COMMONWEALTH OF MASSACHUSETTS

Supreme Judicial Court

NO. SJC-12507

ROSANNA GARCIA & OTHERS,

Plaintiffs-Appellees

v.

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT,

Defendant-Appellant

ON APPEAL FROM AN ORDER OF THE SUFFOLK SUPERIOR COURT

**AMICI CURIAE BRIEF OF THE
MASSACHUSETTS LAW REFORM INSTITUTE,
DISABILITY LAW CENTER & CENTER FOR PUBLIC REPRESENTATION
IN SUPPORT OF APPELLEES**

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INTERESTS OF THE AMICI CURIAE

Amici are Massachusetts and national legal aid organizations that represent individuals experiencing homelessness, including disabled individuals, as well as advocacy groups working to advance the rights of homeless and disabled people.

The **Massachusetts Law Reform Institute** ("MLRI") is a statewide poverty law and policy center. Its mission is to advance economic, racial and social justice for low-income people through legal action, administrative and legislative advocacy, coalition building, and provision of information about laws, policies and practices that affect low-income individuals.

For nearly fifty years MLRI has been recognized as a leading expert in Massachusetts law and practice in housing and statewide benefits programs, including the Emergency Assistance shelter program ("EA"). MLRI has long worked to protect the rights of families experiencing homelessness across the Commonwealth, including those with disabilities, by providing training, support, and technical assistance to families, legal services attorneys, and other

advocates assisting families seeking to enter and currently in the shelter system. MLRI recently published the 9th edition of the EA Advocacy Guide, produced in conjunction with an annual EA shelter training program as part of MCLE's Basic Benefits series, and has produced several policy reports related to the EA shelter system. MLRI and DHCD recently settled a complaint related to the provision of language access services for non-English speakers in the EA system.

In 2015 MLRI, Boston Children's Hospital, and Horizons for Homeless Children were selected as one of four grantee teams for the Boston Foundation's Health Starts at Home project. The four-year initiative seeks to bring housing and healthcare organizations together to demonstrate the positive benefits of stable housing on children's health. The initiative employs custom evaluation processes designed to measure the effectiveness of the grantee programs, and to guide and inform future policies. MLRI serves as the legal arm of its partnership, providing intensive, wraparound legal services to families of young children who receive medical care at a community health center and have been identified as housing

unstable. Many of the legal needs presented relate to EA shelter. The **Center for Public Representation** ("CPR") is a non-profit legal advocacy center for people with disabilities with offices in Northampton and Newton, Massachusetts and Washington D.C. CPR uses legal strategies to promote the integration and full community participation of people with disabilities, including access to integrated and accessible housing and to effective community-based services. CPR staff were among the founding members of the Western Massachusetts Network to End Homelessness.

The **Disability Law Center** ("DLC") is the the federally mandated Protection and Advocacy (P&A) agency for Massachusetts. The P&A system is a national network of disability rights agencies investigating abuse and neglect and providing legal representation and other advocacy services to people with disabilities. See, e.g., Protection & Advocacy for People with Developmental Disabilities (PADD) Act. 42 U.S.C. § 15043(a)(2)(B); Protection & Advocacy for Individuals with Mental Illness (PAIMI) Act , 42 C.F.R. § 51.42(c)(2) and Protection & Advocacy for Individual Rights (PAIR) Act.

DLC's mission is to provide legal advocacy on disability issues that promote the fundamental rights of all people with disabilities to participate fully and equally in the social and economic life of Massachusetts. As part of this work, DLC has provided systemic advocacy and individual representation to persons with disabilities on issues of housing and homelessness.

STATEMENT OF THE CASE AND STATEMENT OF THE FACTS

The amici curiae adopt and incorporate by reference the statement of the case and statement of the facts set forth in Appellee's brief.

SUMMARY OF ARGUMENT

DHCD has two core legal obligations in administering the EA system: to provide shelter to eligible families experiencing homelessness, and to do so in a way that does not discriminate against people with disabilities. At issue in this case is whether the Superior Court properly issued a narrowly tailored injunction instructing DHCD to consider and use hotels as shelter placements for individuals with approved

ADA requests, where a hotel could reasonably accommodate such persons. Specifically, the Superior Court found that a) the Legislature directed DHCD to use hotels and motels as an option in sheltering EA eligible families; b) the ADA and Massachusetts law require DHCD to ensure people with disabilities have full and meaningful access to the EA program; c) the needs of some families with approved reasonable accommodation requests go unmet because DHCD refuses to place them in hotels; and d) those families are suffering irreparable harm.

Plaintiffs have demonstrated that DHCD unlawfully refuses to make hotels available to accommodate disabilities, and the Superior Court made clear that DHCD may not simply avoid its obligation to comply with federal law. The urgent need for the injunction in question is not merely theoretical: against the backdrop of the considerable challenges facing families experiencing homelessness, including the growing shortage of affordable housing, people with disabilities may suffer insurmountable mental and physical harm as a result of inappropriate shelter placements. Amici will provide greater context for the human costs suffered by people with disabilities

who are experiencing homelessness and why DHCD must not be allowed to thwart the underlying intent of the ADA.

ARGUMENT

I. HOTELS AND MOTELS ARE ALREADY PART OF THE EA SHELTER SYSTEM, FOR IMPORTANT PUBLIC POLICY REASONS.

It is undisputed that the families who were granted relief under the court's targeted preliminary injunction include individuals with qualified disabilities who are entitled to a reasonable accommodation. Plaintiff class members have already been determined by DHCD to be qualified individuals with a disability and have been granted an accommodation, yet DHCD refuses to make a hotel available even if the hotel would immediately accommodate the disability. Since there is no argument about whether the class members have a disability, the only issue is whether DHCD, by refusing to even consider hotels as shelter placements, is discriminating against qualified individuals with disabilities. The answer is clearly yes.

What is not at issue in this case is the question of whether hotels should or should not, as a matter of

policy, be used to shelter families experiencing homelessness. The authority over this decision rests with the Legislature, which has explicitly mandated the use of hotels and motels when appropriate. Nor do amici advance the position that hotels are ideal shelter facilities as a general matter.[1] However, where appropriate congregate, co-housing or scattered site placements are not available to disabled persons and their families, a hotel placement is not merely a preference – it is the only lawful placement that DHCD may make available.

Among the factors for the court to weigh in considering whether the injunction was appropriate is where the public interest lies. The damage caused by DHCD's discrimination not only affects the individuals with disabilities who are denied an appropriate shelter placement, but also raises important public

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[1] While amici acknowledge that hotels are imperfect placements for some families, the unfortunate reality is that many congregate, co-housing and scattered site shelters are rife with many of the same issues DHCD claims render hotels inappropriate (unsafe conditions, mold, rodent infestations, lead paint hazards, etc.); amici's experience also shows that homeless services, which DHCD has emphasized as a primary benefit of congregate shelters, are not consistently beneficial to families. Federal and state law obligate DHCD to first consider disabilities in determining appropriate placements, and hotels provide the flexibility to be available when they are needed.

policy implications. Amici describe the urgent and irreparable harm families have suffered as a result of DHCD’s discrimination and place the consequences of these harms in a broader context. Homelessness alone presents many challenges, but for those with disabilities the disruption can be catastrophic. There is a growing body of medical, public health, and social science research demonstrating the negative effects of homelessness on disabled people, particularly children. Medical providers, for example, have begun to identify and measure healthcare spending directly attributable to homelessness and housing instability and are employing innovative strategies to prevent it, such as directing Medicaid dollars towards housing.[2] In fact, Massachusetts has been a national leader in pioneering this type of model, designating Medicaid dollars to provide housing and services for chronically homeless individuals identified as high utilizers of emergency medical care. See CSH, Massachusetts Tenancy Support Service (Fall 2016). DHCD’s discriminatory policy undermines the well-intentioned and laudable goals of providing a

[2] The grant-funded HSAH collaboration between MLRI and Boston Children’s hospital is one example of innovation to specifically address this issue.

comprehensive approach to family homelessness in Massachusetts.

Plaintiffs have demonstrated that this policy discriminates against individuals with disabilities. The EA program as established and funded by the Legislature (including provisions for the use of hotels) cannot be administered in a way that discriminates against people with disabilities – thereby violating state and federal law – unless doing so would require a fundamental alteration to the program. DHCD argues that using hotels and motels to implement approved ADA requests would contravene its "no hotels" policy change and thereby represent a fundamental alteration to the EA system. However, it is difficult to comprehend how this could be, since hotels and motels are specifically authorized by the Legislature, have been used to shelter families for years, and DHCD does not deny that they continue to be used today. P. Br. 15-17; RA 252-255. The words "shelter" and "hotel/motel" regularly appear together in DHCD's public materials and reports. There is no indication that hotels are anything other than an available type of shelter.

II. FAMILY AND CHILD HOMELESSNESS IN MASSACHUSETTS.

Massachusetts and New York hold the dubious distinction of being the only states where families with children make up over half of the shelter population.[3] The number of people experiencing homelessness in Massachusetts is, as it is nationally, steadily increasing.[4] Over 31,000 children experience homelessness in Massachusetts each year, and in the 2016-2017 school year, there were over 21,000 children experiencing homelessness enrolled in Massachusetts public schools – nearly 22% of the approximately 950,000 students enrolled that year. Massachusetts Department of Education and Secondary Education, Information Services – Statistical Reports.

[3] Child homelessness, having first emerged as a major problem in the 1980s, has increased dramatically in a mere three decades or so; data show there were over 1.3 million homeless children in public schools nationwide in the 2015-2016 school year. Bassuk et. Al., America's Youngest Outcasts 14, https://www.air.org/resource/americas-youngest-outcasts-report-card-child-homelessness.

[4] Accurate numbers are difficult to ascertain given variations in definitions of homelessness, methods of counting, and logistical complications, but the upward trends are consistent. Two of the most commonly cited sources of national data are those published by the United States Department of Housing and Urban Development (HUD) and the United States Department of Education (ED). While both likely undercount actual numbers of people experiencing homelessness, they are nevertheless widely cited.

Alleviating homelessness has proven to be as complicated as the factors that cause it. Despite concerted efforts that have been made to end homelessness[5] it persists and, by many indications, is getting worse. National Law Center on Homelessness & Poverty Protect Tenants, Prevent Homelessness (2018) (hereinafter "NLCHP Protect Tenants"). The foreclosure crisis that began in 2006, during which millions of homeowners lost their homes, sparked the 2008 recession, which in turn caused a massive downturn in the labor market. This series of economic crises undoubtedly pushed untold numbers of people into homelessness, and the fallout has not yet ended. See National Coalition for the Homeless et. al., Foreclosure to Homelessness 2009; see also NLCHP Protect Tenants. While there are some signs of uneven recovery in housing sales markets, there are other troubling indications that a new housing crisis is upon us – a renters' crisis marked by skyrocketing

[5] In 2010 the United States Interagency Council on Homelessness unveiled a strategic plan to prevent and end homelessness. See Opening Doors: Federal Strategic Plan to Prevent and End Homelessness (June 2015), https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf; numerous cities and state governments, including Boston, have implemented similar plans.

rents, stagnant wages, evictions, and a lack of affordable housing.

In Massachusetts, the low and dwindling supply of available rental units and quickly climbing rents are obvious contributors to the growing crisis of homelessness. The number of renters is at historically high levels nationwide, and analysts forecast a "bleak picture" for the problem of rent burdens – the amount of income paid toward rent – in the next decade. Charette et. al., Projecting Trends in Severely Cost-Burdened Renters: 2015-2025, Enterprise Community Partners & Joint Center for Housing Studies 6,16 (2015). 38% of Massachusetts households – nearly 1 million – are renters. In 2016 the rental vacancy rates in Massachusetts dipped to 4.1%, the lowest rate since 2001. See U.S. Census Bureau, Rental Vacancy Rate for Massachusetts (MARVAC), retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/MARVAC, April 22, 2018; see also U.S. Census Bureau, Housing Vacancies and Homeownership (2017).

The shortage of vacant, affordable rental housing is more acute for people at lower income levels, and is worst for Extremely Low Income (ELI) households,

defined as those making either less than 30% of the area median income or below the poverty level. See Doherty, Further Evidence of Worsening Affordability for Renters, U.S. Interagency Council on Homelessness (Nov. 2017). There is no state in the country that has enough affordable housing for ELI households. National Low Income Housing Coalition, The Gap: A Shortage of Affordable Homes (hereinafter "NLIHC The Gap") 8 (Mar. 2018). There are nearly 300,000 ELI households in Massachusetts but there are only 137,219 affordable units available – a deficit of over 162,000 rental units for ELI families. This means there are only forty-six available affordable units for every one hundred ELI households statewide. Disabled people are overrepresented in ELI households; nationally, 44% of disabled households with children have extremely low incomes. Id.

Related to the increasing number of renters and shortage of affordable units is the surge in the number of households that are rent or cost burdened. Cost burdened households are defined as those who spend more than 30% of their income in rent, and severely cost burdened households spend more than 50%

of their income on rent.[6] In Massachusetts, 72% of ELI renters paid over 30% of their income for rent, and 60% of them paid over half their income towards rent. National Low Income Housing Coalition, Gap Report: Massachusetts, http://nlihc.org/gap/2016/ma. A Massachusetts worker earning minimum wage (currently $11.00/hr.) would have to work eighty hours a week to afford a modest, one-bedroom apartment. The picture is worse for non-elderly disabled people. There is no state in the country where a person with disability-based Supplemental Social Security Income (SSI) as the sole income source can afford a clean, safe rental unit. In Massachusetts the monthly SSI award amount was $847 in 2016; the average one-bedroom apartment would cost 133% of this amount, leaving no money for food, transportation, or other necessities. Technical Assistance Collaborative, Inc., Priced Out (2016).

The consequences for rent burdened households are dire, forcing families to make impossible choices.

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[6] In 2015, 26% of renter households nationally paid over half their incomes towards housing – a rate that exceeded 70% for households earning less than $15,000 per year. Joint Center for Housing Studies of Harvard University, The State of the Nation's Housing (2017), available at http://www.jchs.harvard.edu/research/state_nations_housing.

Severely cost burdened families with children were found to cut back primarily on food and healthcare spending; they have difficulty saving for emergencies and had to spend more on transportation to reach employment and other needs. Joint Center for Housing Studies, The State of the Nation's Housing (2017) at 33. Cost burdened families are often forced to "sacrifice quality for cost," living in deficient and inadequate housing. Id. Cost burdened families were also more likely to fall behind on rent and be threatened with eviction or be evicted.

This combination of factors traps many families in a vicious cycle – the lack of affordable housing forces families to live in sub-standard housing, causing health problems and increasing the likelihood of evictions; repeated evictions decrease a family's chances of finding suitable new housing, increasing the chances that a family will become homeless. Indeed, new research points to a national eviction crisis, inextricably linked to poverty and race that is leading directly and unsurprisingly to increased homelessness and its many pendant problems.

III. HOMELESSNESS AND DISABILITY.

The fundamental purpose of the ADA, and its reasonable accommodation requirement, is to ensure that individuals with disabilities have equal access to the same benefits, programs, and services as those without disabilities. Thus, with respect to those special accommodations needed to ensure that homeless individuals with disabilities have meaningful access to DHCD's EA program, the public entity must afford those individuals who need accommodations like proximity to health care providers or changes in type of shelter those modifications in a timely manner.

Homelessness in families is associated with poorer physical health, high levels of exposure to conflict trauma and violence, and higher incidence of mental health conditions requiring treatment. Many of Massachusetts’s most vulnerable residents are experiencing family homelessness – a difficult experience for each family in EA shelter. Those families with disabilities experience an even higher level of difficulty, an inequity the ADA was created to help address.

A. **Health and disability among parents, especially mothers, experiencing homelessness.**

The vulnerable populations of homeless families are likely to suffer from a myriad of social, health and other harms that make exiting homeless difficult. This difficulty is exponentially compounded when the caregiver or other family member has a disability. In Massachusetts, as nationally, a typical homeless family is headed by a single woman. See Rog et. al., Homeless Families and Children, 2007 National Symposium on Homelessness Research 5-8; see also Rog et. al., The Growing Challenge of Family Homelessness: Homeless Assistance for Families in Massachusetts, The Boston Foundation (Feb. 2017) 18-19. Her physical and mental health is likely to be poorer than housed mothers[7]. She is four times as likely as the general population to suffer from asthma, ten times as likely to suffer from chronic anemia and four times as likely to suffer from chronic ulcers. Rog, Homeless Families and Children at 5-9.

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[7] Twelve percent of EA households consist solely of a pregnant woman. Rog, Growing Challenge at 18. The common experience of post-partum depression, which can be very disabling, is both a predictor and an outcome of homelessness. Marcal, A Theory of Mental Health and Optimal Service Delivery for Homeless Children¸ 34 Child Adolescent. Soc. Work Journal 349, 351 (2017).

More than 90% of mothers experiencing homelessness had experienced "severe physical and sexual abuse, domestic violence, or random violence." Bassuk et. al., The Characteristics and Needs of Sheltered Homeless and Low-Income Housed Mothers, American Journal of the American Medical Association 640-646 (1996). Therefore it is not surprising that homeless mothers are three times more likely than the general female population to suffer from Post-traumatic Stress Disorder. Hopper et. al., Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings, 2 Open Health Services and Policy J. 131, 147-48 (2009). Homeless mothers are also 2.5 times more likely to have major depressive disorder than the general female population. Rog, Homeless Families and children at 5-9.

These statistics are consistent with the preliminary findings in the HSAH project. In the ongoing study of the Massachusetts housing instable families the project works with, 33% of caregivers characterize their health as fair or poor, well below the self-rated health of MA adults generally. 72% of caregivers experience symptoms of anxiety disorders, and 79% exhibit symptoms of depressive disorders.

One young homeless mother in the HSAH study, L.O., exemplifies much of the above. She is a survivor of domestic violence by the father of her child. She has been diagnosed with Major Depression, an anxiety disorder and PTSD. In the congregate shelter where she and her son resided, the symptoms escalated so much that she was unable to use the shared cooking facilities. She made an ADA request for a transfer to a non-congregate setting. Before the ADA was implemented, she was seen at the emergency room following a panic attack and had to take a Temporary Emergency Shelter Interruption (TESI) rather than return to the congregate shelter.

B. Health and disability among Massachusetts children experiencing homelessness.

Homeless children are at elevated risk for medical, emotional, and behavioral conditions. This prevalence is directly associated with poverty: of Massachusetts children living under the federal poverty rate, 14% have one or more chronic conditions, 19% have asthma, and 12% have ADD/ADHD. Bassuk et. al., America’s Youngest Outcasts at 44 (2014); see also Tobin, Addressing the Challenges of Child and Family Homelessness, 4 J. of Applied Research on

Children: Informing Policy for Children at Risk Art. 9, 4 (2013) (homeless children are four times as likely to have asthma, have higher risk for other health conditions).

There has been increased study of the mental health disabilities in homeless children and their treatment needs during the time they are homeless. Up to 26% of preschoolers and 40% of school-age children experiencing homelessness have conditions requiring clinical or psychiatric mental health interventions. Bassuk et. al., The Prevalence of Mental Illness in Homeless Children: A Systematic Review and Meta-Analysis, 54 J. of the Am. Acad. Of Child and Adolescent Psychiatry 86, 94 (2015). Homeless youth are twice as likely as housed youth to experience emotional distress, suicidal ideation, or suicide attempts. Barnes et. al., Emotional Health Among Youth Experiencing Family Homelessness, 141 Pediatrics 1, 4 (2017). Eighty-six percent of homeless youth report exposure to trauma, with almost two-thirds reporting exposure to multiple traumatic events. Hopper at 148.

Again, these themes comport with the preliminary findings among the HSAH study families. 15% of the

children enrolled in the HSAH study exhibit fair or poor health; 21% showed moderate or high risk for developmental or behavioral disabilities.

C. Types of disability accommodations.

Despite the breadth of challenges presented by parents and children with disabilities who are experiencing homelessness, relatively few families require the type of accommodation that would fall under the narrowly tailored preliminary injunction issued by the Superior Court.[8] Put another way, a hotel or motel is only an appropriate accommodation – even on an interim basis – for a very small set of Massachusetts shelter residents. For those who require it, however, irreparable harm is inflicted by DHCD's refusal to consider hotels when making placement decision.

Changes in placement, type, or accessibility of shelter are required to accommodate disabilities, a fact DHCD acknowledges. For some families, disability-related needs implicate the shelter

[8] As of October 4, 2017 the EA system contained 187 families with approved but unfulfilled ADA requests for transfers due to disability-related needs. RA 397. The evidence suggests that a hotel placement would be an appropriate accommodation for a subset of those families.

environment itself, typically where a congregate shelter is medically inappropriate. For example, MLRI's HSAH attorney represented N.A., a mother with an eight-year-old autistic child, who became homeless after she was forced out of the apartment where she was staying due to her child's autistic behaviors, including noise and boundary issues. When she applied for EA shelter N.A. requested a placement in a non-congregate shelter. She supported her request with medical documentation that a shared, noisy environment would be untenable for her son. For N.A.'s son and others, a non-congregate shelter is required to meaningfully access and participate in the EA program.

For other individuals, accommodations may take the form of proximity to ongoing treatment and care.[9] Where congregate or scattered site shelters are not

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[9] In one study, 32% of homeless adults reported an inability to get needed medical or surgical care and 21% reported an inability to get needed mental health care. Baggett et. al., The Unmet Health Care Needs of Homeless Adults: A National Study, 100 Am. J. of Pub. Health 1326, 1328 (Jul. 2010). While the exact figures are difficult to ascertain, the medical and social costs of delayed care inevitably create additional financial burdens on the Commonwealth. Children's HealthWatch estimates that nationally, $111 billion in healthcare and education costs would be saved over 10 years by addressing family homelessness. Children's HealthWatch, Stable Homes Make Healthy Families (July 2017), http://childrenshealthwatch.org/wp-content/uploads/CHW-Stable-Homes-2-pager-web.pdf.

available nearby, hotels are the only viable option for certain people with disabilities who must remain close to their providers. Experts stress the importance of continued and stable access to care to effective treatment of disabilities and other health conditions. Barnes at 4.

Continuity of care is extremely important to effective management of mental health conditions, as personal, trusting relationships between provider and client are central for recovery and progress. See Adair, Continuity of Care and Health Outcomes Among Persons with Severe Mental Illness, Psychiatric Services 1061, 1068 (finding "consistent, positive relationships between continuity of care and quality of life [and] community functioning [] among persons with severe mental illness"); see also Allen et. al., Continuity of Provider and Site of Care and Preventive Services Receipt in an Adult Medicaid Population with Physical Disabilities, 2 Disability Health J. 180, 187 (2016)("[A] regular site of care and access to one's own doctor [are] two essential features of a delivery system for people with disabilities that enhance access to preventive services").

People with disabilities also need access to

primary care. Studies show that everyone uses primary care more often when there is an established, usual source of primary care available. White et. al., Access to Primary Care Services Among the Homeless: A Synthesis of the Literature Using the Equity of Access to Medical Care Framework, 6(2) J. of Primary Care and Cmty. Health 77, (2015). Not surprisingly, access to primary care is associated with lower mortality; rates of hospitalization increase for preventable conditions when access to primary care is decreased. Id. When access to established primary care is impeded by distance, lack of transportation or other barriers, the ability to manage acute and/or chronic conditions and disabilities decreases. Id. DHCD's approval of ADA requests for access to providers is an acceptance that disabled individuals must be afforded the opportunity of ongoing treatment with providers who have a preexisting familiarity and relationship with the individual.

D. Social networks are important for people with disabilities.

Homelessness is in and of itself a disruption of life; shelter placements that isolate homeless families is detrimental to families who rely on their

social networks for things such as childcare, transportation, help getting to medical care, job opportunities, and emotional support. While remaining in their home community benefits all homeless families, those with disabilities stand to lose access not only to their care, but also all of their support systems. The harmful effects of removal from the home community are amplified when considering the educational impacts on disabled children.

The Legislature has recognized the importance of social networks in its mandate that "an eligible household that is approved for shelter placement shall be placed in a shelter as close as possible to the household's home community unless a household requests otherwise." St. 2017, c. 47, §2, item 7004-0101. An effective social network helps families stay out of homelessness and also assists them in exiting it. This network - forged of formal and informal connections such as relatives, co-workers, providers, religious institutions, and community members – combats isolation; without this network of relationships "it is extremely difficult for families to exit homelessness, and almost impossible for them to remain housed." Tobin at 11.

R.P., a young mother who made ADA requests for a Boston-area placement at the time of her application for EA shelter, was placed in shelter nearly sixty miles from her home community. She was unable to access her ongoing mental health services for psychiatric disabilities related to her experience of domestic violence, and was triggered by frequent knocks on her shelter door at night by unknown persons. Further, she did not have a car and public transportation was inaccessible, so she quickly lost her job in the Boston area. She was transferred to a hotel by DHCD and immediately restarted treatment for herself and her young son. With transportation and child care assistance from her social networks, she was able to find an apartment and moved out of the hotel approximately one month after entering.

The harm of disruptions due to homelessness is readily apparent in the realm of education. Among the important rights provided by the McKinney-Vento Homeless Assistance Act, 42 U.S.C. § 11301 et seq., is that homeless children be allowed to attend the school they were attending before they became

homeless.[10] This continuity is especially critical to children with disabilities. Many children with disabilities have individualized education programs (IEP/ISP) created pursuant state and federal law. 20 U.S.C. §§ 1400-1428 (Individuals with Disability Education Improvement Act); 29 U.S.C. § 794 (Section 504 of Rehabilitation Act); G.L. c. 71B. IEPs/ISPs are specifically and individually tailored for children with special education needs and consistent implementation by trained professionals familiar with the student is critical to a child's education and development.

Even when McKinney-Vento protections allow disabled children to remain in their own school while experiencing homelessness and being placed outside their home community, there are other associated harms, some having to do with the length of transport. Amicus MLRI represented G.L., the mother of a nine-year-old boy with autism spectrum disorder who attends

[10] Despite the McKinney-Vento protections, however, homeless children are twice as likely as their peers to have attended multiple schools in the past six months. Walker et. al., Adolescent Well-Being after Experiencing Family Homelessness, OPRE Report No. 2016-41(June2016) 1, available at https://www.acf.hhs.gov/sites/default/files/opre/opre_homefam_brief3_hhs_adolescents_061016_b508.pdf.

a specialized school and another child with a behavioral disability and related ISP. The family was placed outside their home community and submitted multiple requests under the ADA for a transfer to a shelter location closer to the children's schools. During the pendency of their request (approximately one year) the autistic child frequently became dysregulated on the hour to hour-and-a-half bus rides to his school. On multiple occasions he was so dysregulated by the time he arrived at school that he was unable to join his classmates.

IV. FORCING FAMILIES TO WAIT FOR APPROPRIATE SHELTER PLACEMENTS VIOLATES DISABILITY-BASED DISCRIMINATION LAWS.

DHCD has asserted, both implicitly and explicitly, that they are not refusing to accommodate families' disability-related needs, merely that families have to wait until an appropriate space becomes available. The purpose of the ADA is to ensure that people with disabilities have the same rights as others. Shelters are intended to provide safe, temporary residences for families with children to stay when they have no other options. While shelter living is undeniably challenging, the granting of an accommodation is an acknowledgment that the

accommodation is necessary for the disabled individual to participate in the EA system. The accommodation may be a hotel placement, yet DHCD refuses to make it available.

There are any number of barriers low-income people encounter when seeking to enforce their legal rights, but the unlawful placement of disabled families into inappropriate shelter units is uniquely difficult to challenge. The emergency nature of homelessness combined with the process of shelter application and placement create situations where DHCD effectively holds unilateral power over where the family is placed, whether appropriate or not. The disabled shelter seeker is not free to choose between an appropriate placement and one that will exacerbate her conditions – she <u>must</u> accept the placement that is offered to her or have no place to go that night <u>and also</u> risk being barred from shelter altogether for a full year, even if the placement does not meet her disability related needs.

The EA application process requires families not only to show that they are homeless for a qualifying

reason;[11] they also must have "no feasible alternative housing." In practice, this means that when a family presents at the DHCD office to apply for shelter, in order to be approved for placement they must affirmatively demonstrate that they have nowhere to stay that evening.[12] Then, and only then, their application can be approved and they are given a shelter placement. At that moment, often late in the day, the family has no option but to accept the placement they are offered, even if that placement clearly does not meet the family's disability needs. Furthermore, the regulations create dire consequences for the family if they turn down any shelter placement: "If an applicant EA household […] refuses a placement offered by the Department, the household will be ineligible for EA for the 12 months following the refusal or failure to appear." 760 Code Mass.

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[11] Those prongs are: (1) a household at risk of or homeless after having fled from domestic violence, (2) homeless due to fire, flood or natural disaster, (3) a limited set of types of no-fault evictions, or (4) being in a "housing situation where the household members: a. do not include the primary lease holder; or b. the child(ren) of the household are in a housing situation not meant for human habitation, and where; c. there is a substantial health and safety risk to the family that is likely to result in significant harm should the family remain in such housing situation." 760 Code Mass. Regs. § 67.02.

Reg. 67.02(10).

N.A., the mother discussed above (pg. X, infra) was placed in this quandary. She and her autistic son were offered a placement in a congregate shelter 30 miles from his care. She had no other options and could not face a 12-month ban, so she accepted the placement. Their stay was a disaster from the start. The excessive stimulation of the congregate shelter setting caused her son's behavior to became dysregulated; he began biting his wrists and exhibiting other self-harming behaviors. He lacked the physical control to wait for the shared bathroom to become available and had to urinate in a bucket in the family's room. He soiled himself while waiting to access the shared bathroom for a bowel movement. His in-home therapist was geographically limited from coming to the city where the shelter was located. While the family waited a relatively short time to be transferred to a unit that partially fulfilled the needed accommodation, the days in the inappropriate shelter caused irreparable harm – harm that N.A. and the child's provider's had predicted.

Other families, many without advocates, spend months in similar situations. Y.A. is a homeless

mother of two children who was placed in a congregate shelter unit. Her thirteen-year-old son has been diagnosed with multiple psychiatric and behavioral conditions. After reviewing medical documentation explaining that the shared living conditions were aggravating the son's symptoms and that the family urgently needed to be moved, DHCD approved Y.A.'s request for a transfer to a scattered site or co-housed location in October 2016. Y.A. waited expectantly for news of her transfer while her son's condition worsened daily. In August 2017 -- ten months later – the provider wrote another letter stating that the progress made at the beginning of the son's treatment was lost, and that the inappropriate shelter setting had led to increasing symptoms and significant deterioration of his condition. The stress of the situation was also aggravating to mother's psychiatric disability. Only in October 2017, a full year after DHCD had determined that an accommodation was required under the ADA, was the family transferred. The child is doing significantly better in managing his symptoms since the move.

CONCLUSION

Homelessness is a growing crisis with no simple solutions. Though there is general agreement among policymakers that homelessness prevention represents a cost savings as compared to emergency service provision, efforts are too often stymied by the severe shortage of affordable housing. As policymakers and researchers continue to grapple with causes and effects of the twin tragedies of poverty and homelessness, it is essential to continue to safeguard the legal rights of people experiencing homelessness. While exiting homelessness and finding stability is a challenge for any person, for those who are disabled, just the experience of homelessness can be disastrous if the disability-related needs go unaddressed. This is the very purpose and intent of the ADA – to ensure that people with disabilities are able to access necessary benefits, such as emergency shelter, in the same way that non-disabled people can.

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MASS. R. A. P. 60(K) CERTIFICATION

I certify to the best of my knowledge that this brief complies with court rules pertaining to filing of briefs, including, but not limited to: Mass. R. A. P. 17 (brief of an *Amicus Curiae*) Mass. R. A. P. 16(a)(6) (pertinent findings or memorandum of decision); Mass. R. A. P. 16(e) (references to the record); Mass. R. A. P. 16(f) (reproduction of statutes, rules, regulations); Mass. R. A. P. 16(h) (length of briefs); Mass. R. A. P. 18 (appendix to the briefs); and Mass. R. A. P. 20 (form of briefs, appendices, and other papers).

Date: April 24, 2018

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CERTIFICATE OF SERVICE

I certify that on this day the 24th day of April 2018, I caused two copies of this brief to be served on each party of record via first class mail at the addresses below, and for the original to be filed with the court electronically.

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