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The Need for Group Homes

The term "group home" refers to a congregate housing arrangement for a group of unrelated people. In most cases, the residents of such a facility share a condition, characteristic, or status not typical of the general population.[1] There are numerous other names for congregate living arrangements, however, including "community residential facilities," "group living facilities," "community care homes," "nursing homes," "assisted living facilities," and others. Group homes vary in many respects. They may be permanent or transitional; they may provide varying levels of treatment for their residents; they may be owned or managed by nonprofit or for-profit entities, or even some type of governmental entity.

Group homes provide services for a variety of medical conditions and people, whether with physical or mental disabilities, or with some other characteristic that requires the supportive services of a community living arrangement. Group homes are available for people with a physical disability, such as those who use wheelchairs or other mobility-assisting devices, those who have visual impairments, and those who are hard of hearing. Group homes also provide services for people with cognitive disabilities including dementia, general learning disability, and intellectual disability. Group homes may provide services to people with medical or mental illnesses. For people with a disability without family or whose families are unable to meet their needs, group homes provide a household unit that functions similarly to a

family environment.[2] Moreover, group homes provide services for people with AIDS or other transmittable medical conditions. Group homes further provide care, treatment, and support to recovering drug and alcohol abusers.

Whatever form it takes, the community-based group home has been described as a "preferred model for residential treatment of individuals who are either mentally ill or physically and/or developmentally disabled,"[3] and scientific studies have found group homes to be an effective model for assisting people with disabilities to learn, socialize, and develop,[4] especially when compared with institutional models for living and treatment. In addition, group living facilities serve people beyond just those with physical or cognitive disabilities: group living facilities provide housing for the elderly, for citizens returning to civil society from prison terms, for orphaned or neglected children, and other groups.

As discussed in the Introduction, this book covers aspects of providing for and regulating a variety of types of group homes serving individuals with a variety of characteristics. The fact remains, however, that group homes for people with disabilities are a significant source of controversy, with the added complexity of numerous federal and state laws offering greater protections to group homes for people with disabilities than for congregate living arrangements serving others. While most of the legal protections for group homes for people with disabilities discussed herein are inapplicable to group homes for others, housing facilities for those not within the reach of the Americans with Disabilities Act and the FHAA will also benefit from many of the practical planning and zoning strategies this book covers.

The authors further recognize that there is a growing belief in the scientific and civil rights communities that housing people with disabilities—particularly people with intellectual or psychiatric conditions—in non-congregate, independent settings is the most dignified housing alternative for such individuals, and is the option that offers the greatest likelihood of successful treatment and quality of life for residents.[5] A less heralded benefit of this trend is a reduced amount of public scrutiny—at least in the local land use regulation and approval context—of independent living arrangements as compared with congregate living arrangements. Experience suggests, however, that the greatest source of opposition and challenge for planners and land use attorneys remains the siting of congregate living

arrangements because of a continuing community bias against these types of arrangements. So while this book focuses largely on the planning and land use law issues surrounding group homes and other congregate living arrangements, the reader should be aware that movements toward independent living arrangements for people with disabilities are occurring and may present their own local regulatory challenges now or in the future.

Characteristics of Group Homes

In almost all cases, group homes provide a supportive environment for their residents, and group home operators generally seek to locate in residential areas or other neighborhoods where the residents can be comfortably and unobtrusively integrated with the neighborhood and become essentially a functional family, surrounded by a supportive community. Many group homes operate in single-family, detached houses in suburban or urban residential neighborhoods[6] and often look much like the rest of the structures and properties in the neighborhood where they are located. In most cases, the group home is a single-family residence, and the exterior remains typical of the neighborhood where it is located.[7] Only the use has changed—and even that arguably is no change at all when one considers that such homes function with the residents sharing the benefits and burdens of a single household just like any other "family."

A study of group homes conducted in 1983 found that nonprofit organizations operated more than half of them, while public agencies and for-profit entities operated the remainder.[8] Many private homes, however, operate under contracts with state or local public health agencies. Even more homes used federal, state, or local grants to assist with start-up costs.[9]

Group homes today are generally small. The average occupancy level of a group home in 2011 was 8.2 residents per group housing unit. For group living units for people with intellectual disabilities,[10] there were only 2.5 people per unit.[11] These numbers are representative of dramatic downsizing of congregate living facilities since the 1970s, when the average number of residents per group living facility exceeded 20.[12]

Group home residents, as already noted, function like most other families, with responsibilities for the same daily tasks performed by members of general society: household chores, attending work or school, shopping, and exercising.[13] Residents in a group home setting frequently cook and share meals, recreate together, and forge relationships with one another and with members of the surrounding community.[14] Some group homes have the added element of trained support staff to assist residents with daily household routines or to assist with the management of the home.[15] While some group homes may have 24-hour professional staff, others may have no staff at all,[16] depending on the particular needs of the group home residents and operator. The staff serve the important role of training residents in self-care and life skills, which in turn assists group home residents in becoming self-sufficient and often is an important precursor to the residents obtaining employment and becoming more active participants in the broader economy.[17]

People who reside in group homes come from many backgrounds. Some group home residents may be placed in group homes by a state or local government agency, or by a nonprofit agency previously responsible for the person's care. In many other instances, however, people living in group facilities in a particular neighborhood may actually be longstanding area residents, who previously lived under the care of family members who are no longer able to care for them.[18] Families of those with disabilities may seek out a supportive group home living arrangement to provide long-term care and housing that the family cannot provide.

A Brief History of Treatment of Disabilities and the Group Home Concept

The group home as we know it today is a relatively recent innovation in the treatment of people with disabilities and other people who are unable to live alone. The community-based group home grew out of concerns about past methods of treating those with mental health issues and cognitive disabilities, although the group home model has been applied to groups of people beyond those populations.

For most of history, people with disabilities have been subjected to intense discrimination, which has generally marginalized them.[19] In particular, the treatment of people with cognitive disabilities has varied from discriminatory to subhuman due to a widespread societal fear of mental illness and failure to comprehend the vast range of diagnosed illnesses, treatments, and most important, the differences between mental illness and cognitive disabilities. Before the mid-19th century, people with disabilities were cared for largely by family members due to a lack of government or other medical, educational, or housing facilities for people with disabilities.[20] People with mental illnesses were described as "idiots" and "lunatics," and were sometimes even thought to be bewitched or demonic.[21] Those who could not fend for themselves or whose families were unable to support them were recommended for a variety of treatments, ranging from being placed in workhouses to being permanently hospitalized in institutional settings or even incarcerated. Facilities responsible for housing people with disabilities were almost never regulated by government entities, and thus conditions were often foul and unsanitary.

Homelessness was also a frequent problem among people with disabilities, especially in the early history of the United States.[22] By the mid-19th century it was clear that a public solution was required to deal with the increasing problem of homeless people with mental health problems.[23] This development marked the beginning of a long period of institutionalization of people suffering from mental illness. Institutions, operated by charitable organizations, began opening around the United States. Treatments for those with mental illness at these institutions were often crude and bordered on inhumane. People without mental illness, those with cognitive disabilities, were swept up and indiscriminately institutionalized with others. The primary characteristics of treatment at these institutions were isolation and confinement. As one author notes, "[m]any of the detainees were regularly subjected to now familiar beatings and involuntary confinements even in the early days of operation."[24] In the early 20th century, many institutions began practicing eugenics,[25] which resulted in increased segregation and isolation of people with mental illness and cognitive disabilities and often involved forced sterilizations of them.[26] The award-winning and truly disturbing documentary *Titicut Follies* details the internal workings of one

such institution less than 50 years ago (although the institution's disturbing nature was likely muted by the presence of the film crew).[27]

Conditions inside institutions are described as "hell on earth—human warehouses where residents are isolated from society and often left to gnaw upon themselves, huddling in their own wastes."[28] In almost every way, institutionalization was worse than imprisonment in modern U.S. penitentiaries. The realities of what went on in these institutions, which from the mid-1800s through the 1960s and 1970s housed and treated the vast majority of people with disabilities not living with their families, were largely unknown to the general public. The vast majority of society had no connection to the institutions or the people in them, and therefore little was known about what happened behind the institutions' walls.

However, a number of events in the 1960s and 1970s brought greater attention to the problems of institutions. In 1963, President John F. Kennedy, whose sister, Rose Marie Kennedy,[29] personally experienced the abuses of the institution system, sent a legislative package to Congress to increase funding for community mental health programs.[30] Kennedy called for a wholesale change in treatment of those with mental health and cognitive disabilities, calling attention to the "harsh environmental conditions" that faced many institutionalized people.[31] At the same time, increasing scientific knowledge in the fields of medicine, and particularly psychiatry, resulted in a greater understanding of mental illness among medical professionals and other social scientists, who began to question the treatment methods used at major institutions.

Additionally, class action court cases brought on behalf of institutionalized people forced further public critiques of the institution system.[32] These cases introduced courts and the public to the "scandalous" conditions that existed inside institutions.[33] In one of these cases, *Wyatt v. Stickney*, filed in response to conditions at an Alabama psychiatric hospital, it was found that over 1,500 elderly geriatric patients were improperly housed at the psychiatric hospital, the state department overseeing the hospital had failed to meet the minimum standards for federal funding, and per-patient spending at the hospital in 1970 was just $6.58 per day.[34] The plaintiffs brought constitutional due process claims. U.S. District Judge Frank Johnson, who heard the case, condemned the actions of the state, saying:

> There can be no legal (or moral) justification for the State of Alabama's failing to afford treatment—and adequate treatment from a medical standpoint—to the several thousand patients who have been civilly committed to Bryce's [Hospital] for treatment purposes. To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.[35]

Many of the class action suits resulted in judicial orders requiring states to find alternative locations for the placement and housing of people with disabilities.[36] Public outcry over conditions in institutions also led to the formation of political and social organizations advocating for those with disabilities. These judicial rulings, combined with the actions and findings of government and the scientific community and the support of these nascent but powerful advocacy organizations, called for a dramatic shift in the housing and treatment of people with disabilities.

Attention then began to turn toward community-based residential facilities as a solution to the problems that plagued institutions. By the 1970s, the medical community had reached the consensus that smaller living arrangements would provide the best opportunity for humane treatment of people with disabilities, which would assist people with mental illness or cognitive disabilities in reaching their full social and economic potential. The move to community-based group homes has been summed up as follows:

> Since the 1960s, this nation has increasingly accepted the notion that training, treatment, and habilitation of people with mental disabilities is generally more effective when provided in small, community-based programs rather than in large, isolated institutions. For example, in 1961 the Joint Commission on Mental Illness and Health recommended that action be taken to both improve conditions in state hospitals and develop community alternatives to state hospitals. Furthermore, Congress, courts, and states called for deinstitutionalization and the development of community programs for people with mental illness and developmental disabilities. As a result, the number of people with mental disabilities in institutions has dwindled . . . .[37]

The community-based group living facility became a common form of housing and treatment for people beyond just those with cognitive disabilities or mental illness, but also including people recovering from drug and alcohol addictions, citizens returning to society from incarceration, the homeless, victims of domestic violence, elderly people, orphans, and children in need of custodial care. The widespread acceptance of the group home as the preferred method for treatment and housing of people outside of households led to a tenfold increase in the number of group homes in just eight years through the 1970s and 1980s: in 1974, there were 611 group homes around the United States, but there were over 6,400 by 1982.[38] Meanwhile, the number of people in state psychiatric hospitals plummeted 90 percent from over 500,000 in the mid-1950s to fewer than 50,000 by 2008.[39]

Despite the near-universal belief that community-based group homes have dramatically improved the well-being of people with disabilities, these homes have been discriminated against more than any other form of housing.[40] The housing choices faced by people with disabilities have been severely curtailed, often by local government restrictions that come about as a result of fears and biases of community members.[41] In 1994, it was estimated that group homes failed to be established on half of the sites where they were proposed as a result of community opposition and discrimination.[42] Many of the people with disabilities remaining in state care have not moved into group homes because of shortages in the number of group homes.[43] The failure of local zoning officials and community members to actively support group homes is in significant part to blame for the shortage in this needed form of housing.

More recently, and particularly relating to people with cognitive disabilities or some form of mental illness, there has been a movement in both the scientific and civil rights fields toward individualized, independent living arrangements (often termed "supportive housing") that allow an individual with disabilities to reside in his or her own dwelling while receiving necessary support.[44] Such arrangements allow the resident to maintain a broad range of choices in the type and location of housing, attain greater levels of independence and quality of life, and therefore reduce the cost burden of providing treatment and care while providing the dignity that people with disabilities deserve but are often denied.[45] Furthermore, the law has

caught up with progressions in science and general attitudes toward housing for people with disabilities. In 1999, in the case of *Olmstead v. L.C.*,[46] the U.S. Supreme Court interpreted the Americans with Disabilities Act to require governmental providers of services to people with cognitive disabilities to provide community-based, supported independent living for people with cognitive disabilities where such arrangements could be reasonably accommodated given the budgetary and programmatic constraints of the agency.[47] In particular, the Supreme Court found that "unjustified isolation . . . is properly regarded as discrimination based on disability" and that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."[48] While congregate living facilities still play a major role in the treatment of some forms of disability or illness—and indeed, congregate living arrangements are the focus of this book—the result of *Olmstead* has been a legal obligation for service providers and increasing enforcement efforts by the Department of Justice to require placement of people with disabilities in independent settings where feasible.

Types of Group Homes

There are many types of group homes, and numerous authors have attempted to craft typologies of the various homes one might encounter.[49] Daniel Lauber identifies four principal types of disabilities—developmental disabilities, mental illnesses, physical disabilities, and drug and alcohol addictions—and describes the types of group living facilities that would provide support for people suffering from these disabilities.[50] Beyond group homes for people with disabilities, there are group living facilities for people with numerous other conditions, such as homelessness, recent incarceration, and so on.

Group homes for people with physical disabilities is a relatively straightforward concept. The physical structure of the home is designed for people with physical disabilities, including features such as ramps for wheelchair access, interior elevators, and accessible restrooms. Trained staff in group

homes for those with physical disabilities will often have medical credentials appropriate for assisting such residents. These group homes may provide transportation in cases where the residents are unable to drive or lack access to transit options.

Group homes for people with mental or cognitive disabilities may have structures and building layouts that differ little from typical single-family residences. The social environment in these homes often resembles that of a family home, where residents may be responsible for household chores, residents dine and recreate together, and the residents often live on similar schedules.[51] Trained staff provides support and education for the residents of the home, and these individuals assist with household tasks that the residents may be unable to perform independently. As with homes for people with physical disabilities, transportation is typically provided for the residents, who are often unable to drive personal automobiles. People with mental illness and those with cognitive disabilities may have accommodations arranged for them in group homes by family members, or by hospitals or state agencies.

Another type of group home—and perhaps the one that generates the greatest amount of litigation and community opposition—is the home for recovering substance abusers, which may alternately be called "sober living homes," "halfway houses," "recovery communities," or other names.[52] These facilities are a common form of therapy for drug or alcohol abuse because they provide a supportive community environment, with stringent rules on tenants' behavior.[53] The residents of these facilities—which serve as one step in a longer process of rehabilitation—provide support for one another as they proceed through the process of recovery.[54] These homes are often transitional; that is, they provide accommodations for those in recovery for shorter periods of time than other forms of group living facilities that provide a permanent dwelling. Sober living facilities vary in their operation; some are corporation-owned, while others may be owned by individual landlords, and they range in the number of tenants to whom they provide services.[55] Residents of these facilities are generally required to have completed a full detoxification before they are permitted to live in the home, and researchers have found that halfway houses tend to provide the best treatment support when there are approximately 10 to

15 residents in the home.[56] The largest and best-known provider of housing for those recovering from substance abuse is Oxford House, a national nonprofit organization that is affiliated with numerous houses around the nation for recovering addicts.[57]

There may be other group living facilities that serve other types of disabilities, or which may at least provide services for people who are incapable of or have difficulty living alone. Care facilities for the elderly, ranging from nursing homes to assisted living facilities, are one example of such housing.[58] Additional examples are facilities for orphaned or delinquent children, homes for battered or abused women and children, and facilities serving the homeless population (many of which provide services for homeless people with various forms of disability). Group living facilities for citizens returning to society from incarceration are also commonplace.

Outside of group homes are two types of semi-independent living facilities: board and care homes and supportive housing. Board and care homes provide a place to sleep, as well as meals, generally to residents with psychiatric disabilities.[59] These homes may be staffed part-time. Board and care homes frequently are either unstaffed or provide less supervision than other congregate living facilities, and such homes are typically not state licensed.[60] Most board and care homes are small arrangements, although some have been known to have over 200 residents.[61]

Another form of semi-independent living arrangement that has more recently become the preferred alternative for housing people with cognitive disabilities is frequently termed "supportive housing."[62] Supportive housing is the term used for situations where people with disabilities live in individual apartment or home units, where services are delivered to the unit, but where the person is generally responsible for day-to-day management of his or her housing unit.[63] Supportive housing is preferred over congregate living facilities in cases where the resident is willing and able to live in an independent setting.

Benefits of Group Homes

Group homes provide significant benefits, both for their residents and for the communities in which they are located. The normalized atmosphere of a group home in a residential neighborhood, as opposed to major institutions that isolate people with disabilities, encourages group home residents to improve their communication skills, learn acceptable social behaviors, and obtain education and employment.[64] In many cases, studies have found that institutionalization of people with disabilities creates additional stresses and medical problems, slowing down improvements that might otherwise be made.[65] Group homes have also been found to reduce hospitalizations for those with mental illness, improve quality of life for people with disabilities, and reduce the cost and time burdens on the medical system.[66] Group homes also provide a significant economic benefit: the staff training and attention available in group homes and the community atmosphere encourage residents to learn valuable skills that allow them to become employed, earn wages, and add significant value to the community and society.[67] For people recovering from drug or alcohol addictions, group homes provide an environment that encourages positive social interactions without the temptation to participate in alcohol or drug activity, and one that forges social bonding and companionship that is crucial to full recovery.[68]

Group homes for people without disabilities also provide significant benefits. For example, pre-parole facilities for inmates returning to society serve the important role of reeducating inmates and assisting them with transitions back to civilian life.[69] Approximately 700,000 people are released from prisons every year, but many of these people lack access to services to assist them with reentry. Pre-parole facilities have been found to reduce the recidivism rate, as these facilities provide important training services that reduce the likelihood that former inmates will return to criminality. Furthermore, a lack of homes for juvenile offenders may leave more children exposed to criminality and drug addiction. Facilities serving the homeless population and shelters for victims of domestic violence also provide needed services to vulnerable populations. A lack of such facilities means that homeless people will remain on the streets, while a lack of shelters for victims of domestic violence may result in further abuse and battery. Many

of the above conditions may overlap; citizens returning from prison often face mental health challenges or homelessness, and many victims of abuse or violence struggle with mental health issues or disabilities.[70]

Group homes have considerable cost and efficiency benefits over larger institutional settings. The delivery of services to people with disabilities and other group home residents is much more cost-effective when done in smaller residential facilities than in large institutions.[71] As Michael Gerrard notes:

> Only slight changes in personal circumstances and the availability of different kinds of facilities determine whether certain individuals reside, at any given moment, in low-income housing, homeless shelters, group homes, hospitals or jails. For this population, all these facilities are either provided or heavily subsidized by the government, with some help (except for jails) from the charitable sector, yet even that help receives a significant tax subsidy. The cost of these facilities varies widely; hospital and jail beds, for example, are much more expensive to provide than are affordable housing units and group homes.[72]

For people with disabilities without adequate living facilities, the likelihood of homelessness, criminal activity, or illness increases dramatically, causing a direct increase in the cost to taxpayers. A 2012 report prepared by the state of Virginia's Department of Behavioral Health and Developmental Services found that the annual cost of housing a person with a disability in a group home was $44,000, compared with $214,000 in state-operated hospitals.[73] The department further estimated that the cost to the state of transferring mentally ill or substance-addicted people to the criminal justice system was $613 million.[74] And beyond the "hard cost" savings that group homes provide over alternative methods of disability treatment, group homes provide an indirect savings to society by mitigating the widespread costs of criminal activity, reduced economic productivity, and the emotional and economic costs borne by families of people with disabilities or addiction issues.[75]

One of the major challenges surrounding zoning for group homes is the preferred location for their establishment in residential neighborhoods—usually neighborhoods characterized by single-family, detached houses. A

stable residential community is important in caring for people with physical and mental disabilities, as it offers an environment affording equal treatment and opportunities for integration of people with disabilities (and without disabilities) into the community.[76] Group homes and other housing arrangements for people with disabilities are sited in residential neighborhoods for many reasons, all of which have been found to provide better livability outcomes for the homes' residents. For instance, residential neighborhoods provide a less restrictive environment than alternative facilities where people with disabilities and who may be service-dependent reside in a treatment and housing facility.[77] Additionally, residential neighborhoods increase group home residents' ability to cope with their surroundings. Single-family residential neighborhoods are quieter and safer than many other locations; a better ability to cope also means that treatment services for group home residents are more effective.[78] For group home residents with cognitive disabilities, living in residential neighborhoods helps them to better adapt their behaviors to community life and encourages greater socialization.[79] The placement of group homes in high-crime neighborhoods or commercial and industrial zones seriously undermines the ability of people with disabilities to be part of the mainstream of society and to get any necessary treatment or assistance.[80] For people recovering from drug or alcohol addictions, residing in a neighborhood is crucial for avoiding relapse.[81]

Demand for Group Homes

Identifying the true demand for group homes is a difficult task, since there is limited information—particularly from government sources—available about the numbers of people with disabilities and their particular needs. For people without disabilities who might benefit from residing in a group living facility, there is almost no information. While some data exist on the nationwide population of people with disabilities, it is particularly difficult to get data on local populations, especially in smaller cities or towns. This section paints a picture of some of the information available on the disability population from nationwide sources, while Chapter 6 offers suggestions as

to how planners and local government lawyers can find further information about local disability populations. Identifying a community's need for group homes is an important part of the planning process for group homes.

The U.S. Census Bureau estimated in 2010 that 36.4 million Americans, or approximately 12 percent of the total U.S. population, had some form of disability, including people with hearing or seeing problems.[82] Of the population 65 years and older, an estimated 14.3 million had some form of disability, composing approximately 37 percent of the nation's elderly population.[83] Of those people with disabilities in the United States, an estimated 13.8 million had a cognitive difficulty that gave them serious difficulty concentrating, remembering, or making decisions due to a physical, mental, or emotional condition.[84] An estimated 19.5 million people had some form of ambulatory difficulty, which is described as serious difficulty walking or climbing stairs, and an estimated 7.4 million people had a self-care difficulty, meaning a serious difficulty with cleaning or bathing. Finally, an estimated 13 million people over age 18 reported an independent-living difficulty, meaning serious difficulty doing routine errands alone. Nearly 17.5 million people reported having two or more disabilities.

While the cost of a disability cannot be directly monetized, the best estimates of the economic costs of disabilities are unquestionably large for the individuals with disabilities and society at large. In 2010, the Census Bureau estimated that 73 percent of those with disabilities were not in the labor force, and for people over 16 years old with disabilities who were employed, their median income was $19,500, or about $10,000 less than for the population without disabilities. Twenty-one percent of people with disabilities earned less than the poverty level in 2010, compared with only 12 percent of the population without disabilities. Moreover, scientific studies have demonstrated that the adversity and stress faced by people in lower socioeconomic strata create and worsen disabilities as these people grow and develop,[85] forming a vicious cycle of poverty and disability that exacerbates the need for community-based group homes.

While a large portion of the American population has a disability, not all disabilities are completely debilitating, nor do they require those people with disabilities to live in group living facilities. In fact, an estimated 80 percent of people with disabilities either live with their families or live

on their own, sometimes with support services.[86] In the period from 2006 to 2010, the U.S. Census Bureau estimated that approximately 8 million Americans lived in group quarters,[87] of which 1.5 million lived in what the Census Bureau terms "nursing facilities" or "skilled-care facilities."[88] Median annual earnings for people in these facilities were less than $9,000, and an estimated 20,000 people living in such facilities received government food assistance.

Demand for group home facilities has increased dramatically in the past half century due to the widespread closure of state institutions and increased consensus that group homes are a better treatment option for those people with disabilities who are unable to live alone. Despite the massive growth in group home facilities in the late 20th century, demand for such facilities remains high. Even in cities where housing vacancy rates have increased significantly, there are frequently shortages of housing for people with disabilities.[89] Stories of bed shortages in group homes are frequent, despite the fact that over 40 years have passed since deinstitutionalization began. For example, Virginia has 23 group homes statewide, serving approximately 300 residents with mental health disabilities, but over 160 others with disabilities statewide are on waiting lists for spaces in group homes.[90]

The shortage of group homes is evidenced in what we know about homelessness among people with disabilities. A 1988 study of homelessness in some of the largest U.S. cities found that nearly one-fifth of requests for emergency shelter for homeless people were unmet.[91] It is estimated that one-third of the entire homeless population of the United States suffers from some form of mental illness.[92] Moreover, mentally ill people without a supportive community are prone to criminality: 7 to 16 percent of prison inmates are mentally ill or suffer from a cognitive disability.[93]

As the elderly population increases due to the aging baby boomer generation, the number of facilities required for people with disabilities is likely to increase, given that the elderly population has the greatest percentage of those people with disabilities.[94] Moreover, as aging baby boomers become unable to care for their own children with cognitive and physical disabilities, those people will require treatment and supportive residential settings. The real estate market slowdown that began in the late 2000s has further

reduced housing opportunities for people with disabilities, since new construction of dwelling units has slowed and older buildings have not been rehabilitated to meet the needs of this population.[95]

In particular, continuing problems of substance abuse are causing a pressing demand for drug and alcohol rehabilitation centers. In 2010, an estimated 22.6 million Americans over age 12—that is 8.9 percent of that population—were current illicit drug users.[96] As a percentage of the U.S. population, the number of current drug users was higher in 2010 than in any year of the prior decade.[97] Also in 2010, 16.9 million Americans, or approximately 6.7 percent of the U.S. population over 12 years old, were "heavy drinkers," meaning they consumed more than five drinks per occasion on five occasions in the month prior to the survey.[98] According to the U.S. Department of Health and Human Services' (HHS) 2010 annual report on drug and alcohol abuse, "an estimated 22.1 million persons aged 12 or older were classified with substance dependence or abuse in the past year (8.7 percent of the population aged 12 or older). Of these, 2.9 million were classified with dependence or abuse of alcohol and illicit drugs, 4.2 million had dependence or abuse of illicit drugs but not alcohol, and 15.0 million had dependence or abuse of alcohol but not illicit drugs."[99] The report continues, saying, "In 2010, 4.1 million persons aged 12 or older (1.6 percent of the population) received treatment for a problem related to the use of alcohol or illicit drugs." In the same year, among those people receiving treatment, a million of them received treatment at a rehabilitation facility as an inpatient.[100] The HHS report found significant unmet demand for drug and alcohol treatment, highlighting one of the key areas of demand for group homes:

> In 2010, 23.1 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.1 percent of persons aged 12 or older). Of these, 2.6 million (1.0 percent of persons aged 12 or older and 11.2 percent of those who needed treatment) received treatment at a specialty facility. Thus, *20.5 million persons (8.1 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year.*[101]

Thus, the nation currently faces a clear shortage of facilities for people with drug and alcohol addictions. Group homes are critical in meeting this need.

Conclusion

Group homes provide an important function for people in the community who are unable to live alone or in a household. Since the rise of the modern group home in the mid-20th century, the average occupancy in such facilities has decreased as social scientists and the medical community determined that smaller, community-based environments achieved better results in terms of helping residents become part of the mainstream and in their own self-improvement. In turn, group homes have had a strong beneficial effect on improving the lives of those with disabilities, and in providing an important housing option for certain categories of people without disabilities. Despite all of the positive effects of group homes, there remain extreme shortages of such homes in many communities and states. This problem is exacerbated by discrimination of community members against group homes and their residents.

The remainder of this book will discuss how federal and state laws have enabled group homes to locate in communities, and how such laws have given rights of legal action to group home operators and residents who experience discrimination.

Notes

1. *See, e.g.*, Daniel R. Mandelker, *Housing Quotas for People with Disabilities: Legislating Exclusion*, 43 Urb. Law. 915, 917 (2011).
2. Douglas E. Miller, Note, *The Fair Housing Act, Oxford House, and the Limits of Local Control over the Regulation of Group Homes for Recovering Addicts*, 36 Wm. & Mary L. Rev. 1467, 1475–76 (1995).

3. Todd H. Carlisle, Note, Mains Farm v. Worthington*: Fair Housing Laws and Fear of Adult Family Homes*, 18 Seattle U. L. Rev. 425, 427 (1995). Note that this book discusses alternatives to congregate living arrangements, but those alternatives are not the focus of this book.
4. James T. Hogan, Comment, *Community Housing Rights for the Mentally Retarded*, 1987 Detroit C. L. Rev. 869, 903 (1987).
5. Michael Allen, Judge David L. Bazelon Ctr. for Mental Health Law, Just Like Where You and I Live: Integrated Housing Options for People with Mental Illnesses (Mar. 19, 2004), *available at* http://www.bazelon.org/LinkClick.aspx?fileticket=4sZjOa313oI%3D&tabid=245.
6. Peter W. Salsich, Jr., *Group Homes, Shelters and Congregate Housing: Deinstitutionalization Policies and the NIMBY Syndrome*, 21 Real Prop. Prob. & Tr. J. 413, 419 (1986).
7. Hogan, *supra* note 4, at 903.
8. Salsich, *supra* note 6, at 418.
9. *Id*. at 418–19.
10. "Intellectual disability" is a prevailing term for what has also been called "developmental disability." While legal definitions of "developmental disability" vary, the term generally refers to a disability that is related in some capacity to a cognitive disability, such as cerebral palsy, epilepsy, autism, or another neurological condition. The standard federal legal definition of developmental disability can be found in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. § 15002(8).
11. Mundelker, s*upra* note 1, at 918.
12. *Id*.
13. Daniel Lauber, *A Real LULU: Zoning for Group Homes and Halfway Houses Under the Fair Housing Amendments Act of 1988*, 29 J. Marshall L. Rev. 369, 383–84 (1996).
14. *Id*. at 383.
15. *Id*.
16. Salsich, *supra* note 6, at 418.
17. Hogan, *supra* note 4, at 897.
18. Martin Jaffe & Thomas P. Smith, Am. Planning Ass'n, Rep. No. 397, Siting Group Homes for Developmentally Disabled Persons 2 (1986).
19. Christina Kubiak, *Everyone Deserves a Decent Place to Live: Why the Disabled Are Systematically Denied Fair Housing Despite Federal Legislation*, 5 Rutgers J.L. & Pub. Pol'y 561, 570 (2008); *see also* Hogan, *supra* note 4, at 870 ("Throughout history, the mentally retarded population has been segregated and forgotten by the community.").
20. Hogan, *supra* note 4, at 873.
21. *Id*. at 872.
22. *Id*. at 874.
23. *Id*.
24. *Id*. at 875.
25. "Eugenics" is the term used to describe the study of human genetics and the development of methods to genetically engineer the population, primarily to reduce instances of disease and mental illness. The concept of eugenics was developed in

the 1920s and gained significant acceptance in the developed world during the era leading up to World War II. The most notable national effort at practicing eugenics, however, was Nazi Germany's effort to create a "master race" by sterilizing and eliminating undesired people and groups from its population. *See, e.g.*, Kim Severson, *Thousands Sterilized, A State Weighs Restitution*, N.Y. Times, Dec. 10, 2011, at A1.

26. *Id.* at 873..
27. *Titicut Follies*, (Zipporah Films 1956), *available at* http://www.youtube.com/watch?v=R5FFqWE6NWw (last visited Sept. 2, 2013) (a documentary by Frederick Wiseman about Bridgewater (Mass.) State Hospital for the Criminally Insane).
28. Marcia K. Lippincott, *"A Sanctuary for People": Strategies for Overcoming Zoning Restrictions on Community Homes for Retarded Persons*, 31 Stan. L. Rev. 767, 768 (1979).
29. Rose Marie (often "Rosemary," and known as "Rosie" within the family) Kennedy's story is a tragic one. She was a person with an intellectual disability who struggled in school. In 1941, by the time she was 23 years old, she had become more assertive, with mood swings and sometimes violent outbursts. Doctors recommended and performed a lobotomy that essentially incapacitated her. Robert Kessler, The Sins of the Father: Joseph P. Kennedy and the Dynasty He Founded (1996); Laurence Leamer, The Kennedy Women: The Saga of an American Family (1994); Jennie Weiss Block, Copious Hosting: A Theology of Access for People with Disabilities 56 (2002).
30. Robert L. Schonfeld, *"Five-Hundred-Year Flood Plains" and Other Unconstitutional Challenges to the Establishment of Community Residences for the Mentally Retarded*, 16 Fordham Urb. L.J. 1, 3 (1987).
31. *Id.* at 3, n.9.
32. Hogan, *supra* note 4, at 876–88 (citing Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971); Halderman v. Pennhurst State Sch. & Hosp., 446 F. Supp. 1295, 1298–99 (E.D. Penn. 1977)); *see also* Lauber, *supra* note 13, at 372, n.11.
33. Hogan, *supra* note 4, at 877.
34. *Wyatt*, 325 F. Supp. at 784.
35. *Id.* at 785.
36. Lauber, *supra* note 13, at 373.
37. Arlene S. Kanter, *A Home of One's Own: The Fair Housing Amendments Act of 1988 and Housing Discrimination Against People with Mental Disabilities*, 43 Am. U. L. Rev. 925, 929 (1994) (citations omitted).
38. Jaffe & Smith, *supra* note 18, at 1.
39. Kubiak, *supra* note 19, at 564–65.
40. *Id.* at 928–30; *see also infra* notes 64–81 (discussing benefits of group homes).
41. Salsich, *supra* note 6, at 419.
42. Michael B. Gerrard, *The Victims of NIMBY*, 21 Fordham Urb. L.J. 495, 509 (1994).
43. *See, e.g.*, Laura Vozzella, *Space in Va. Group Homes Scarce, Some Mentally Ill Languish in State Care*, Wash. Post (June 26, 2012), http://www.washingtonpost.com/local/dc-politics/lack-of-enough-beds-in-va-communities-leaves-mentally-ill-languishing-in-state-care/2012/06/26/gJQAdDUV5V_story.html.
44. *See* Allen, *supra* note 5.

45. *Id*. at 8.
46. 527 U.S. 581 (1999).
47. *See* U.S. Dep't of Justice, Civil Rights Division, 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.* (2011), *available at* http://www.ada.gov/olmstead/q&a_olmstead.htm.
48. *Olmstead*, 527 U.S. at 597, 600.
49. *See, e.g.*, Lauber, *supra* note 13; Mandelker, *supra* note 1.
50. *See generally* Lauber, *supra* note 13.
51. *See, e.g.*, *Adults: Residential Choices*, Aspire of Illinois, http://www.aspireofillinois.org/who-we-help/adult-residential-options.html (last visited Aug. 6, 2012).
52. *See generally* Matthew M. Gorman et al., *Fair Housing for Sober Living: How the Fair Housing Act Addresses Recovery Homes for Drug and Alcohol Addiction*, 42 Urb. Law. 607, 608 (2010).
53. Lauber, *supra* note 13, at 379.
54. *Id*.
55. Gorman, *supra* note 52, at 608.
56. Lauber, *supra* note 13, at 379.
57. Oxford House, http://www.oxfordhouse.org.
58. *See generally* Michael J. Davis & Karen L. Gaus, *Protecting Group Homes for the Non-Handicapped: Zoning in the Post-*Edmonds *Era*, 46 U. Kan. L. Rev. 777, 803–05 (1998).
59. Mandelker, *supra* note 1, at 918–19.
60. *Id*.
61. *Id*.
62. *Id*. at 920.
63. *Id*.
64. Kanter, *supra* note 37, at 961–62; Lauber, *supra* note 13, at 380–81.
65. Salsich, *supra* note 6, at 431.
66. *Id*. at 962.
67. Hogan, *supra* note 4, at 905.
68. Miller, *supra* note 2, at 1502.
69. *CCA on Pre-release and Reentry Services*, Corr. Corp. of Am., http://cca.com/insidecca/cca-on-pre-release-and-reentry-services#.UpQk3o0uG2x (last visited Aug. 6, 2012).
70. *See, e.g.*, Jennifer Brown & Karen E. Crummy, *Half of Parolees Who Murdered Spent Time in Solitary Confinement*, Denver Post, Sept. 23, 2013, at A1. The *Denver Post* published a multipart series in September 2013 highlighting challenges facing the Colorado state parole system; issues of mental health, disabilities, and homelessness were prominent among Colorado parolees. *See id*.
71. *See, e.g.*, Salsich, *supra* note 6, at 431.
72. Gerrard, *supra* note 42, at 513.
73. Vozzella, *supra* note 43.

74. VA. DEP'T OF BEHAVIORAL HEALTH & DEVELOPMENTAL SERVS., COMPREHENSIVE STATE PLAN 2012–2018, at 36 (Dec. 2011), *available at* http://www.dbhds.virginia.gov/documents/reports/opd-StatePlan2012thru2018.pdf.
75. Miller, *supra* note 2, at 1501.
76. Carlisle, *supra* note 3, at 431.
77. Salsich, *supra* note 6, at 431.
78. *Id.*
79. Hogan, *supra* note 4, at 906.
80. JAFFE & SMITH, *supra* note 18, at 8.
81. Miller, *supra* note 2, at 1475.
82. U.S. CENSUS BUREAU, AMERICAN COMMUNITY SURVEY 1-YEAR ESTIMATES, 2010.
83. *Id.*
84. *See American Community Survey Subject Definitions 2010*, U.S. CENSUS BUREAU, http://www.census.gov/acs/www/Downloads/data_documentation/SubjectDefinitions/2010_ACSSubjectDefinitions.pdf (last visited Sept. 19, 2013).
85. *See generally* Bruce P. Dohrenwend et al., *Socioeconomic Status and Psychiatric Disorders: The Causation-Selection Issue*, 255 SCIENCE 946 (1992).
86. Lauber, *supra* note 13, at 374.
87. Group quarters facilities are all non-household facilities. These include prisons and jails, college or university dormitories, and group homes, among other types of facilities.
88. The Census Bureau defines "nursing facilities" or "skilled care facilities" as "facilities licensed to provide medical care with seven day, twenty-four hour coverage for people requiring long-term non-acute care." The Census Bureau also collects data on in-patient hospice facilities, mental (psychiatric) hospitals and units, and residential schools for the disabled. U.S. CENSUS BUREAU, 2011 CENSUS SUMMARY, FILE 1, TECHNICAL DOCUMENTATION (Sept. 2012) at B-15, B-16.
89. Kubiak, *supra* note 19, at 564.
90. Vozzella, *supra* note 43.
91. Gerrard, *supra* note 42, at 509.
92. *Id.* at 566; *see also* Alicia Hancock Apfel, *Cast Adrift: Homeless Mentally Ill, Alcoholic and Drug Addicted*, 44 CATH. U. L. REV. 551, 552–53 (1995).
93. *Id.*; *see also* Brown & Crummy, *supra* note 70.
94. Apfel, *supra* note 92, at 591.
95. *Id.* at 592.
96. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NSDUH SERIES H-41, HHS PUB. NO. (SMA) 11-4658, RESULTS FROM THE 2010 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS (2011), *available at* http://www.samhsa.gov/data/NSDUH/2k10NSDUH/2k10Results.htm#Ch2.
97. *Id.*
98. *Id.*
99. *Id.*
100. *Id.*
101. *Id.* (emphasis added).