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Solving Unsheltered Homelessness Starts with Rejecting the Current Interpretation of *Olmstead* (1999):

A CLINICAL AND POLICY PERSPECTIVE

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The U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.* found the unjustified segregation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act (ADA). Since that decision, *Olmstead* has been interpreted to require community living in the least restrictive setting for anyone with a disability addressed by the ADA. As a result, one demographic that has been severely penalized is Americans living with serious mental illness (SMI) and addiction unsheltered and untreated on our streets.

The federal interpretation of the court finding has been translated to mean that those with disabilities related to serious mental illness (SMI) and addiction who lack shelter must be housed in single dwelling units within communities and that any necessary medical or psychiatric services be provided. This is unworkable.

Many with such disabilities have cognitive issues that prevent attendance at clinical visits. The expectation is that medical services be brought to the individual because these conditions impact a person's understanding that they have an illness that warrants treatment and features cognitive deficits resulting in the inability to organize one's daily activities to appropriately care for life needs. Keeping medical appointments is just one example. Moreover, the interpretation of Olmstead has resulted in the closing of nursing homes, group homes, and other congregate settings in favor of services to be delivered to individuals in single dwellings. This has led to circumstances across the nation where people with many types of disabilities cannot access needed skilled care. Instead, a system of home health care was put in place that is rife with fraud and too often fails to provide the necessary level of care.

The *Olmstead* decision and its interpretation by the federal government have contributed to a lack of necessary treatment resources and housing for the population of Americans with SMI and/or severe substance use disorders. In the most severe cases, the complexity of accessing resources and treatment leads to cycles of unsheltered homelessness, incarceration, and chaos on American streets. The patchwork of government solutions available at the federal, state, and local levels to provide healthcare, housing, and support has become a morass that too often results in a failure of systems and individuals going untreated and living unsheltered on the streets. The consequences are deadly and contribute to a level of destitution, poverty and illness that is unacceptable and requires change

The Clinical Perspective

Serious mental illnesses including schizophrenia, schizoaffective disorder, and bipolar disorder have a well-researched set of data exploring the long-term course of these diseases. One fact is that nonadherence to prescribed medications and untreated psychosis have serious adverse effects on the individual and disease course (Sarpal 2017; Maximo et al 2020). Brain changes that impair thinking and reasoning are associated with symptoms that become more resistant to antipsychotic treatment over time and lead to the need for higher medication doses and increased side effects (Hiroyoshi 2019). Increased social withdrawal and loss of motivation, violent behaviors in some with such histories, as well as increased

hospitalizations, and early death often by suicide have all been associated with treatment noncompliance (Correll and Schooler 2020; Korkmas and Simsek 2025; Hawton et al 2005). One of the symptoms of psychotic disorders is anosognosia or the lack of awareness that one has an illness needing medical treatment. This symptom is also prominent in those with severe drug and alcohol use disorders.

Another fact is the ability for those who receive involuntary treatment to resolve hallucinations and delusions and regain the cognitive ability to care for themselves in the community. Those with SMI who have documented histories of violence - be it toward self, others or property - need to be compelled by civil commitment to continue mental health treatment. This is necessary for public safety and for the health of the affected person. However, people with SMI often argue that they should not be compelled to continue medication or other therapeutic interventions. The courts too often accept this rationale pushed by protection and advocacy groups that work to release seriously ill people from any obligation to adhere to psychiatric treatment. Regardless of a person's history, being released from treatment often continues a sad tale of multiple psychotic breaks, hospitalizations, criminality and incarceration, and unsheltered homelessness.

Impacts on Therapeutic Settings

Olmstead's interpretation requires independent community living for individuals with very serious mental illnesses. This mandate, in conjunction with efforts from protection and advocacy groups (Disability Law Centers nationwide), has relegated over 147,000 to the streets and even more to jails. Protection and advocacy groups argue aggressively to permit ongoing untreated illness and against the placement of the seriously mentally ill into therapeutic settings putting at odds the clinical needs of this demographic with the purported civil liberty perspective of these advocate groups.

People with SMI have an illness characterized by chronicity of disorganized thinking, paranoia, delusions, and hallucinations most often of an auditory or visual nature. They generally benefit significantly from administration of antipsychotic medication. Those with the most serious mental illnesses may not have complete symptom resolution, but enough remittance to be able to live in the community. Today, people with SMI are often drug users. Cannabis and methamphetamine are the most frequently used drugs and exacerbate psychosis (Urits et al 2020; Glasner-Edwards and Mooney 2014). Currently, these individuals, need ongoing oversight for their safety and for the safety of the community.

Skilled behavioral health oversight that is inclusive of long-term psychiatric and other medical care is not currently available in independent home living. Those with severe mental illnesses and substance use disorders who have lived with family may become so ill and dangerous that family support is no longer possible. Indeed, some families apply for restraining orders because of the threat of violence when their family member is experiencing delusional psychosis. Such individuals need housing and treatment.

Policies adopted after *Olmstead* have limited group home settings in favor of single residency facilities resulting in a severe decline in the availability of groups homes, nursing homes, and other congregate facilities to serve this demographic. Medicaid has increased scrutiny to reimbursement of congregate facilities such as group homes that is so restrictive that the establishment of these critically necessary facilities is impractical. CMS approaches group homes as "presumptively institutional" settings and subjects them to added and unnecessary rigor. CMS requires state agencies to closely review specific categories of group homes. These include group homes that are part of institutional settings (for example, step-down units for individuals who have been hospitalized and are moving toward community placement), group homes located near an institutional setting such as a hospital or nursing home, or any group home that is deemed to be separating disabled individuals from the greater community. Group homes are closely monitored on personalized treatment and autonomy and must ensure choice in setting daily schedules, roommates, living arrangements and access to visitors. Further, there must be opportunities for employment, access to community resources, and no restrictions with whom residents interact.

The physical environment required of group homes must be that of a typical residential home including private or semi-private rooms with locking doors (CMS 2022). Some of these requirements are nonsensical for group homes that attend to the needs of people living with SMI and addiction. For example, in a therapeutic setting it is important to have client/resident participation in some home activities as a means of monitoring mental status and any needs that will require attention daily. Further, it is a safety risk to put locking doors on resident rooms for individuals with histories of self-harm or harm to others. Visitation must also be controlled particularly for those recovering from substance use disorders. To allow visitors who may have or be using drugs into a facility assisting people to recover from drug use disorders or whose mental illness would be exacerbated by substance use requires that staff monitor visitors and maintain a safe environment.

Staffing

Healthcare provider shortages in behavioral health makes the rigid enforcement of *Olmstead* for unsheltered homeless with SMI and addiction unworkable and condemns some of our most vulnerable to no treatment and no shelter. The current status quo assures continued unsheltered homelessness and incarceration as well as inappropriate use of emergency departments for crisis intervention.

There currently exists a severe shortage of mental health providers, according to the Health Resources and Services Administration (HRSA). In 2025, 40 percent (137 million) of the U.S. population lives in a Mental Health Professional Shortage Area (Mental Health HPSA). There is a substantial deficit in the psychiatric and addiction workforces, which has been forecasted to continue and projected by 2038 to reach shortages of nearly 100,000 mental health counselors and 43,000 psychiatrists (HRSA 2025). These shortage estimates do not

include consideration of the more intensive behavioral health services that are necessary to provide single-home occupancy services to those currently living unsheltered on American streets with SMI and addiction. This lack of behavioral health providers undermines the task of frequent interaction with individuals with these disorders to assure treatment compliance, address any adverse effects of treatment, other illnesses, and safety issues.

Policy Recommendations

To address the crisis caused by the lack of treatment to the unsheltered with SMI and substance use disorders broad policy reforms should be considered to immediately remedy the current situation:

- **Increase the implementation of the Certified Community Behavioral Health Clinics** to increase access to integrated mental health, substance use disorder, and physical health treatment and crisis interventions,
- **Facilitate the establishment of 16 bed (or smaller) group homes** to address the shortage of therapeutic living facilities. Placement of group homes that are 16 beds or less should be within communities where access to community resources and services, as well as employment opportunities for those able to work are readily available.
- **Expand the use of HUD Continuum of Care funds to pair mental health and substance abuse treatment with housing**, preferably in group settings that can provide 24/7 oversight to clients. Make resources available at the state level with assistance from federal agencies to address mental health care, physical healthcare, and housing simultaneously using a multidisciplinary team approach and community supports to achieve positive treatment and housing outcomes.
- **Expand state hospital bed numbers** to provide long-term respite in a secure setting for individuals with the most refractory illness who do not respond to medication.
- **More clearly define what constitutes serious mental illness and severe substance use disorders** to require compelled treatment.
- **Require courts to review behavioral health and criminal records** of individuals with SMI and/or substance use disorders in determining the need for compulsory treatment.
- **Expand civil commitment laws** to extend treatment requirements for those most severely ill from months to years.
- **Utilize state and local opioid settlement funds** to help to establish necessary services, facilities, and housing not currently available in communities.

- **Lift the IMD exclusion** to provide long-term inpatient care for those with the most severe and refractory illness who have not been able to be safely maintained in the community due to an inability to resolve psychotic symptoms.
- **Free state hospital beds** to accommodate those with the most severe mental illness by instituting jail-based competency restoration rather than using state hospital beds for that purpose.
- **Maintain community-based psychiatric services for the most severely ill**, penalizing facilities with a reduction in reimbursements should they fail to continue effective medication regimens, meet ongoing treatment needs, or renew civil commitments in those with a history of SMI and court-ordered compulsory treatment. Concomitantly, institute a tiered payment system to behavioral health clinical programs in which clinical care and service provision to those with the most serious mental illnesses is compensated at a higher rate than for those with mild to moderate mental health conditions.
- **Remove the incentive for psychiatric professionals to let civil commitments lapse** by requiring medical staff to appear in court to testify as to why a civil commitment should be discontinued in addition to the current standard of court appearance to establish and continue civil commitment.
- **Update the Medicaid Home and Community-Based Services (HCBS) Settings Rule** specifically to address the health and safety issues of people with SMI and/or severe substance use disorders. This would make it possible to staff group homes 24/7 and provide the ongoing mental health and medical services that are crucial to the ability of this population to live successfully in the community.
- **Address staffing shortages** by assuring continuity of residential substance abuse treatment programs through a robust vocational rehabilitation program that teaches skills, serves the community, and generates income back to the program. This also provides a means of gainful employment to the program participant upon completion of treatment.
- **Support group homes** by allowing the use of Medicaid funds to pay for the "room and board" (the physical rent, beds, or building capital costs) of a group home. Utilize HUD Continuum of Care funds to support the establishment of group homes or other congregate facilities that will address the high need population of those with SMI and severe addiction should also be permitted.
- **Require State departments of health, mental health and substance use disorder services to make regular inspection** of facilities within their jurisdictions. Utilize funding from Protection and Advocacy for Individuals with Mental Illness (PAIMI) to state authorities to assure safety and appropriate care of residents in facilities.

Summary

Addressing the needs of unsheltered homeless with SMI and/or severe substance use disorders includes both behavioral health treatment and housing. These needs can be addressed by discarding the current interpretation of *Olmstead* regarding community living for disabled people and implementing policies that address critical health needs rather than condemning people to ongoing illness, homelessness, and incarceration. The United States already has state and federal programs that can address all these needs with some changes to interpretation of existing regulation. We should do this quickly to stem the tide of unsheltered homelessness and the misery it brings both to those suffering with mental illness and addiction and to the community at large.

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