 2019, the DOJ and National Disability Rights Network have offered technical assistance and training for advocates nationwide.[159] The decision provides a game changing rubric for litigation in states like Vermont where the community-based mental health service system is working hard to meet its *Vision 2030* but, meanwhile, failing to provide individuals with mental illness meaningful opportunities to live and receive services in the most integrated settings.[160] Interestingly, in March 2020, the key expert witness in *U.S. v. Mississippi*, Melodie Peet, M.P.H., published a report with DRVT, *Wrongly Confined*, exploring the unfulfilled promise of *Olmstead* in Vermont—and, by extension, key points of weakness in the system where Vermont could face liability for violations.[161]

[159] I recommend advocates connect on this issue with Vermont DOJ's Civil Division Chief, Jules Torti, at julia.torti@usdoj.gov. Interested advocates should also connect with the following nationwide *Olmstead* experts: Regan Rush and Patrick Hulkins, DOJ Civil Division Special Litigation Section at regan.rush@usdoj.gov and Patrick.hulkins@usdoj.gov; Kevin Martone, Executive Director of the Technical Assistance Collaborative, Inc., http://www.tacinc.org/; and Jennifer Mathis, Deputy Director of the Bazelon Center for Mental Health Law, http://www.bazelon.org/.

[160] *See Olmstead Enforcement*, ADA.gov (accessed November 30, 2020), *available at* https://www.ada.gov/olmstead/olmstead_cases_list2.htm#miss. Not to mention that Vermont is doing this while also pursuing the construction of additional locked hospital beds to alleviate emergency departments. *See supra* note 113.

[161] *Wrongly Confined: A Disability Rights Vermont Report in Consultation with Melodie Peet, M.P.H.* (March 2020), *available at* http://www.disabilityrightsvt.org/pdfs/Publications/DRVT-Olmstead-Report-2020.pdf.

Conclusion

COVID-19 has piled onto Vermont's intersecting mental health and housing challenges by ravaging economies, stalling the availability of new vacancies for individuals doing housing search, and exacerbating barriers to accessing services. At the same time, COVID-19 has pushed the system and the public to embrace the notion that housing is healthcare like never before. In Vermont, COVID-19 has virtually stopped evictions and ended literal homelessness. As my colleagues Maryellen Griffin and Mairead O'Reilly brilliantly suggested,

> The eviction moratoriums and related assistance programs provide an invaluable opportunity to observe a statewide experiment, in real time, that replaces the eviction process with alternatives. This moment is demanding that we consider whether our housing-related policy choices in normal times align with our community values and interests. And if we can radically reduce evictions in the name of public health now, why can't we continue deploying these and other related tools to maintain a lower eviction rate after the pandemic ends?

Pandemic offers lessons in reducing evictions, VT Digger (November 24, 2020), *available at* https://vtdigger.org/2020/11/24/maryellen-griffin-mairead-oreilly-pandemic-offers-lessons-in-reducing-evictions/. As this report explored, underlying sustainable alternatives to eviction is the need for an adequately resourced community mental health service sector, one that supports meaningful opportunities for individuals with disabilities to live and receive services in community-integrated settings appropriate to their wants and needs.

Over two years ago, I was asked to dive into Vermont's mental health and housing systems, provide clients with a variety of direct legal services, identify systems issues, undertake advocacy projects, and, ultimately, share what I learned.

My parting hope for this report is that it: (1) synthesizes our many discussions about the challenges we are encountering and opportunities for next steps; (2) centralizes the institutional knowledge that colleagues and partners so generously bestowed on me; and (3) serves as a reference guide for future advocates in the work ahead.

More globally, my parting hope is that we will never return to the status quo. I hope advocates will continue seizing this moment to pursue sustainable and accessible housing as a human right for all, and to fulfill *Olmstead*'s promise for low-income Vermonters with mental health concerns.

Appendix A: Case Examples

Below is a sampling of clients on whose cases I offered representation or consultation support.

Adam: Adam faced eviction for cause from subsidized housing for reasons relating to his psychiatric disabilities. Around the same time, Adam's local mental health agency denied his application for mental health case management services. Adam needed legal help with submitting an appeal. With increased services in place, he could assert his fair housing rights to be reasonably accommodated by his housing provider in the form of a second chance. Our legal intervention resulted in Adam's enrollment in the desired case management services and a withdrawal of his termination notice.

Bryn: Bryn lost her rental assistance after being evicted from her last apartment for cause for reasons relating to her psychiatric disabilities as well as the domestic violence she was experiencing. She eventually began living in a new, below-market apartment that was still unaffordable for her based on her limited Social Security income. She needed legal help with asserting her fair housing right to a second chance at rental assistance program compliance. Our legal intervention helped Bryn to get her subsidy reinstated.

Cary: Cary was emergently discharged from her long-term care facility for cause for reasons relating to her psychiatric disabilities. She then moved into community housing prematurely, giving rise to a period of housing instability and, sometimes, homelessness. Over a period of two years, she needed legal help with a variety of issues, including: making a discrimination complaint to the Vermont Human Rights Commission; negotiating a mutual termination of tenancy with her landlord; negotiating a revised care plan with her mental health agency which was ceasing subsidizing her rent; appealing DCF's denial of emergency housing assistance; and seeking reasonable accommodations from her shelter provider. Our legal interventions have helped Cary to achieve stable housing, as well as a sense of justice (finally) being served. Cary is now securely housed in a supportive housing setting. She recently settled her VHRC case against the facility, securing damages, attorney's fees, and considerable policy reforms to prevent the home from discriminating again.

***Donna*:** Donna faced eviction for cause from subsidized housing for reasons relating to her psychiatric disabilities. After several neighbor-neighbor disputes and associated lease violations, Donna's housing provider forced her to move apartments without Donna's input, in a misguided attempt to reasonably accommodate her disabilities. This forced move to an even less accessible unit gave rise to more neighbor-neighbor disputes and lease violations. Donna needed legal help with asserting her rights to be heard on her past reasonable accommodation requests and her termination grievance. She also needed help with asserting her fair housing rights to be reasonably accommodated in the form of a second chance at program compliance. This required an increased service plan, which had to be negotiated with her case management agency. Our legal intervention resulted in Donna's enrollment in her desired increased services, the implementation of reasonable soundproofing modifications to her unit, and the withdrawal of her termination notice.

Earl: Earl faced rental assistance termination and eviction for cause for reasons relating to his disabilities. He needed legal help with grieving his termination, but he had no viable fair housing defenses available. This is because he and his service providers were unable to agree an increased care plan that would be reasonably likely to remediate lease violation behaviors. This plan was necessary to substantiate a reasonable accommodation in the form of a second chance at program and lease compliance. Earl was not interested in negotiating a move out with his current landlord and wanted to fight the eviction. Unfortunately, we could not offer Earl with full representation and closed the case after giving brief advice.

Frank: Frank could not continue living at his apartment for reasons relating to his mental disabilities and needed state financial assistance to move into a different apartment. Program rules prevent administrators from funding relocations to new apartments if the tenancy at the current apartment is not under threat. Frank needed legal help with asserting his fair housing and ADA rights to be reasonably accommodated in the form of a change to the program rules. He needed financial help to move into alternative housing that was more accessible to him as a person with mental disabilities. Ultimately, Frank did not feel comfortable making the request and asked that his mental health case manager speak for him, since his case manager was the person applying for financial relief in the first place on Frank's behalf. His case manager declined to be involved in an advocacy for fear of retribution toward the case manager's other clients.

Greg: Greg faced no cause eviction from his subsidized apartment, despite no cause evictions being disallowed by subsidy program rules. His service providers suspected the eviction was really for cause. He needed legal help with dismissing his eviction case, investigating any fair housing issues lurking behind the no cause eviction, and requesting reasonable accommodations to remediate tenancy issues that were putting Greg at imminent risk of for cause eviction. Unfortunately, Greg's service providers declined his request for an increased service plan to help him remediate said issues. While the no cause eviction was dropped, if Greg faces eviction for cause in the future, he will be unable to substantiate a reasonable accommodation request for a second chance without his service providers coming to the table.

Hannah: Hannah faced eviction for cause from her DMH-subsidized apartment while she was receiving in-patient mental health treatment in an institutional setting. She had fair housing claims to save both her apartment and her subsidy but decided not to risk losing her subsidy by trying to save her tenancy at this particular apartment. She needed help with realigning with her service providers, legal help with negotiating a move out to avoid eviction, and legal help with obtaining a reasonable accommodation in the form of another chance at subsidy program compliance. The latter was difficult to navigate as program rules are not regulatory and lack clarity. Co-counsel's legal intervention allowed Hannah to remain in the subsidy program pending she moved to a different apartment.

Isaac: Isaac is an elderly homeowner with hoarding disorder and other psychiatric disabilities who periodically faces adverse legal actions by his community. After years of somewhat "friendlier" attempts to help address the clutter, now his community is trying to force

him to declutter at pain of losing his home. Isaac needed legal help with staving off an injunction action and obtaining reasonable accommodations and additional services, including those funded by Choices for Care Medicaid. Isaac's property manager even went so far as to threaten to petition for guardianship over Isaac, so the property manager could move Isaac into assisted living over Isaac's objection. Our legal intervention allowed Isaac to remain in his home.

Jon: Jon is a self-represented defendant in a for cause eviction proceeding whose relationship with his service provider has broken down. He and his *pro bono* housing attorney needed help with investigating Jon's grievances against his service provider. While his provider evinced an unwillingness to meaningfully help Jon further, there did not appear to be evidence available to support a formal grievance, and anyway the provider would have 90 days to respond by which time Jon would likely have been evicted. Ultimately, the court appointed a Guardian Ad Litem (GAL), and Jon began submitting separate motions against advice from his housing attorney who continued to represent Jon under the direction of the GAL.

Kate: Kate and her neighbors live in dense, project-based subsidized housing and are frequently triggering one another and erupting in conflict. All appear to be at risk of eviction for cause (or no cause) for reasons relating to their disabilities. Kate received a notice terminating her tenancy right before the COVID-19 eviction moratorium. The notice has since expired without further legal action. Now, Kate needs legal help with attending a "lease addendum" meeting with her housing provider. This meeting indicates an effort on the part of the housing provider to give Kate a second chance reasonable accommodation in lieu of re-terminating her, pursuant to Kate's fair housing rights. However, the proposed addendum includes a highly specific health treatment plan for Kate, including tenant obligations to regularly attend AA and Turning Point at pain of violating her lease, health treatment that the housing provider is not qualified to prescribe. Kate is at a loss for what to counteroffer. She is not interested in working with her local mental health agency after a previous bad experience, and otherwise does not have access to a case manager to help her coordinate her care. Even if Kate agrees a lease addendum, she is worried being evicted for no cause when her lease is due for renewal later this winter.

Appendix B: Consultations

Stakeholders I consulted include the following (with their catchment area in parenthetical):

Service providers: Howard Center (Chittenden); Washington County Mental Health Services (Washington); Northwestern Counselling & Support Services (Franklin); Health Care & Rehabilitation Services of Vermont (Windsor, Windham); Northeast Kingdom Human Services (Orleans, Caledonia, Essex); Pathways VT (Statewide); Homelessness Prevention Center (Rutland); Northeastern Family Institute Vermont (Franklin, Chittenden, Lamoille, Caledonia, Essex, Windsor, Windham); Age Well (Addison, Chittenden, Franklin, Grand Isle); Northeast Kingdom Council on Aging (Orleans, Caledonia, Essex); Senior Solutions (Windsor, Windham); Support and Services at Home (Statewide); Brattleboro Retreat (Statewide; Windsor, Windham); University of Vermont Health Network (Statewide); Forensic Consultation and Counselling Services (Rutland); Mercy Connections (Chittenden); Champlain Valley Office of Economic Opportunity (Addison, Chittenden, Franklin, Grand Isle); Northeast Kingdom Community Action (Orleans, Caledonia, Essex); Groundworks Collaborative (Windham); Association of Africans Living in Vermont (Statewide).

Housing providers: Burlington Housing Authority Housing Retention Team; Vermont State Housing Authority; Lund Vermont (Chittenden); Champlain Housing Trust (Chittenden, Franklin, Grand Isle); Committee on Temporary Shelter (Chittenden).

Advocacy organizations: Disability Rights Vermont (Statewide); Vermont Care Partners (Statewide); Vermont Psychiatric Survivors (Statewide); National Alliance on Mental Illness Vermont (Statewide); American Civil Liberties Union of Vermont (Statewide); Vermonters for Criminal Justice Reform (Statewide).

Coalitions: Chittenden Hoarding Task Force; Chittenden County Homelessness Alliance; Vermont Coalition to End Homelessness (Addison, Caledonia, Essex, Bennington, Franklin, Grand Isle, Lamoille, Orange, Orleans, Washington, Windham, Windsor); Local HUD continua of care for Windsor, Windham, Franklin; Vermont Coalition of Runaway & Homeless Youth Programs (Statewide); Vermont Care Partners' Community and Rehabilitation and Treatment Directors' Network (Statewide).

State agencies: Human Rights Commission (Statewide); Secretariat of the Legislature; Department of Mental Health; Department of Disabilities, Aging, And Independent Living; Prisoners' Rights Office; Office of the Defender General Appellate Division.

Municipal agencies: Burlington Office of the City Attorney; Burlington Community Economic Development Office; Burlington Community Justice Center; Greater Falls Community Justice Center (Windham).

Judiciary: Supreme Court of Vermont; Civil Division Oversight Committee; Long-Term Planning Committee; Office of the State Court Administrator; presiding judges and administrators of the mental health and substance use disorder treatment dockets of the Criminal Division.

Attendance at Trainings: Attended the Substance Abuse and Mental Health Services Administration Homeless and Housing Resource Network's annual symposia 2019 and 2020; Attended the Vermont State Independent Living Council's 2020 *Olmstead* meeting; Attended the National Disability Rights Network's annual symposium 2020; Attended the biennial Vermont Affordable Housing Conference 2018; Attended various webinars and meetings hosted by various state and national advocacy groups focused on mental health and housing.

Appendix C: Limitations

I want to name four areas where my limitations affected my work and the information contained in this report.

First, I wish I had consulted and partnered more closely with more individuals who have lived experience, especially self and peer advocates. I do not have personal experience with the challenges explored by my fellowship topic. While I consulted and worked with clients and providers with lived experience, I wish I had been more intentional and consistent about heeding the disability rights call for "nothing about us without us."

Second, I wish I had brought an intersectional and antiracist lens to my work. In Vermont, Black, Indigenous and People of Color (BIPOC) are more likely to experience conditions that make and keep people poor and that put people in the position of defending against evictions and foreclosures, all of which create traumatic and stressful conditions that compromise and exacerbate mental health challenges.[162] BIPOC adults are also more likely to experience depression than white non-Hispanic adults and BIPOC youth are more likely to make a suicide attempt requiring medical attention than white non-Hispanic youth.[163] However, over the course of my fellowship, I represented just one individual who identified as BIPOC. This signifies a need to refocus resources and outreach in communities where they are most needed, to make our services truly accessible and safe for everyone. Furthermore, I did not deeply explore the intersection of mental health, housing, and domestic violence. Domestic violence is a leading cause of homelessness for Vermont women, an issue magnified for women of color who experience disparate rates of HUD-defined "housing problems" and compounded barriers to accessing legal protection, healthcare, and shelter—barriers even further aggravated for trans women of color. I should have been more mindful about taking cases and consulting partners to center antiracism and gender equity in the course of my work.

Third, despite efforts to diversify my caseload and catchment area, there were certain counties and rural areas that my fellowship casework did not reach. My only experience in Bennington County was a speaking engagement at a VBA event in Manchester. I also did not represent any clients receiving services from Lamoille County Mental Health Services or the Clara

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[162] *Vermont Housing Needs Assessment reveals racial disparities*, Vermont Housing Finance Agency (June 19, 2020), *available at* https://www.vhfa.org/news/blog/vermont-housing-needs-assessment-reveals-racial-disparities (citing Vermont Housing Needs Assessment, *supra* note 3). Furthermore, the 2019 VLA and LSV Vermont Legal Needs Assessment included targeted consultations with New American communities, which gave rise to the following conclusions: "As with many other groups, housing is a primary concern, but one that is even more pronounced for this community…. The other most notable area of need is to ensure that these communities have effective access to the legal services system, especially through a greater number of community meetings, educational sessions, and in-person clinics and opportunities for intake, in order to bridge the barriers posed by limited English proficiency and unfamiliarity with the legal system." *Legal Services Vermont and Vermont Legal Aid Statewide Legal Needs Assessment* at 27-28 (December 6, 2019), *available at* https://www.vtlegalaid.org/sites/default/files/2019-VERMONT-LEGAL-NEEDS-ASSESSMENT.pdf

[163] *See Vermont Statistics on Suicide*, Vermont Suicide Prevention Center (accessed November 30, 2020), *available at* https://vtspc.org/vermont-statistics-on-suicide/ (citing DMH Statistical Report Cards).

Martin Center. I was frequently guilty of the Chittenden-centricity of many Vermont services. I wish I was more successful at stretching the fellowship's footprint to all corners of Vermont.

Finally, a structural challenge of the fellowship is trying to balance the exploration a diverse array of policy issues and areas of legal practice with becoming a knowledgeable and effective advocate on any one topic. My hope is that this report's synthesis of what dozens of client-experts and expert-clients so generously shared with me will prove somehow helpful to my colleagues who will be taking up more focused advocacy on mental health-related homelessness and housing instability moving forward.

I aim to critically reflect on these limitations and improve the ways I approach access to justice work in the future.

Appendix D: Housing Supports

Below is a non-exhaustive list of organizations providing some type of housing supports for individuals with mental health challenges, presented in no particular order:

Housing First organizations like Pathways VT (Statewide)[164] and the lower fidelity Homelessness Prevention Center (Rutland).[165] These organizations provide clients with diverse, intensive case management services by interdisciplinary teams focused explicitly on securing housing and stabilizing housing through wraparound services.

Designated and specialized community mental health agencies (Statewide).[166] These organizations provide clients with an array of voluntary and court-ordered home- and community-based case management services including on housing. Individuals with severe and persistent mental illness and a recent inpatient treatment history are eligible for 1:1 case management through the Community Rehabilitation and Treatment program. Some agencies offer a lower intensity case management services for subacute individuals, as well.

Intellectual and developmental disability (I/DD) services continuum, including the designated and specialized service agencies.[167] Through 1:1 case management and other home- and community-based supports, agencies promote independent and supported living individuals with a primary diagnosis of I/DD, including some who have a dually diagnosed mental health disability.

Substance use disorder (SUD) services continuum.[168] I've worked with dually diagnosed individuals who receive some degree of office-based case management support at SUD providers like Turning Point.[169] Sober living and residential treatment facilities also offer case management to promote the transition to independent living, but strict program rules and a lack of grievance rights can make these settings unstable living environments for many from my client population.

DMH designated hospitals.[170] Hospitals providing inpatient and outpatient medical and psychiatric care offer a variety of case management services. Some hospitals and designated mental health agencies also partner with affordable housing organizations to provide transitional or supported housing programs in the community setting.[171] I've worked with clients receiving case management from community outreach nurses at the Brattleboro Memorial Hospital, social workers embedded at the University of Vermont Medical Center, and the social work team at the Brattleboro Retreat. In my experience, some health workers go beyond the call of duty in making

[164] https://www.pathwaysvermont.org/get-support/
[165] https://www.hpcvt.org/
[166] https://mentalhealth.vermont.gov/individuals-and-families/designated-and-specialized-service-agencies.
[167] https://ddsd.vermont.gov/services-providers/providers.
[168] https://www.healthvermont.gov/alcohol-drug-abuse/how-get-help/find-treatment; https://vthelplink.org/.
[169] https://turningpointcentervt.org/.
[170] https://mentalhealth.vermont.gov/about-us/designated-providers
[171] See e.g. https://www.huduser.gov/portal/casestudies/study-081718.html.

service connections and providing supports, while others appear unresponsive to clients' community-based case managers or other support people.

Community health centers like Community Health Centers of Burlington and Gifford Health Care have behavioral health teams providing counseling services and, sometimes, care coordination and case management-like supports.[172]

Veterans' service continuum.[173] Community organizations like the Supportive Services for Veteran Families program at Pathways offer case management and wrap around mental health and housing supports.[174] The U.S. Department of Veterans Affairs and the Vermont Office of Veterans Affairs also coordinate health, housing, and benefits supports for eligible veterans, including clinic- and community-based case management and subsidized supported housing for individuals with high acuity.

Support and Services at Home (SASH).[175] SASH is a coordinated care program providing health-focused, in-home case management supports to about 5,000 Medicare recipients living in affordable, congregate settings statewide.[176] SASH is cited nationally as an emerging best practice, but we caution tenants that SASH coordinators' case notes become part of their housing provider's records and can be used against tenants in termination or eviction proceedings. Chittenden residents can access SASH and other specialized housing supports through Burlington Housing Authority's Housing Retention Services.[177] Also regularly cited as an emerging supportive housing model, case manager notes also become part of housing provider records and can be used against tenants in termination or eviction proceedings.

Community Action agencies.[178] Among the five nonprofit benefits navigation agencies in Vermont, several housing navigation case managers, coordinated entry specialists, and other staff provide a range of office-and community-based assistance relating to individuals' housing or experiences of homelessness. These agencies are not charged with providing mental health case management, but I've observed staff going beyond the call of duty to help individuals with mental health-related housing challenges such as hoarding. I've also observed staff who were unresponsive to requests for help for reasons clients and their families felt might be implicit bias.

Agencies on aging.[179] Vermont designates five regional organizations with responsibility for coordinating care for elderly Vermonters that promotes safe, healthy, independent living. These organizations affiliate through a central lobbying body, the Vermont Association of Area Agencies on Aging, and work in partnership with many of the services and organizations referenced in this section. Agencies provide case management or similar services and help to enroll clients in other

[172] See, e.g., https://giffordhealthcare.org/ and https://www.chcb.org/.
[173] See, e.g., https://veterans.vermont.gov/ and https://www.va.gov/directory/guide/state.asp?STATE=VT&dnum=ALL.
[174] See https://www.pathwaysvermont.org/what-we-do/our-programs/ssvf/.
[175] https://sashvt.org/admin/.
[176] https://sashvt.org/wp-content/uploads/2018/11/2018-Overview-BetterHealthierSmarter.pdf.
[177] https://burlingtonhousing.org/housing-retention-and-services.
[178] https://dcf.vermont.gov/partners/caps.
[179] https://www.vermont4a.org/.

home- and community-based supports. Among those supports agencies on aging connect elderly Vermonters with, the Vermont Chronic Care Initiative and Choices for Care (CFC) offer Medicaid-enrolled individuals with short- and long-term case management and care coordination (respectively) to promote healthy independent living, including housing supports.[180] These programs do not target individuals whose primary needs are psychiatric, but many enrollees have mental health as well as physical health concerns with completing activities of daily living (ADLs). However, I've observed individuals with mental health concerns being denied access to CFC based on a determination that their primary needs are psychiatric rather than help with ADLs. Many elder care advocates have shared concerns that these determinations are symptomatic of implicit bias against individuals with mental illness and an aversion to the higher costs associated with reasonably accommodating this population in the course of providing help with ADLs.

Residential services continuum.[181] The Vermont Department of Aging and Independent Living (DAIL) designates and oversees a system of long-term residential care—including nursing homes, assisted living, and residential care homes—as well as home shares and adult family care settings. These services are reserved for individuals with I/DDS in need of residential care as well as assistance with ADLs, including those who have psychosocial care needs pertaining to their mental health. These service environments provide necessary housing and supports for individuals who are dually diagnosed with a mental health disability and can partner with designated mental health agencies to meet residents' care needs. During my fellowship, I collaborated with a VLA workgroup, as well as the journalists behind the *Worse for Care* expose series,[182] to monitor facilities' reported pattern and practice of discharging or denying access to individuals with serious mental health concerns for pretextual reasons permitted by DAIL regulations.

Youth homelessness service continuum.[183] Agencies providing coordinated health and housing supports for youth and young adults experiencing housing instability or homelessness coordinate through the Vermont Coalition of Runaway and Homeless Youth Programs. As with the agencies on aging, youth agencies work in partnership with many of the services and organizations referenced here and provide case management and help to enroll clients in other home- and community-based supports including supportive housing. Agencies also provide shelter and temporary housing. Some have partnered with designated and specialized service mental health agencies to meet youth mental health needs with, what I've heard anecdotally, mixed results.

Adult and family homelessness service continuum, including service and shelter providers like the Committee on Temporary Shelter in Burlington and the Groundworks Collaborative in Brattleboro,[184] who coordinate services and allocate supportive housing subsidies coordinated entry with their local continua of care networks.[185] Temporary shelter, socialization, housing

[180] https://www.greenmountaincare.org/state-health-initiatives.
[181] https://asd.vermont.gov/services/residential-options.
[182] See https://www.sevendaysvt.com/vermont/eldercare/Category?oid=28998357 and https://www.vpr.org/term/worse-care#stream/0.
[183] https://vcrhyp.org/.
[184] https://cotsonline.org/ and https://groundworksvt.org/about/.
[185] *See supra* note 116. *See also* https://helpingtohousevt.org/localcontinuaofcare/ and http://www.cchavt.org/.

navigation, benefits administration and office-based case management number among the services offered.

Several Vermont state agencies also provide individuals with voluntary and involuntary housing supports, including case management, incidental to a substantial loss of individuals' rights. For example, the Department of Children and Families (DCF) coordinates, and provides the case management component for, a specialized supportive housing program for DCF-involved families and youth called the Family Reunification Program.[186] DCF also provides case management and care coordination for enrolled youth and for young adults transitioning out of DCF custody and into independent living. In another example, under court supervision, the Office of Public Guardian (OPG) assists individuals who have a primary I/DD diagnosis, or individuals over 60 with a primary mental health disability diagnosis, with decision-making and action in "critical life areas" including health and housing.[187] I have worked with several clients who successfully litigated the removal of their guardianship order and later lamented the loss of the OPG's housing supports and lay advocacy. One client considered reaching out to the state's attorney to request a new petition for limited guardianship to assist with managing the client's subsidized tenancy. Other clients missed having the housing supports, but were understandably unwilling to forgo individual rights and personal liberties for the sake of receiving new guardianships just to receive the home-based case management supports they need.

[186] https://dcf.vermont.gov/oeo/fup.
[187] https://ddsd.vermont.gov/programs/public-guardian.