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BRIDGING THE BARRIERS: PUBLIC HEALTH STRATEGIES FOR EXPANDING DRUG TREATMENT IN COMMUNITIES

Introduction

Alcoholism and drug dependence exact a tremendous cost on individuals, families, and communities across the United States.¹ As the public searches for common sense approaches to reducing the toll, public health strategies that promote prevention and treatment are being relied upon increasingly as a necessary tool, both separate from and in conjunction with law enforcement efforts.² The value and indispensability of this strategy is supported by the growing body of medical and

1 The societal cost of drug abuse, alone, in 1998 was estimated at \$143.4 billion. Sixty-nine percent (69%) of the cost related to lost productivity resulting from incarceration, crime careers, drug abuse related illness, and premature death; 22% related to criminal justice and social welfare costs; and 9% related to health care costs for drug treatment and medical conditions related to addiction. OFFICE OF NATIONAL DRUG CONTROL POLICY, THE ECONOMIC COSTS OF DRUG ABUSE IN THE UNITED STATES: 1992-1998 2-9 (Sept. 2001). The societal cost of alcohol abuse in 1998 was estimated at \$184.6 billion. Seventy-two percent (72%) of the cost resulted from lost earnings; 14% related to health care costs for alcohol treatment or medical conditions related to abuse; and 13% related to criminal justice and other damage costs. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, UPDATING ESTIMATES OF THE ECONOMIC COSTS OF ALCOHOL ABUSE IN THE UNITED STATES 1 (Dec. 2000).

2 Many states, including Alabama, Arizona, California, Hawaii, Kansas, New Mexico, Oklahoma, Oregon, and Washington, have implemented programs that either mandate or permit diversion of drug offenders from prisons and jails to treatment, and others, including Florida, Idaho, Indiana, Mississippi, North Dakota, and Wyoming, have implemented or expanded drug court programs that emphasize treatment for alcohol and drug dependence. A. COLKER, HEALTH POLICY TRACKING SERVICE, CALIFORNIA'S PROPOSITION 36 AND OTHER STATE DIVERSION PROGRAMS: MOVING DRUG OFFENDERS OUT OF PRISONS AND INTO TREATMENT 8-23 (July 1, 2003). Implementing these policies requires the expansion of comprehensive alcohol and drug treatment services. Indeed, the implementation of California's Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, which permits individuals convicted of drug possession or use crimes to be diverted to treatment, has resulted in a 42% increase in the number of licensed or certified treatment programs since the Act's passage. Licensed residential programs increased by 17% and certified outpatient programs increased by 81%. *Id.* at 6.

scientific data that unravels this “brain disease”³ and bolsters the principles underlying civil rights laws that, since the mid-1970’s, have recognized alcoholism and drug dependence as disabilities.

A significant impediment to the success of a public health strategy, however, has been community opposition to the siting of treatment programs and the official and quasi-official support of community resistance through government zoning policies. Zoning is one of the critical links in the effort to increase alcohol and drug treatment capacity. Without the ability to identify appropriate sites for new services⁴ and quickly obtain approval for occupancy, it is impossible to increase capacity in a timely way. Zoning standards and the “message” those standards send to a community can either promote or prevent the establishment of treatment services.

The magnitude of the “not in my backyard” (NIMBY) problem is not easily documented, but evidence abounds that many local governments and communities have resisted the right of alcohol and drug treatment services to locate in communities on the same terms as other medical services.⁵ Even the

3 See discussion *infra* at text accompanying notes 18-20.

4 This assumes that specialized programs will continue to be the primary vehicle for delivering alcohol and drug treatment services. Efforts have been made to better integrate drug treatment into primary medical care, and that process, as discussed in Part II, will advance the acceptance of these services in the community. The recent approval of medical office-based buprenorphine treatment for opiate dependence is a significant step in that direction. See Drug Addiction Treatment Act of 2000, 21 U.S.C. § 823(g). The National Institute on Drug Abuse has also funded research on the use of immunotherapies for some drugs of addictions, including cocaine, PCP and methamphetamines. If ultimately approved for use, such immunotherapies could also be administered through a medical office-based setting with linkages to other necessary counseling and supportive services. See NEW TREATMENTS FOR ADDICTION: BEHAVIORAL, ETHICAL, LEGAL, AND SOCIAL QUESTIONS (Henrick Harwood and Tracy Myers, ed., 2004), available at www.nap.edu.

5 JOIN TOGETHER, ENDING DISCRIMINATION AGAINST PEOPLE WITH ALCOHOL AND DRUG PROBLEMS: RECOMMENDATIONS FROM A NATIONAL POLICY PANEL 8 (2003), at www.jointogether.org/discrimination (last visited Feb. 16, 2004). The Institute of Medicine noted in its 1995 study of methadone maintenance

best know spokesperson for alcohol and drug treatment and those in recovery, former First Lady Betty Ford, experienced unyielding community opposition when the Betty Ford Center tried to provide housing for patients receiving treatment. Testifying before a national policy panel convened by the American Bar Association's Standing Committee on Substance Abuse to address discrimination against individuals seeking alcohol and drug treatment, Mrs. Ford described her experience:

One of our treatment programs works with state diversion groups who refer physicians, dentists, pharmacists, nurses, and attorneys. Often these professional programs want their clients in treatment for 60-90 days. We leased 14 single-family homes on a single street that was blocks away from other residential developments. The week we moved our patients into these homes, the nearby residents began to protest. Not only did they take their protests to the city and the press, but they also picketed in front of these homes and had their young children marching with them. They screamed and yelled at our patients to go home. They threatened to videotape our patients going to and from the homes and make public their tapes. We met with the residents on several occasions and were always shouted down. Both the city and the local newspaper came to our support but there was no change in the residents' behavior. So, the Betty Ford Center, maybe the best-known treatment center in the world, had to find alternate housing for our patients. NIMBY is alive and well in 2002.⁶

Civil rights laws, including the Americans With Disabilities Act⁷ and the Fair Housing Act,⁸

treatment that negative public attitudes about addiction have “strongly affected the number and location of treatment clinics. The effort to open a methadone treatment clinic often arouses intense local opposition from the prospective neighbors, both poor and middle class. Instances abound of local community groups barring the opening of such clinics, and forcing clinics to close or move out of neighborhoods.” INSTITUTE OF MEDICINE, FEDERAL REGULATION OF METHADONE TREATMENT 29 (Richard A. Rettig & Adam Yarmolinsky eds., 1995). The National League of Cities spearheaded several efforts in the late 1990's to eliminate protections under the Fair Housing Act for group homes that provide treatment and housing to individuals in recovery from alcohol and drug dependence. *See infra* n. 9.

⁶ Testimony of Betty Ford, *quoted in* JOIN TOGETHER, ENDING DISCRIMINATION AGAINST PEOPLE WITH ALCOHOL AND DRUG PROBLEMS, *supra* n. 5, at 8.

⁷ 42 U.S.C. § 12101 *et. seq.*

protect individuals with disabilities – including those with histories of alcoholism and drug addiction -- from discrimination in zoning and, thus, prohibit public entities from barring treatment programs and group homes for individuals in recovery on the basis of their disability. These laws are valuable tools to challenge discriminatory bars to siting and to establish the right to locate like other medical services. At the same time, the existence and enforcement of civil rights protections has not necessarily changed the negative attitudes, stigma and stereotypes that underlie resistance to the siting of alcohol and drug treatment programs.⁹ Those attitudes have often resulted in the erection of zoning barriers that service

8 42 U.S.C. § 3601 *et. seq.* The Fair Housing Amendments Act extended non-discrimination protections to individuals with disabilities and has been interpreted to encompass zoning practices. A number of cases that have shaped the FHAA’s zoning parameters have been brought on behalf of individuals in recovery from alcohol and drug problems. Indeed, the only FHAA case to reach the Supreme Court, *City of Edmonds v. Oxford House, Inc*, 514 U.S. 725 (1995), involved a group home for persons in recovery from alcohol and drug dependence. *See infra* Part III.

9 Less than ten years after the enactment of the Fair Housing Amendments Act (FHAA), the National League of Cities mounted a legislative effort to strip protections for individuals with disabilities. The initial bill, the Fair Housing Reform and Freedom of Speech Act of 1997 (H.R. 589), sought to gain a foothold by focusing on the most unpopular groups: “convicted felons, sex offenders, and recovering drug addicts.” Individuals with alcohol and drug dependence were, in fact, the only population among the targeted groups that is protected under the FHAA. The bill would have permitted localities to enact zoning laws that restrict the maximum number of unrelated occupants in a group home for persons in recovery and the proximity of such homes to one another. H.B. 589 did not get beyond the Committee phase, but the following year, the National League of Cities backed a more expansive bill – the Fair Housing Amendments Act of 1998 (H.R. 3206) – that would have, among other things, permitted local jurisdictions to restrict the number of unrelated individuals who could reside in a group recovery home in residential neighborhoods, impose dispersal requirements for residential treatment services for persons with any disability, and impose restrictions on residential services for persons with disabilities who had a felony conviction record. Well organized opposition by civil rights groups prevented the passage of the legislation.

New Jersey Congressman Robert E. Andrews has also sought on several occasions to amend a provision of the Public Health Services Act that creates a fund to establish group recovery homes to give local jurisdictions control over the siting of homes that are established with that fund. The Substance Abuse Group Homes Amendments of 2003 (H.R. 2159) would have required officials to notify those residing, attending school or operating a businesses within a ten-mile radius of a proposed group home

providers doggedly defeat only to find others erected in their place. This process deters providers from establishing new programs or forces them to walk away from such efforts when faced with animus against clients and the prospect of a lengthy legal battle just to open their doors.¹⁰

This author was involved in one attempt to overcome these official and quasi-official practices through the use of a litigation-based strategy based on the Americans with Disabilities Act. The story of that litigation in Baltimore County, Maryland and its aftermath provides important evidence that a more complex strategy is called for. This article will explore what can be done to address discriminatory barriers to siting alcohol and drug treatment services and, at the same time, build a base of support for these life-saving services. Part I provides a brief overview of the etiology of alcohol and drug dependence and the efficacy and availability of treatment services. Part II identifies how our national policies regarding “drug control” and the delivery of alcoholism and drug dependence treatment have contributed to the NIMBY response. Part III identifies the legal standards under the ADA and FHA that protect individuals with alcohol and drug dependence and the programs that serve them from being excluded from or segregated in communities on the basis of disability. Part IV describes how local governments establish policies and practices that facilitate the exclusion of alcohol and drug treatment

and provide an opportunity to consult about the proposal and impose conditions on the group home’s operation.

10 Individuals in need of treatment services are not the only losers when this happens. All parties – the community, program provider and proposed clients -- suffer the cost of these siting conflicts. As Dear has observed, “community fabric can be irreparably damaged by the anger, frustration and divisiveness engendered by a proposed facility siting; service operators can be financially weakened by prolonged legal battles and other forms of local opposition; and potential clients can be temporarily or permanently denied access to much needed care and assistance.” MICHAEL DEAR ET AL., CAMPAIGN FOR NEW COMMUNITY, HIERARCHIES OF ACCEPTANCE 1 (Resource Document Series 1996).

services from their communities and the community sentiment around such practices by examining the zoning practices of two jurisdictions in Maryland – Baltimore County and Baltimore City – which are emblematic of exclusionary practices around the country. Part IV concludes with an analysis of the legality of the Baltimore City zoning scheme under the ADA and FHA. Part V captures the perspective of Baltimore residents and city officials regarding the establishment and operation of community-based treatment services in an effort to understand community concerns. Part VI applies a theoretical framework to evaluate whether a litigation-based strategy will effectively address the exclusion of treatment services, based on these two case studies, and then identifies the comprehensive strategies that must be implemented to promote greater acceptance of treatment services and ensure availability in communities where people reside.

The existence of clear statutory rights does not necessarily ensure that fair zoning standards or treatment services will be established. Court-ordered remedies on behalf of an unpopular and poorly organized group of individuals fall short of what is needed to address community needs and political concerns. Thus, the strategies to expand access to alcohol and drug treatment must be as comprehensive and complex as the disease itself¹¹ and recognize the uniquely political nature of drug dependence.¹² Just as this disease involves biological and behavioral components that are influenced by one's environment, effective siting solutions must address the behavior of all parties involved in the zoning

11 Alan I. Leshner, *Addiction Is A Brain Disease*, 17 ISSUES IN SCIENCE AND TECHNOLOGY 75, 75-77 (Spring 2001).

12 DAVID MUSTO, *THE AMERICAN DISEASE: ORIGINS OF NARCOTICS CONTROL* 294 (3rd ed. 1999). (“American concern with narcotics is more than a medical or legal problem – it is in the fullest sense a political problem.”)

process – government officials, the treatment providers and communities – and change the legal, social and political environment in which providers operate. Thus, traditional legal strategies that rely on litigation to enforce civil rights statutes may be useful to articulate the existence of rights, compensate for damages incurred by programs that have been shut out of a community or to nudge political leaders, who want political cover, into negotiation about fair standards. But experience also teaches that litigation, even when successful, may not be the most effective means to ensure the delivery of desperately needed services. Multi-dimensional, collaborative approaches that harness for political purposes the public sentiment favoring treatment, give communities a voice in what is needed to serve residents, educate the public about addiction and the efficacy and value of treatment, provide incentives to establish non-discriminatory zoning standards, and integrate alcohol and drug treatment into mainstream medical care are necessary to create meaningful progress.

I. Alcohol and Drug Dependence: The Public Health Perspective

A. The Disease and the Treatment

Alcohol and drug dependence affects an estimated 22 million Americans aged 12 years or older (9.4% of the total population).¹³ Of this population, 14.9 million are dependent on alcohol; 3.9 million are dependent on illicit drugs; and 3.2 million are dependent on both alcohol and illicit drugs. Of the 7.1

13 DEPARTMENT OF HEALTH AND HUMAN SERVICES, OVERVIEW OF FINDINGS FROM THE 2002 NATIONAL SURVEY ON DRUG USE AND HEALTH 27 (2003), available at <http://www.DrugAbuseStatistics.SAMHSA.gov>. (hereinafter NSDUH). The NSDUH, an annual survey conducted by the Substance Abuse and Mental Health Services Administration, reports data on both drug and alcohol *use* by individuals over the age of twelve as well as drug and alcohol *dependence and abuse* among the same population. A designation of dependence or abuse is based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). The above data reflects those classified with either dependence or abuse. *Id.*

million who are dependent on illicit drugs, more than half -- 4.3 million Americans -- are dependent on marijuana, 1.5 million are dependent on cocaine, and 1.5 are dependent on non-medical use of pain relievers.¹⁴ The rate of alcohol and drug dependence varies substantially among racial/ethnic groups, but is essentially the same among African-Americans and whites.¹⁵

Drug dependence has been termed the “American Disease,”¹⁶ but debate still exists over whether alcohol and drug dependence is a “disease” or a failure of will or strength of character. Twenty years of scientific research, however, has convinced the majority of the biomedical community – if not the public generally¹⁷ – that addiction is a brain disease: a condition caused by persistent changes in brain structure and function. Scientific evidence suggests that long-lasting brain changes are responsible for the distortions of cognitive and emotional functioning that characterize persons with addiction, including the defining feature of addiction – the compulsion to use drugs even in the face of adverse medical, social, employment, education and family consequences.¹⁸

14 *Id.* at 27. The figures do not add up to 7.1 million because some are dependent on more than one drug.

15 The rate of alcohol and drug dependence among blacks is 9.5% and 9.3% among whites. The rate is highest among American Indians/Alaska Natives (14.1%) and followed by persons reporting to be two or more races (13%). The rate among Hispanics is 10.4% and 4.2% among Asians. NSDUH at 27.

16 David Musto coined this term in his seminal work on the history of drug abuse and narcotics control in America, *THE AMERICAN DISEASE: ORIGINS OF NARCOTICS CONTROL*, *supra* n. 12. The title comes from a 1919 interview with the New York City Health Commissioner who called drug abuse “emphatically an American disease.” *Id.* at viii.

17 In 1995, the Institute of Medicine observed that “the debate over the extent to which addiction is a disease or a moral failure remains unsettled in the public mind.” *FEDERAL REGULATION OF METHADONE TREATMENT*, *supra* n. 5, at 29.

18 Leshner, *supra* n. 11. For a summary of the opposing viewpoint, see S. Satel, *Is Drug Addiction a*

Like other illnesses, including other brain diseases, the development of and treatment for addiction depends on biology, behavior and social context. While addiction may be distinguishable from other brain diseases insofar as it begins with a clearly voluntary behavior – the initial decision to use drugs – voluntary behavior patterns are involved in the etiology and progression of many other illnesses. The onset of hypertension, arteriosclerosis and other cardiovascular diseases, diabetes and some forms of cancer is heavily influenced by an individual’s diet, exercise, smoking and other behaviors. Moreover, the susceptibility to becoming addicted is influenced by environmental and biological, particularly genetic, factors. At the point at which an individual loses control over the initial voluntary behavior and drug use becomes compulsive, the behavior is, for many, uncontrollable and requires treatment.¹⁹ Research has also demonstrated that, like other illnesses with environmental and biological components, alcohol and drug dependence are best understood and treated as a chronic recurring illness, rather than a curable, acute condition. Many individuals experience relapse, and repeated treatments become necessary to increase the intervals between and diminish the severity of relapses until abstinence is achieved.²⁰

Alcohol and drug treatment consists of a range of approaches to treat addiction, including behavioral therapy (such as counseling, cognitive therapy or psychotherapy); medications (methadone, naltrexone,

Brain Disease, in ONE HUNDRED YEARS OF HEROIN (David Musto ed., 2002).

¹⁹ Thus, just as persons with schizophrenia cannot control their hallucinations and delusions, Parkinson’s patients cannot control their trembling and clinically depressed patients cannot control their moods without treatment, persons with addictions require treatment to control their compulsive use of drugs. Few can simply stop their behavior on their own. Leshner, *supra* n 11.

²⁰ *Id.* at 76.

buprenorphine, antibuse) or a combination of both; case management; and, as needed, referral to other medical, psychological, and social services. The best treatment programs, according to the National Institute on Drug Abuse (NIDA), provide a combination of therapies and other services to meet the needs of the individual patient, which take into consideration issues such as age, race, culture, sexual orientation, gender, pregnancy, family structure, housing and employment, as well as physical and sexual abuse. Although scarce funds often limit the availability of ancillary services, a comprehensive treatment program includes provision of or linkages to the following components: child care services, vocational services, mental health services, medical services, educational services, AIDS/HIV services, legal services, financial services, housing/transportation services, and family services.²¹ Treatment is provided in an out-patient, residential or in-patient hospital setting.²² The same principles apply to treatment for alcoholism.

21 NATIONAL INSTITUTE ON DRUG ABUSE, *PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH BASED GUIDE* 13-14 (1999).

22 The Substance Abuse and Mental Health Services Administration (SAMHSA) tracks the types of facilities that offer alcohol and drug treatment services and the services offered. The 2002 National Survey of Substance Abuse Treatment Services (N-SSATS), the most current source of data on alcohol and drug treatment facilities, found that 13,720 facilities offered treatment and served approximately 1.1 million patients on March 29, 2002. The overwhelming majority, 74%, offer outpatient treatment; 26% offer residential rehabilitation; 7% offer inpatient detoxification; and 7% offer methadone treatment. Treatment services vary but over 75% reported offering assessments, individual therapy, group therapy, discharge planning, family counseling and aftercare counseling. Medical services were less frequently provided, with approximately 25% offering testing for hepatitis and sexually transmitted diseases, 37% and 33% offering screening for tuberculosis and HIV, respectively, and 19% offering pharmacotherapy and prescription medications. NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS): 2002 DATA ON SUBSTANCE ABUSE TREATMENT FACILITIES (2003), *available at* <http://www.DrugAbuseStatistics.samhsa.gov> (hereafter N-SSATS).

B. Treatment Efficacy

Treatment has proven to be an effective and cost-effective response to alcohol and drug dependence; more cost effective than any other intervention designed to stem the use of illicit drugs.²³ Treatment reduces drug use by 40% to 60%, saving lives and money.²⁴ Studies have demonstrated that every \$1 invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs and theft alone.²⁵ Savings are boosted further if health care costs are

23 RAND analysts found that the United States could reduce cocaine consumption by 1% by investing \$34 million in treatment but would have to invest considerably more to achieve that same outcome through domestic drug law enforcement (\$246 million), interdiction (\$366 million), or source country controls (\$738 million). P. RYDELL & S. EVERINGHAM, RAND CORPORATION, CONTROLLING COCAINE: SUPPLY VERSUS DEMAND PROGRAMS xiii (1994). A second study estimated that spending \$1 million to expand mandatory minimum sentencing for drug offenders would reduce national cocaine consumption by 13 kilograms, while using that same money to expand drug treatment to heavy users would reduce cocaine consumption by more than 100 kilograms. J.P. CAULKINS, RAND CORPORATION, MANDATORY MINIMUM DRUG SENTENCES: THROWING AWAY THE KEY OR THE TAXPAYERS' MONEY? (1997). Researchers have also observed that increasingly tough law enforcement during the period 1981 to 1995 did not result in raising the price of drugs or decreasing availability. ROBERT MACCOUN & PETER REUTER, DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES, & PLACES 30-32 (2001).

24 PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* n. 21, at 15-16.

25 Research has consistently demonstrated that treatment significantly reduces criminal activity during and after treatment, regardless of the treatment modality. A 1995 report by the Institute of Medicine, which summarized the results of over 300 published reports regarding methadone treatment, concluded that patients in methadone maintenance treatment significantly reduced their level of illicit drug use and criminal activity. One study concluded that crime rates declined from a pretreatment level of 237 crime days per year per 100 addicted persons to 69 crime days per year per 100 patients during the first four months of treatment; a reduction of over 70% from pretreatment levels. The number of crime days declined further for individuals who remained in treatment more than one year and was reduced to approximately 12 crime days per year per 100 patients after three years in treatment. THE FEDERAL REGULATION OF METHADONE TREATMENT, *supra* n. 5, at 21-25.

The National Treatment Improvement Evaluation Study (hereafter NTIES), a national evaluation of the effectiveness of alcohol and drug treatment delivered by programs funded through federal demonstration grants between fiscal years 1992 and 1995, revealed significant declines in criminal activities, including selling drugs, shoplifting, using a weapon or force to steal, and attacking or

factored in, with total savings exceeding costs by a ratio of 12 to 1.²⁶ Health care savings are recognized because treatment can prevent the costly health and social consequences related to untreated dependence. Nationally, injection drug use has accounted for more than one-third of AIDS cases in the United States since the epidemic began, and the trend has continued with almost one-quarter of new

threatening someone. Among 490 clients who entered treatment for both alcohol and crack cocaine use, about one-third ($\frac{1}{3}$) reported at intake selling drugs and shoplifting, 17% reported attacking or threatening someone, and 7% reported using a weapon or force to steal. During the year after treatment, the proportion who reported attacking or threatening someone declined by almost three-fourths ($\frac{3}{4}$) and the proportion who reported selling drugs, shoplifting and using weapons or force to steal declined by more than half. CENTER FOR SUBSTANCE ABUSE TREATMENT, TREATMENT OUTCOMES FOR POLYSUBSTANCE USERS: ALCOHOL AND CRACK COCAINE (NEDS Fact Sheet 100, Nov. 2001). Similar reductions in criminal activity were reported by approximately 370 individuals who entered drug treatment for both heroin and cocaine powder use. At intake, approximately 45% of the clients reported shoplifting and selling drugs, 15% reported attacking or threatening someone, and 9% using a weapon or force to steal. During the year after treatment, the proportion who reported using a weapon or force to steal declined by more than three-fourths ($\frac{3}{4}$) and the proportion that reported attacking or threatening someone, selling drugs, and shoplifting declined by more than one-half ($\frac{1}{2}$). CENTER FOR SUBSTANCE ABUSE TREATMENT, TREATMENT OUTCOMES FOR POLYSUBSTANCE USERS: HEROIN AND COCAINE POWDER (NEDS Fact Sheet 103, Dec. 2001).

These same reductions in drug use and criminal activity were reported in a recent study of nearly 1000 individuals who participated in publicly-funded out-patient treatment in Baltimore, Maryland from 1998 to 1999. Heroin use declined over the first thirty (30) days of treatment by 72% and was sustained at a 69% reduction one year later. Cocaine use also declined over the first thirty (30) days of treatment by 64% and was sustained at 48% one year after treatment. The reduction in heroin and cocaine use was greatest for those who were treated in methadone treatment programs. Crime rates dropped precipitously, mirroring the decline in drug use. Participants engaged in illegal activities 64% less at one year after entry into treatment, and reduced the amount of illegal income received by 69%. BALTIMORE SUBSTANCE ABUSE SYSTEMS, STEPS TO SUCCESS: BALTIMORE DRUG AND ALCOHOL TREATMENT OUTCOME STUDY 3-5 (Executive Summary, 2002).

26 PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* n. 21, at 21. The California Drug and Alcohol Treatment Assessment (CALDATA) showed that treatment reduced hospitalizations by 36% for physical health problems, 58% for drug overdoses and 44% for mental health problems. D. R. GERSTEIN ET AL., EVALUATING RECOVERY SERVICES: THE CALIFORNIA DRUG AND ALCOHOL TREATMENT ASSESSMENT 41 (April 1994).

AIDS cases in 2002 being associated with injection drug use.²⁷ and Hepatitis C and sexually transmitted diseases are prevalent among injection drug users.²⁸ Numerous studies have demonstrated that drug treatment is primary prevention for HIV infection and reduces sexual and needle sharing behavior that contributes to Hepatitis C and sexually transmitted diseases.²⁹ Treatment also ameliorates the mental health problems of those with co-occurring mental illness and drug dependence.³⁰ In addition to the

27 CENTERS FOR DISEASE CONTROL, DRUG-ASSOCIATED HIV TRANSMISSION CONTINUES IN THE UNITED STATES (May 2002) and Surveillance Report Vol. 14, Table 16, available at <http://www.cdc.gov/hiv>.

28 In a study of patients in treatment programs in six cities in the United States, 79% of injection drug users in treatment tested positive for Hepatitis C. An estimated 70% will ultimately develop chronic liver disease, for which there is no cure except liver transplantation. CENTER FOR SUBSTANCE ABUSE RESEARCH, DRUGS IN MARYLAND: 2003 UPDATE 12 (2003).

29 The NTIES revealed a reduction of high-risk sexual behaviors (prostitution, sex exchange for drugs or ten or more sexual partners in a year) among two groups of patients one year after treatment: persons who sought treatment for alcohol and crack cocaine use and those who sought treatment for heroin and cocaine powder use. Among the first group at intake, about one-fourth ($\frac{1}{4}$) of the clients reported sex exchange or prostitution and one-tenth ($\frac{1}{10}$) reported having ten or more sexual partners. After one year in treatment, the proportion of clients who reported sex exchange or multiple sex partners declined by half ($\frac{1}{2}$) and the proportion who reported engaging in prostitution declined by over two-thirds ($\frac{2}{3}$). NEDS Fact Sheet 100, *supra* n. 25. Among the second group at intake, about one-fourth ($\frac{1}{4}$) of clients reported prostitution and sex exchange and 11% reported having multiple partners. After one year in treatment, the proportion of clients who reported prostitution declined by over two-thirds ($\frac{2}{3}$) and the proportion reporting multiple sex partners and sex exchange declined by about one-half ($\frac{1}{2}$). NEDS Fact Sheet 103, *supra* n. 25.

30 The NSDUH found a high co-occurrence of serious mental illness (SMI) with alcohol and drug dependence and abuse. Among adults with SMI in 2002, 23.2% (4 million people) were dependent on or abused alcohol or illicit drugs, while the dependence rate among adults without SMI was only 8.2%. Among adults with alcohol or drug dependence, 20.4% had SMI, while the rate of SMI was 7% among adults who did not have alcohol or drug dependence. NSDUH, *supra* n. 13, at 32.

NTIES examined the effect of treatment on individuals who reported depression, attempted suicide and receipt of outpatient mental health treatment. At intake among those receiving treatment for alcohol and crack cocaine use, 62% reported depression, 29% reported having attempted suicide and 15% reported having received outpatient mental health services. In the year after treatment, 39% reported depression, 4% reported attempted suicide and 11% reported receiving mental health services.

savings generated from reduced criminal activity and improved health, treatment increases employment and earnings for many who receive treatment.³¹

When measured against treatment outcomes for other chronic medical conditions, alcohol and drug treatment proves to be just as effective as treatment for other chronic medical conditions. Persons in treatment for alcohol and drug dependence adhere to medical regimens and relapse to problematic behaviors at rates comparable to persons who receive treatment for three other chronic illnesses: type 1 diabetes mellitus, hypertension and asthma.³²

NEDS Fact Sheet 100, *supra* n. 25. Similar declines were reported for patients receiving treatment for heroin and powder cocaine. At intake, 53% reported depression, 22% reported attempted suicide and 20% reported receiving outpatient mental health services. In the year after treatment, 37% reported depression, 4% reported attempted suicide and 10% reported receiving mental health services. NEDS Fact Sheet 103 *supra* n. 25.

31 The NTIES found that the proportion of men employed after one year of treatment increased by half and the proportion of women increased by almost two-thirds. CENTER FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE TREATMENT BENEFITS: EMPLOYABILITY OF MALE AND FEMALE CLIENTS (NEDS Fact Sheet 137, Sept. 2002). Employment improved across all racial groups. The proportion of clients employed after one year in treatment increased by over two-thirds for white clients, over half for African-American clients and almost half for Hispanic clients. CENTER FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE TREATMENT BENEFITS: EMPLOYABILITY ACROSS RACIAL/ETHNIC GROUPS (NEDS Fact Sheet 114, March 2002). Participants in the CALDATA study who completed more than four months of residential treatment increased their employment by more than 30%, notwithstanding a recession in the state during the study period. THE CALIFORNIA DRUG AND ALCOHOL TREATMENT ASSESSMENT, *supra* n. 26, at 55. The study also concluded that women who received welfare before entering treatment reduced their participation in welfare programs by 22% after treatment. D.R. GERSTEIN ET AL., ALCOHOL AND OTHER DRUG TREATMENT FOR PARENTS AND WELFARE RECIPIENTS: OUTCOMES, COSTS AND BENEFITS 29 (Jan. 1997).

32 One-year post-discharge follow-up studies of individuals who participated in alcohol or drug treatment have typically shown that about 40% to 60% of discharged patients are continuously abstinent, and an additional 15% to 30% have not resumed dependent use during this period. Favorable outcomes typically continue beyond the one-year period for patients who comply with the recommended regimen of education, counseling and medication, i.e., remaining in methadone maintenance or maintaining abstinence through participation in self-help groups such as Alcoholics Anonymous (AA) or Narcotics

C. Treatment Accessibility

All things being equal, treatment for alcohol and drug dependence should be an accepted and readily available medical service in most communities. It hasn't worked that way.³³ While local governments and the public voice support for alcohol and drug treatment,³⁴ public and private funding

Anonymous (NA). Similarly, outcome studies indicate that 30% to 50% of adult patients with type 1 diabetes and approximately 50% to 70% of adult patients with hypertension or asthma experience recurrence of symptoms each year to a degree that requires medical care to reestablish symptom remission. Adherence to medication regimens and behavioral and diet changes, which are critical to prevent recurrence of these disorders, are also comparable to those with addictions: less than 30% of patients adhere to prescribed diet and/or behavioral changes. In addition, research has demonstrated that compliance with a medical regimen and outcome across all four of these medical conditions is poorest among persons with low socioeconomic status, lack of family and social supports or significant psychiatric co-morbidity. Thomas A. McLellan et al., *Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcome Evaluation*, 284 J. OF THE AMER. MED. ASSN. 1689, 1693 (Oct. 4, 2000).

33 Thus, while the societal costs of alcohol and drug problems in the United States soared above \$184 billion and \$143 billion, respectively, in 1998, alcohol and drug treatment comprised only \$7.5 billion (4%) and \$4.9 billion (3.4%) of those costs, respectively. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, *supra* n. 1, at 1; OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* n. 1, at 5.

A study that examined state expenditures for substance abuse (defined as alcohol, drug or nicotine) found that of every dollar states spent on substance abuse in 1998, 95.8 cents went to pay for the burden of this problem on public programs, while only 3.7 cents went to fund prevention, treatment and research programs aimed at reducing the incidence and consequences of substance abuse. NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY, SHOVELING UP: THE IMPACT OF SUBSTANCE ABUSE ON STATE BUDGETS 2 (Jan. 2001), *available at* <http://www.casacolumbia.org>. The trend persists today. In Maryland, for example, the estimated cost of alcohol and drug abuse in 2002 is \$5.6 billion, with treatment comprising 3% of that cost. An untreated drug abuser is estimated to cost the state \$43,300 annually. Incarcerating that individual costs an estimated \$39,600, while providing treatment costs between \$1,050 and \$7,421, depending upon the treatment modality. MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, OUTLOOK AND OUTCOMES IN MARYLAND SUBSTANCE ABUSE TREATMENT 9 (FY 2002).

34 In a nationwide telephone survey of 1,056 adults conducted from September 6-17, 2001, Americans, by two to one, described drug abuse as a medical problem that should be handled mainly through counseling and treatment (63%) rather than as a serious crime that should be handled mainly by the courts and prison system (31%). This view was shared across the political spectrum, with majorities of

for treatment services is a fraction of that needed to meet the demand.³⁵ In 2002, an estimated 7.7 million people (ages 12 and older) needed treatment for an illicit drug problem, and 18.6 million needed treatment for an alcohol problem.³⁶ Only 1.4 million received drug treatment and 1.5 million received

fundamentalist Protestants (54%) and Republicans (51%) sharing this sentiment. PETER D. HART RESEARCH ASSOC., INC., CHANGING PUBLIC ATTITUDES TOWARD THE CRIMINAL JUSTICE SYSTEM: SUMMARY OF FINDINGS 5 (Feb. 2002). Nationwide, 76% favored a proposal requiring supervised mandatory drug treatment and community service rather than prison time for people convicted of drug possession. Seventy-one percent (71%) of those polled also favored this approach for those found guilty of selling small amounts of drugs. *Id.* at 10.

A Fall 2003 poll of 704 Maryland registered voters from across the state revealed similar views. An overwhelming majority of those polled – 73% compared to 11% -- believed drug treatment is more effective than prison in stopping illegal drug use. Even self-described “very conservative” voters supported treatment over prison by 65%. POTOMAC INCORPORATED, MARYLAND VOTER SURVEY 2-11 (Dec. 2003). Moreover, 86% of those polled thought judges should have the option to order supervised treatment and counseling rather than prison for some drug users. *Id.* at 2-12. Voters favored prison over treatment, however, for those who sell drugs by a margin of 66% to 30%. *Id.* at 2-13.

35 Spending for substance abuse treatment in 1997 was \$11.9 billion, with public funding (state and federal funding including Medicare, Medicaid and federal block grant and other funding) totaling \$7.3 billion and private funding (including out-of-pocket and private insurance) totaling \$4.5 billion. From 1987 to 1997, reliance on public payers increased from 50.3% of total substance abuse spending to 61.8%. Private insurance spending for substance abuse treatment grew particularly slowly during this period: only 1.9% annually. Tami L. Mark, et al., *Spending On Mental Health and Substance Abuse Treatment, 1987-1997*, 19 HEALTH AFFAIRS 108, 112, 115 (2000). See Sonja B. Starr, *Simple Fairness: Ending Discrimination in Health Insurance Coverage of Addiction Treatment*, 111 YALE L.J. 2321 (2002) (describing exclusion and caps on coverage for alcohol and drug treatment in private insurance and efforts to obtain treatment parity).

The NSDUH found that the source of payment for specialty drug or alcohol treatment was reported to be from the individual’s “own savings or earnings” or family members (50% to 60%); private health insurance (30%); public assistance, including Medicaid (43% to 49%) and Medicare (20%). NSDUH, *supra* n. 13, at 28.

36 NSDUH, *supra* n. 13, at 30. The NSDUH defines as individual as needing treatment if he or she is dependent on or abused alcohol or drugs or received specialty treatment for alcohol or drug dependence in the prior twelve months. *Id.* at 28. Specialty treatment is treatment that is received at inpatient or outpatient alcohol or drug rehabilitation facilities, in-patient hospital, or mental health facilities. It excludes treatment at an emergency room, doctor’s office, self-help group, prison or jail or out-patient hospital care. *Id.*

alcohol treatment at a specialty substance abuse facility.³⁷

Even when treatment funds are available, some local governments and communities resist establishing programs, citing fear of crime, lower property values and loss of tax revenue.³⁸ Objective data casts significant doubt on these fears. Studies conducted from the late 1970's through the late

37 *Id.* at 30. Of the 6.3 million who did not receive drug treatment in a specialty facility, an estimated 362,000 reported that they felt they needed treatment and an estimated 88,000 of those reported that they had made an effort but were unable to get treatment. Of the 17.1 million who did not receive alcohol treatment in a specialty facility, an estimated 761,000 reported that they felt they needed treatment for their alcohol problem and an estimated 266,000 reported that they had made an effort but were unable to get treatment.

38 Research suggests that there are wide variations in the degree to which facility siting triggers community opposition and the level of that opposition. Michael Dear, who has studied community opposition to social services extensively, suggests that variations in opposition can be analyzed by looking at three factors: the host community, facility design and client population. Among the client populations that are most often rejected by communities are individuals with alcohol and drug problems. Various scales have been used to measure the "hierarchy of acceptance" of individuals with disabilities. Studies over time have found that "alcoholism" ranks among the least accepted disability, slightly more acceptable over time than "mental illness," "mental retardation," and "AIDS." One study that looked at "drug addiction" found that it was ranked as the least acceptable disability, and a second study found that "people in recovery from drug and alcohol dependency" ranked next to the last in desirability, second only to people with psychiatric problems. Michael Dear, *supra* n. 10, at 6-7 and 16-17. Similarly, hierarchies of *facility* acceptance rank facilities for persons with drug and alcohol problems in the most undesirable category; a ranking that has also persisted over time. *Id.* at 8-9. In some studies, these facilities rank with or just above facilities such as landfills and waste treatment plants. *Id.* at 12.

Researchers who have tried to explain the variations in acceptability have identified several different, but not mutually exclusive, factors: (1) level of functionality; (2) aesthetic and social interaction effect; (3) level of individual responsibility for the condition; (4) reversibility of condition; and (5) personal vulnerability to a particular condition. The second and third factors adversely influence the acceptability of individuals with alcohol and drug problems and the facilities that serve them because these individuals are often viewed as engaging in unpredictable and dangerous behavior and being responsible for their own disabling condition. *Id.* at 13-14. The persistence of drug and alcohol problems as well as the relapsing nature of the disease also make this population less acceptable. The fact that all individuals are vulnerable to alcohol and drug problems and most know someone who has had such problems has not necessarily enhanced the acceptability of those who have this condition.

1980's concluded that the siting of human service facilities has little impact on the community's property values, crime, business, or traffic.³⁹ More recent studies in cities throughout the country have also found a limited impact in the area of property values and crime rates.⁴⁰ Nonetheless, resistance runs

39 Michael Dear et al., Campaign for New Community, FACTORS INFLUENCING COMMUNITY ACCEPTANCE: SUMMARY OF THE EVIDENCE 6-7 (Resource Document Series, 1996), and studies cited therein; G. Galster et al., *The Impact of Supportive Housing on Neighborhood Crime Rates*, 24 J. OF URB. AFFAIRS, 289, 292 (2002) (noting that studies conducted in the 1980's reached this conclusion, but that some more recent analysis have concluded that with certain circumstances and kinds of developments, supportive housing for persons with chronic mental illness can create harmful effects on proximate property values). Herbert A. Eastman, *War on Drugs or on Drug Users? Drug Treatment and the NIMBY Syndrome*, 5 B. U. PUB. INT. L. J. 15, 21 (1995); Laurie C. Malkin, *Trouble at the Doorstep: The Fair Housing Amendments Act of 1988 and Group Homes for Recovering Substance Abusers*, 144 U. PA. L. R. 757, 792-98 (1995).

40 A 2002 study in San Diego County examining the effect of licensed residential alcohol and drug treatment facilities on property values and crime rates near those centers revealed that the facilities promoted community safety and enhanced property values. To evaluate property values of homes in the vicinity of the facilities, a licensed realtor measured the sale value of seventy-one (71) homes, comparing those located within five blocks of eight treatment facilities with those located farther from but in the same general areas. The facilities were located in different types of neighborhoods; urban, suburban, residential, commercial, high and low crime. In five locations, property values near treatment facilities were slightly higher than in the comparison areas; in one location property values were approximately the same, and in one, property values were slightly lower. An analysis of crime rates compared crime incident data reported in September and October 2002 in the area immediately adjacent to facilities in nine diverse neighborhoods with incidents reported in the larger surrounding neighborhood. Crime levels were consistently lower next to licensed treatment facilities than elsewhere in the same areas. Higher crime rates tended to center around alcohol sales outlets and other areas with higher risks of drug availability. INSTITUTE FOR PUBLIC STRATEGIES, COMMUNITY STABILITY AND SAFETY: THE IMPACT OF LICENSED RESIDENTIAL ALCOHOL AND DRUG TREATMENT CENTERS 1-2 (May 2003), available at <http://www.publicstrategies.org>.

In the District of Columbia, an analysis of the impact of halfway houses and community-based services for former criminal offenders on neighborhood property values and crime rates showed similar results. The resale value of homes in neighborhoods within a six to eight block radius of seven different facilities in diverse neighborhoods was examined over the five year period, December 1997 to March 2002. The data revealed that community-based facilities did not contribute to a decrease in housing values. Homes that sold within a one-block radius of the facilities increased in value, and all the neighborhoods with these facilities experienced an increase in housing value both on the street and within the zip code of where the facility was located. CENTER ON JUVENILE AND CRIMINAL JUSTICE,

deep and persists over time.⁴¹

Part II: National Policies that Promote NIMBY

The American public and government have struggled for over 140 years to find an effective

POLICY BRIEF: DO HALFWAY HOUSES AND COMMUNITY CORRECTION FACILITIES CAUSE PROPERTY VALUES TO DECREASE? 1-9, *available at* <http://www.dcprisonerhelp.org>.

Another study analyzed crime rates by comparing all reported Part 1 crimes (homicide, sex abuse, robbery, assault with a deadly weapon, burglary, theft, theft from an automobile, stolen automobile and arson) within 1,000 feet of the seven facilities with the crime rate within 1,000 of other randomly selected sites, including businesses, grocery stores, libraries and schools, for the period 1997 to 2001. The data revealed that crime trends in neighborhoods with facilities serving former criminal offenders were similar to those in neighborhoods with services (library, grocery store, private school) not normally associated with crime. CENTER ON JUVENILE AND CRIMINAL JUSTICE, POLICY BRIEF: DO COMMUNITY REHABILITATION FACILITIES INCREASE CRIME IN THEIR NEIGHBORHOOD? 10-16, *available at* <http://www.dcprisonerhelp.org>.

Finally, a study in Denver, Colorado, examined the effect of fourteen supportive housing facilities established between 1992 and 1995 on crime rates, defined as reported crimes involving property, violence, criminal mischief, disorderly conduct and total (all crimes). The study examined crime rates at various distances from the facilities – 500 feet, 501 to 1000 feet and 1001 to 2000 feet. It also examined whether crime rates differed based on clientele, specifically clients who were perceived as more threatening (defined as persons with criminal records and those with mental health and drug and alcohol histories), or facility scale (facilities with a maximum of eight residents versus those facilities that served 50 to 100 individuals). The study concluded that there were no statistically significant increases in the rates of any category of reported crime rates within any distance of a supportive housing facility, including those that served more threatening clients. A modest but statistically significant upsurge in reported violent and total crimes occurred within 500 feet of the large facilities. The study concluded that the residents of the larger facilities were not the perpetrators of the crime, but that the larger facilities attracted more crime. These facilities either provided a mass of victims (many of the larger facilities served persons who were physically compromised and often elderly) and/or eroded the collective efficacy of the neighborhood, i.e. the social cohesion among neighbors and their capacity to enforce norms of civil, lawful behavior through informal social controls. G. Galster, *supra* n. 39, at 307-8.

41 For example, New York City's zoning battles to establish treatment programs in 1919 were essentially repeated fifty years later when it sought to establish a network of methadone treatment programs. R. NEWMAN, *Relationship with the Community*, in METHADONE TREATMENT IN NARCOTIC ADDICTION: PROGRAM MANAGEMENT, FINDINGS, AND PROSPECTS FOR THE FUTURE (1977). As of 1993, only three new methadone programs had been able to open throughout New York State in the previous twenty (20) years. FEDERAL REGULATION OF METHADONE TREATMENT, *supra* n. 5, at 29.

response to alcohol and drug use and dependence among its citizens. The American response, according to Musto, swings predictably from periods of drug tolerance to drug intolerance with virtually no happy medium or equilibrium.⁴² Our most recent wave of drug problems, which began in the mid-1960's, was met first with tolerance in the 1970's followed quickly by severe intolerance beginning in the early 1980's. The pervasive intolerant national response to drug and alcohol problems certainly contributes to the NIMBY syndrome.

First, and perhaps most important, our nation's punitive, "lock 'em up" approach to drug dependence over the past twenty years has made it acceptable to dismiss individuals with these problems as a group to be feared and undeserving of treatment all together, much less fair and equal treatment.⁴³ Since 1975, every state has passed a mandatory minimum sentencing law requiring incarceration for weapons offenses, habitual offenders and other categories. According to Mauer, these laws have been applied most frequently to drug offenses, resulting in an increase in the proportion of arrested drug offenders who are sentenced to prison and an increase in the length of time offenders serve. Congress also enacted harsh "anti-drug" mandatory sentencing laws in 1986 and 1988.⁴⁴ This punitive response

42 David Musto, *supra* n. 12, at x.

43 As the Institute of Medicine observed in evaluating the public's support for methadone treatment, "the stereotype of addicts are of individuals engaged in criminal activity, predatory toward others, and unable or unwilling to respect the norms of acceptable social behavior or participate in the work force. The public's fear of opiate addicts creates a reluctance to spend "treatment" dollars on them; it also creates sympathy for a criminal justice response." FEDERAL REGULATION OF METHADONE TREATMENT, *supra* n. 5, at 29.

44 According to Mauer and others, both state and federal sentencing policies have captured an overwhelming majority of low-level dealers or accomplices who are considered low-risk based on their limited criminal histories. A study of the more than 150,000 drug offenders incarcerated in state prisons

has spilled over into federal civil rights, health, education, housing and welfare policies. Millions of individuals have lost important civil rights protections, educational opportunities and basic housing and subsistence because of an alcohol or drug problem or drug-related criminal activities.⁴⁵

in 1991, revealed that 84% of these offenders, almost 127,000 people, had no history of a prior incarceration for a violent crime and that 50% had no prior incarcerations at all. MARC MAUER, THE SENTENCING PROJECT, RACE TO INCARCERATE 151-157 (1999).

A recent study that examined incarceration trends in Maryland found that, for prisoners held on June 30, 2001, the largest single category of conviction offense, according to the Department of Corrections, was “drug abuse,” accounting for 23.6% of those incarcerated in the state system. Cases involving drug offenses comprised more than half (53%) of the sentences imposed by judges in 2000 and 2001, and, in 63% of these cases, the offender was sentenced to a prison term. Prison terms were imposed in 54% of the cases involving simple possession of drugs, a misdemeanor offense, and in over 8000 cases involving convictions for drug distribution, 64% of the offenders were sentenced to prison, even though a mandatory minimum sentence was not required. The authors of the study concluded that State could safely mandate treatment rather than incarceration for persons convicted of drug possession, distribution, all but the most serious burglary offense, and all theft cases where the offender is a drug abuser. JUDITH GREENE & TIMOTHY ROCHE, JUSTICE POLICY INSTITUTE, CUTTING CORRECTLY IN MARYLAND 14-17, 20 (Feb. 2003), *available at* <http://www.justicepolicy.org>.

45 In 1989 and 1990, when Congress enacted the Fair Housing Amendments Act and the Americans with Disabilities Act, providing broad civil rights protections for individuals with disabilities, it eliminated statutory protections for individuals with *current* drug problems, which had been in place since 1978 under Section 504 of the federal Rehabilitation Act. The Congress and the Bush Administration excluded these individuals from civil rights protections because they did not want to enact a law that was seen as being “soft” on drugs.

In 1996, Congress and the Clinton Administration made sweeping changes in eligibility requirements for federally funded subsistence programs that excluded individuals with alcohol and drug dependence. Congress first amended the standards governing the federal Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI) programs, excluding individuals whose disability diagnosis was based on their alcoholism or drug dependence. 42 U.S.C. § 423(d)(2). Exclusion from the SSI and SSDI programs also stripped these individuals of Medicaid coverage. That same year, Congress amended public housing laws to facilitate the exclusion of individuals involved in drug-related activities from public, federally assisted and/or Section 8 housing. Under the so-called “one-strike” standards, public housing providers are required to include a lease provision that requires the termination of tenancy of a leaseholder if he, his family member, or a guest or other person under the leaseholder’s control engages in drug-related activity on or off the premises. 42 U.S.C. § 1437d(l)(6). Individuals who have been evicted from public, federally assisted or Section 8 housing because of drug-related criminal activity are ineligible for such housing for three years from the date of the eviction. 42

Closely associated with the dramatic increase in incarceration of persons convicted of drug crimes, is the public perception – albeit inaccurate – that drug addiction is a problem that primarily affects people of color.⁴⁶ The perception of the “drug problem” as existing in and involving primarily poor, African-American communities results from at least two factors: the disparate rate of arrest, prosecution and incarceration of African-American men and women for drug-related crimes⁴⁷ and the high visibility

U.S.C. § 13661(a). Those who have engaged in any drug-related activity may be denied tenancy if the activity occurred within a reasonable time prior to their seeking admission to housing. 42 U.S.C. § 13661(c). Finally, the Personal Responsibility and Work Opportunity Reconciliation Act, enacted on August 22, 1996, permanently bars any individual with a drug-related felony conviction from receiving cash assistance (Temporary Assistance for Needy Families or “TANF”) and food stamps during the individual’s lifetime, unless the state opts out of or modifies the drug felon bar. 21 U.S.C. § 862a. The welfare law also prohibits states from providing TANF, Supplemental Security Income, public and federally-assisted housing, and food stamps to individuals who are violating a condition of probation or parole. 42 U.S.C. § 608(a)(9)(A)(ii). States were also authorized to test welfare recipients for drug use and sanction those who test positive. 21 U.S.C. §862b.

Most recently, in 1998, Congress amended the Higher Education Act, suspending the eligibility for any grant, loan or work assistance for students convicted of drug-related offenses. Persons who have been convicted of possession of a controlled substance lose eligibility for one year for the first offense, two years for the second and indefinitely for a third or subsequent offense. The penalty for a sales conviction is stiffer: a two-year ineligibility for the first offense and indefinite suspension for any subsequent convictions. 20 U.S.C. § 1901(r).

46 Mauer, *supra* n. 44, at 148-51.

47 The racial and ethnic breakdown of drug offenders in state prisons in 1997 revealed that four out of every five drug prisoners are members of racial and ethnic minorities – 56 % African-American and 23% Hispanic. Between 1985 and 1995 the number of white drug offenders (those convicted only of a drug offense) increased by 306% while the number of African-American drug offenders increased by 707%. During this period, drug offenders constituted 42% of the rise in African-American state prison population, while constituting 26% of the increase in white prison population. Mauer, *supra* n. 44, at 152-53.

During this period, the racial characteristics of those incarcerated for drug crimes sharply contrasted with the demographic profile of drug users nationally. Indeed, much like the 2002 National Survey on Drug Use and Health statistics (*see supra*. n. 15), in 1997, African-Americans constituted 13% of monthly drug users and Hispanics, 9%. Whites constituted 74% of monthly drug users, but only 20% of the drug offenders in state prisons. RYAN KING & MARC MAUER, THE SENTENCING PROJECT,

of drug-related criminal activity in inner-city, minority communities. The causes of the racially disparate incarceration rates are complex, but the phenomenon is not explained by the rate of drug use or dependence among racial minorities.⁴⁸ As noted above, the rate of drug dependence among blacks and whites is virtually identical, with rates slightly higher among Hispanics. The rate of drug *use* among racial and ethnic minorities reveals a similar pattern: in 2002, 8.5% of whites, 9.7% of African-Americans and 7.2% of Hispanics reported using illicit drugs in the preceding month. Among youth age 12 to 17, 10% of African-Americans, 10.7% of Hispanics and 12.6% of whites reported using illicit drugs in the preceding month.⁴⁹

Notwithstanding the relatively comparable rates of drug use among African-Americans and whites, the drug trade is more visible in African-American communities and has had a harsher impact on those communities. Drug dealing in inner-city, impoverished neighborhoods, a large share of whose

DISTORTED PRIORITIES: DRUG OFFENDERS IN STATE PRISONS 11 (Sept. 2002).

In Maryland, the racial disparity among those convicted of drug crimes is even starker. Maryland ranks third in the nation for total annual prison admissions for drug offenses. Nationally, 27% of prison admissions are for drug offenses, while 42% of Maryland's prison admissions are for drug offenses. In 2003, 68% of those arrested for drug crimes and 90% of those imprisoned for drug offenses were African-American. The disparity is marked since the enactment of federal mandatory minimum sentences. In 1986, African-Americans and whites entered Maryland prisons for drug offenses in roughly equal proportions – 15% and 17%, respectively. By 1999, nearly half of all African-American admissions to prison (47%) were for drug offenses compared with 21% for whites. Between 1986 and 1999, the increase in African-American admissions to prison on a drug offense was 18 times greater than the increase in white drug offender admissions. VINCENT SCHIRALDI & JASON ZIEDENBERG, JUSTICE POLICY INSTITUTE, RACE AND INCARCERATION IN MARYLAND 10-13 (2003).

48 An exploration of the reasons underlying this trend is beyond the scope of and not essential to this article.

49 NSDUH, *supra* n. 13, at 12-13. Drug dependence also was also more prevalent in rural communities than urban communities for this age group. *Id.* at Tables 5.9 A and B.

residents are African-American, is more likely to take place on the street, in open-air drug markets. In contrast, drug dealing in suburban neighborhoods takes place behind closed doors through word-of-mouth contact.⁵⁰ The impact of this drug trade is readily observed in increased violence, loss of social capital and communities wrecked by high rates of incarceration.⁵¹ To the extent treatment programs are

50 Mauer, *supra* n. 44, at 148-50; and MacCoun, *supra* n. 23, at 114. The high visibility of the drug trade does not necessarily translate into a higher level of drug use and dependence. One study examined the visibility of drug sales and drug use in more than 2100 neighborhoods across 41 sites. It concluded that, while the drug trade was more visible in minority communities than white neighborhoods, those same neighborhoods had lower scores on drug use and drug dependency. It found that the neighborhoods that had the most visible drug problems were those that were the most disadvantaged (measured by unemployed adult population, high school dropouts, female-headed households, individuals receiving public assistance and individuals living in households below the poverty level), had higher proportions of minority residents and high levels of population density. Visible drug sales were 6.3 times more likely to be reported in the most disadvantaged neighborhoods than the least disadvantaged, while illicit drug use was only 1.3 times more likely. L. Saxe et al., *The Visibility of Illicit Drugs: Implications for Community-Based Drug Control Strategies*, 91 AM. J. OF PUB. HEALTH 1987, 1989 (Dec. 2001).

51 According to MacCoun, the high prevalence of drug selling in the inner city has generated drug dependence, encouraged violence for self-protection at the individual and community levels, decreased the prevalence of positive role models, and, for the large numbers of incarcerated individuals, minimized the ability and time to develop as members of the community, family and workforce. MacCoun, *supra* n. 23 at 114-15. Similarly, Saxe observed that drug markets, which get established in disadvantaged neighborhoods, in part, because of the low social capital in those neighborhoods, further erodes the social capital. Saxe, *supra* n. 50, at 1992-93.

Sociologist Jeanette Covington has observed that “resource deprivation” causes minority communities to suffer more intensely from drug problems than more affluent communities. Limited access to good schools and primary labor market jobs make it more difficult for individuals in impoverished communities to support a drug habit through employment or family support and loans -- avenues more readily available to more affluent individuals with drug problems. Minorities also face a greater disadvantage when seeking treatment for their drug problem, as they must frequently rely on the publicly funded treatment system, which, because of insufficient funding, has limited slots and often less comprehensive services. Sustaining recovery is also more difficult for individuals who do not have access to employment, housing and a family support system. Jeanette Covington, *The Social Construction of the Minority Drug Problem*, 24 SOCIAL JUSTICE 117 (1997)

While individuals who are employed and have homes and private health insurance may also face limited access to treatment, the response to a drug problem is entirely different. As Mauer observed, a

associated with addressing the “visible” problem, white and more affluent communities do not perceive a need for those services and fear exposing their neighborhoods to people who do not fit the racial and socio-economic profile and who engage in destructive behavior. Thus, racial bias and stereotypes simmer beneath the surface of many battles over the siting of a drug treatment program.⁵²

Second, while treatment for alcoholism and drug dependence has expanded and been supported by federal and state entities, it is not well integrated into mainstream medical practice and is not financed on par with other medical care. Since the inception of a national alcohol and drug treatment system, services have been provided primarily by specialty providers.⁵³ Indeed, methadone maintenance

middle class family in suburbia who realizes its seventeen year old son is selling and using cocaine does not call the police, demand that he be arrested, and expose him to a mandatory five-year sentence for possession and sales. The son of family in a low- income, minority community who engages in the same behavior, however, is much more likely to be picked up on the street, charged with drug possession and intent to sell, and face a stiff penalty rather than receive treatment. Mauer, *supra* n. 44, at 142-43. For a discussion of how resource deprivation in some minority communities plays out in the battles over siting treatment services *see infra* text accompanying notes 270 and 271.

52 Racial and ethnic discrimination has been at the core of the national response to drug control since the turn of twentieth century. Musto describes how the South in the early 1900’s feared cocaine because Southern whites feared that black cocaine users would become “oblivious of their prescribed bounds and attack white society.” Musto, *supra* n. 12, at 6. This perception prevailed even though cocaine use was popular among both whites and blacks in both the North and South for medicinal and non-medicinal purposes at the turn of the century (cocaine was added to commercial products such as soda pop, wine, ointments and sprays), and there was no evidence that cocaine caused a crime wave among blacks. According to Musto, white fear of violence, not the reality of cocaine’s effects, provided one more reason for the repression of blacks. *Id.* at 8-10, 295.

53 The alcohol and drug treatment system traces its roots to the narcotics prison-hospitals in Lexington, Kentucky and Fort Worth, Texas, established in 1932 and 1938, respectively. These facilities were established to address over-crowded prison conditions that resulted from the unprecedented level of incarceration of opiate dependent persons in the 1920’s. These federal prison-hospitals provided the only narcotics addiction treatment in the United States at the time, and, thus, served individuals who voluntarily committed themselves in addition to criminal offenders. INSTITUTE OF MEDICINE, TREATING DRUG PROBLEMS 48-50 (Dean Gerstein & Henrick Harwood, eds., 1990); H. Kleber, *Methadone: The*

treatment, one of the most controversial treatment modalities for opiate addiction, is essentially available only at hospitals or highly regulated treatment centers.⁵⁴ Most medical schools and residency programs cast a blind eye to alcoholism and drug addiction in their curricula.⁵⁵ Private health insurance often

Drug, the Treatment, the Controversy, in ONE HUNDRED YEARS OF HEROIN 150 (David Musto ed., 2002).

Alcohol and drug treatment continues to be delivered primarily through specialty providers that are not integrated with the larger general medical care system. The 2002 N-SSATS reported that 60% of the 13,720 facilities offering alcohol and drug treatment designate themselves as substance abuse treatment settings. Twenty-five percent (25%) are combined substance abuse and mental health organizations, 8% are mental health organizations and 3% are health care settings. Sixty-one percent (61%) operate as not-for-profit and 25% operate as private for-profits, with the remaining 14% a combination of state and local government, federal agencies and tribal government. N-SSATS, *supra* n. 22, at Highlights and Figure 2.

54 Since 1972, methadone has been subject to special regulatory standards that prescribe how and under what circumstances it may be used to treat narcotic addiction. No other medication is so highly regulated. These standards were implemented initially to respond to real abuses and perceived threats of diversion of methadone into illicit channels while creating standards that would permit community-based services to be available. By the mid-1990's, however, when Congress asked the Institute of Medicine (IOM) to examine whether these additional regulatory restrictions remained necessary, the IOM concluded that no compelling medical reason existed for regulating methadone differently from other FDA approved medications, including schedule II controlled substances. The IOM found that the regulations had deprived society of reaping the full benefit of methadone as an effective treatment for addiction and preventative measure for violence and other public health problems. The regulations had prevented some individuals from obtaining treatment tailored to their needs, prevented doctors from exercising professional judgment in treating patients, resulted in the isolation of treatment programs from mainstream medical care, and imposed significant economic costs to ensure compliance. The IOM recommended, among other things, readjustment of the regulatory controls to reduce government oversight and increase reliance on clinical practice guidelines, provision of maintenance treatment outside a licensed treatment program, and greater latitude to obtain take-home doses after the first three months of treatment. FEDERAL REGULATION OF METHADONE TREATMENT, *supra* n. 5, at 30-31, and 200-204. While the federal government revised the regulations in 2001 to address some of these concerns, it retained the most problematic structural features – the need for daily attendance by most patients at a centralized location to obtain medication – that continue to undermine the expansion of services. Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction, 21 C.F.R. § 291 and 42 C.F.R. § 8 (2003).

55 McLellan, *supra* n. 32, at 1689. This limited education has implications for subsequent diagnosis and

excludes coverage for addiction treatment and rarely provides coverage that is comparable to that for other non-psychiatric medical conditions.

Taken together, these legal and social standards and practices have created, fueled and perpetuated the stigma that is associated with alcoholism and drug dependence.⁵⁶ On the local level, stigma is often manifested in opposition to treatment services based on a lack of understanding about what happens within the walls of a treatment program and a fear of the persons in treatment that our punitive policies

referral for treatment. Surveys indicate that most physicians fail to screen for alcohol or drug dependence during routine examinations, and many health professionals view such screening efforts as a waste of time. Moreover, a survey of general practice physicians and nurses indicated that most believed no available medical or health care interventions would be appropriate or effective in treating addiction. *Id.*

56 For a discussion of the role of law as both a source of stigma and a basis for challenging stigma in the public health context, see S. Burris, *Disease Stigma in U.S. Public Health Law*, 30 J. OF LAW, MED. & ETHICS 179 (2002). Burris summarizes the literature on stigma and how it operates in society as a mode of social control. Understanding this framework is useful for purposes of crafting effective responses to NIMBY.

Stigma is conceptualized as the understanding that a particular trait “spoils” the identity of those who possess that trait and that both the person possessing the trait – the stigmatized -- and those who do not – the “normals” in the social group – share the view that the trait is discrediting. Stigma operates at two levels of social organization, the individual and society. On the societal level, stigma exists, according to some theorists, when four elements co-occur in a power situation: people distinguish and label human differences; the dominant culture links labeled individuals to undesirable characteristics – negative stereotypes; labeled individuals are placed in distinct categories and “separated” from those who do not possess the label; and labeled persons experience loss and discrimination that result in unequal outcomes.

On an individual level, theorists have observed that a person who possesses a stigmatized condition that is concealable will respond in one of two ways: either accept the stigma and conceal the condition to avoid the intolerant attitudes and potential discrimination or reject the stigma and adopt resistance strategies to educate the public about the condition and develop social supports to address mistreatment. Rejecting stigma may have two benefits. First, it can reduce an individual’s hidden distress that results from the stress of concealment and self-imposed isolation to ensure concealment. Second, it can challenge conventional views and gradually reduce the impact of stigma on both the individual and society at large. *Id.* at 179-83.

have constructed.⁵⁷

PART III: CIVIL RIGHTS LAWS AND ZONING DISCRIMINATION

Civil rights laws that protect individuals with disabilities against discrimination – the Rehabilitation Act of 1973,⁵⁸ the Americans with Disabilities Act (ADA) and the Fair Housing Act

57 One court recently condemned as deplorable the “hyperbolic and intemperate language” used by one locality to describe individuals who sought methadone treatment and the programs that serve them. The court cited the following examples from the locality’s brief: “residents who live in a community, when apprised that a methadone clinic may open, can – without undertaking scientific analysis – oppose the idea simply on the basis that the clientele who have abused heroin have engaged in numerous illegal acts and other opprobrious behavior; “it takes a certain quality, so to speak, to want to inject yourself with something worse than lighter fluid;” and “It is the people (the self-inflicted disabled who ignore the laws) that Baltimore County is to embrace into their neighborhoods.” *Start, Inc. v. Baltimore County, Md.*, 295 F.Supp.2d 569 (D.Md. 2003); *see infra* text accompanying notes 204, 205, 268 and 269.

58 Section 504 of the Rehabilitation Act provided the legal framework and basic non-discrimination standards that Congress adopted and expanded in the enactment of the ADA and FHA. This discussion will focus primarily on the ADA and FHA because of those statutes’ broader reach (*see infra* text accompanying notes 70-73 and 127) and weave in the Section 504 standards where relevant. It is important to note, however, that Section 504 may fill an important gap in remedial relief against States and entities deemed to be an “arm of the State” under the Supreme Court’s evolving sovereign immunity jurisprudence. Under the Supreme Court’s decision in *Board of Trustees v. Garrett*, 531 U.S. 356 (2001), states are immune from private suit for monetary damages under Title I of the ADA (the employment discrimination provisions). The Supreme Court has not yet decided whether Congress similarly exceeded its authority to abrogate the States’ Eleventh Amendment immunity (*see* 42 U.S.C. § 12202) under the Title II of the ADA, the public entity provisions under which zoning discrimination actions are brought (*see Hason v. Medical Board of California*, 279 F.3d 1167 (9th Cir. 2002), *cert dismissed*, 123 S. Ct. 1779 (2003), but is expected to address that issue in the 2003 term in *Tennessee v. Lane*, 315 F. 3d 680 (6th Cir. 2003), *cert. granted*, 123 S. Ct. 2622 (2003)). To the extent, the Supreme Court finds that States are not subject to private damage actions under Title II, private parties may be able to bring such actions under Section 504. The Rehabilitation Act, unlike the ADA, was enacted pursuant to the Spending Clause, and Congress explicitly waived immunity under 42 U.S.C. § 200d-7. Several federal appellate courts have held that a State has knowingly waived its Eleventh Amendment immunity by accepting federal funding. *See Koslow v. Commonwealth of Pennsylvania*, 302 F.3d 161 (3rd Cir. 2002), *cert. denied*, 537 U.S. 1232 (2003); *Nihiser v. Ohio Environmental Protection Agency*, 269 F.3d 626 (6th Cir. 2001), *cert. denied*, 122 S. Ct. 2588 (2002); *Kvorjak v. State of Maine*, 259 F.3d 48 (1st Cir. 2001); *Douglas v. California Dept. of Youth Authority*, 271 F.3d 910 (9th Cir. 2001); *Jim C. v. United States*, 235 F.3d 1079 (8th Cir. 2000), *cert. denied*, 533 U.S. 949 (2001); and *Stanley v.*

(FHA) – were enacted to end the isolation and exclusion of individuals with disabilities from mainstream society and to prevent decision-making based on stereotypical attitudes and biases. These laws protect individuals with histories of alcoholism and drug dependence from discrimination in the receipt of public services, including zoning, and housing. While courts have not consistently interpreted these civil rights laws to protect individuals with disabilities in the broad fashion normally afforded the beneficiaries of civil rights statutes,⁵⁹ they establish clear standards that should make local officials think twice before adopting zoning practices that bar alcohol and drug treatment programs from communities or treat them differently from other medical services.

A. Title II of the Americans With Disabilities Act and the Fair Housing Act

Title II of the ADA prohibits all public entities from discriminating against qualified individuals with a disability or denying those individuals the benefit of or participation in its services, programs or activities on the basis of disability.⁶⁰ Title II extends the anti-discrimination requirements of Section 504 of the Rehabilitation Act to all public entities, regardless of whether they receive federal financial assistance.⁶¹ Title II also provides, at a minimum, the same level of protection as provided under

Litscher, 213 F.3d 340 (7th Cir. 2000). *But see, Pace v. Bogalusa City School Board*, 325 F.3d 609 (5th Cir. 2003); *Garcia v. S.U.N.Y. Health Sciences Center of Brooklyn*, 280 F.3d 98 (2nd Cir. 2001). The Supreme Court will undoubtedly address the Eleventh Amendment waiver issue in the near future.

⁵⁹ See *infra* text accompanying note 78 (definition of disability) and *supra* note 58 (abrogation of immunity).

⁶⁰ 42 U.S.C. § 12132 provides:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

⁶¹ Section 504, 29 U.S.C. § 794 provides in pertinent part:

Section 504.⁶²

The FHA makes it unlawful to discriminate in the sale or rental, or to otherwise make unavailable or deny a dwelling to any buyer or renter because of a handicap. The FHA also prohibits discrimination in the terms, conditions, or privileges of sale or rental of a dwelling or in the provision of services in connection with a dwelling.⁶³ The term “dwelling” has been construed broadly by the courts

No otherwise qualified individual with a disability in the United States, as defined in section 706(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by an Executive agency or by the United States Postal Service. . . .

Apart from the requirement of federal financial assistance, the key difference between the substantive standard established under Section 504 and Title II is, according to some courts, that disability must be the “sole” basis for discrimination under Section 504, while it need only be a motivating reason under Title II. *See Baird v. Rose*, 192 F.3d 462 (4th Cir. 1999).

62 The ADA provides that, “[e]xcept as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. §790 *et seq.*) or the regulations issued by Federal agencies pursuant to such title.” 42 U.S.C. § 12201(a).

63 42 U.S.C. § 3604(f)(1) and (2) makes it unlawful:

- (1) To discriminate in the sale or rental, or to otherwise make unavailable or deny, a dwelling to any buyer or renter because of a handicap of –
 - (A) that buyer or renter;
 - (B) a person residing in or intending to reside in that dwelling after it is so sold, rented, or made available; or
 - (C) any person associated with that buyer or renter.
- (2) To discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection with such dwelling, because of a handicap of –
 - (A) that person; or
 - (B) a person residing in or intending to reside in that dwelling after it is so sold, rented, or made available; or
 - (C) any person associated with that person.

to include “a temporary or permanent dwelling place, abode or habitation to which one intends to return as distinguished from the place of temporary sojourn or transient visit.”⁶⁴ Courts have applied the FHA’s non-discrimination requirements to a wide range of “dwellings” in which individuals in treatment for or in recovery from alcohol and drug dependence reside: a residential treatment program;⁶⁵ a group home for individuals attending an out-patient treatment program;⁶⁶ an apartment for individuals who have completed a year-long residential treatment program and are monitored by the treatment program;⁶⁷ a halfway house in which treatment program staff reside with individuals in recovery;⁶⁸ and self-run sober group homes.⁶⁹

Four basic questions must be considered when evaluating whether zoning standards that restrict the siting of alcohol and drug treatment services may be challenged under Title II or the FHA: (1) are zoning decisions subject to anti-discrimination statutes; (2) who is protected against discrimination; (3) what constitutes discrimination; and (4) how is discrimination proved.

⁶⁴ *United States v. Hughes Memorial Home*, 396 F. Supp. 544, 549 (W.D. Va. 1975).

⁶⁵ *Behavioral Health Services, Inc. v. City of Gardenia*, 2003 WL 21750852, at * 5 (C.D. Cal. Feb. 6, 2003) (six to twelve month residential treatment program for women and their children); *Corporation of the Episcopal Church in Utah v. West Valley City*, 119 F. Supp.2d 1215, 1217 (D. Utah 2000) (proposed residential program that would house approximately seventeen individuals for two to three months.); *Project Life, Inc. v. Glendening*, 1998 WL 1119864 at * 2 (D. Md. Nov. 30, 1998) (proposed residential program for women located on ship would be a “dwelling”).

⁶⁶ *Connecticut Hospital v. City of New London*, 129 F. Supp.2d 123, 132-34 (D. Conn. 2001).

⁶⁷ *U.S. v. Southern Management Corp.*, 955 F.2d 914 (1992).

⁶⁸ *Elliot v. City of Athens*, 960 F.2d 975 (11th Cir. 1992).

⁶⁹ See, e.g., *Tsombanidis v. City of West Haven, Conn.*, 129 F. Supp.2d 136 (D.Conn. 2001), *aff’d in part, rev’d in part*, 352 F.3d 565 (2nd Cir. 2003); *Oxford House, Inc. v. Town of Babylon*, 819 F. Supp. 1179 (E.D.N.Y. 1993).

1. Are Zoning Decisions Subject to Anti-Discrimination Protections

Congress did not define what constitutes a “service, program or activity” under Title II, but courts have generally construed the term broadly to include **all** activities of a public entity. This construction is supported by the definition of “program or activity” under Section 504 as well as the Title II regulations promulgated by the Department of Justice (DOJ).⁷⁰ Section 504 defines “program or activity” to mean “**all** of the operations” of a department, agency, special purpose district, or other instrumentality of a State or local government.⁷¹ The DOJ regulations, like the statute, do not define these terms, but the agency’s preamble to the regulations explains that “title II applies to anything a public entity does.”⁷² Courts have relied on this authority as well as Title II’s catch-all prohibition against discrimination by a public entity to conclude that municipal zoning is an activity or a service that is covered under Title II.⁷³

70 28 C.F.R. § 35 (2003). *See Sullivan v. City of Pittsburgh, Pa.*, 811 F.2d 171 (3rd Cir. 1987) (section 504 claim exists in case challenging city’s refusal to issue zoning permits and award community block grant funds).

71 29 U.S.C. § 794(b) (emphasis added).

72 28 C.F.R. § 35, App. A, § 35.102 Application (2003).

73 *Bay Area Addiction Research and Treatment, Inc. v. City of Antioch*, 179 F.3d 725, 730-32 (9th Cir. 1999); *Innovative Health Systems v. City of White Plains*, 117 F.3d 37, 44-46 (2nd Cir. 1997); *Tsombanidis v. City of West Haven, Conn.*, 129 F. Supp.2d at 150-51, *aff’d*, 352 F.3d at 574; *MX Group, Inc. v. City of Covington*, 106 F. Supp.2d 914, 920 (D. Ky. 2000), *aff’d*, 293 F.3d 326 (6th Cir. 2002); *Smith-Berch, Inc. v. Baltimore County*, 68 F. Supp.2d 602, 623 (D. Md. 1999); *but see Robinson v. City of Friendswood*, 890 F. Supp. 616, 620 (S.D. Tex. 1995); *United States v. City of Charlotte, N. Ca.*, 904 F. Supp. 482, 484-85 (W.D. N.Ca. 1995). The DOJ’s Title II Technical Assistance Manual specifically references the implementation of a municipal zoning ordinance as an activity that would be subject to the Title II reasonable accommodation requirement. UNITED STATES DEPT. OF JUSTICE, AMERICANS WITH DISABILITIES ACT, TITLE II TECHNICAL ASSISTANCE MANUAL, II-3.6100, Illustration 1 (1993).

Zoning and land use requirements are also subject to the FHA.⁷⁴ The legislative history of the FHA explains:

These new subsections would also apply to state or local land use and health and safety laws, regulations, practices or decisions which discriminate against individuals with handicaps. While state and local governments have authority to protect safety and health, and to regulate use of land, that authority has sometimes been used to restrict the ability of individuals with handicaps to live in communities. This has been accomplished by such means as the enactment or imposition of health, safety or land-use requirements on congregate living arrangements among non-related persons with disabilities. Since these requirements are not imposed on families and groups of similar size or other unrelated people, these requirements have the effect of discriminating against persons with disabilities.

The Committee intends that the prohibition against discrimination against those with handicaps apply to zoning decisions and practices. The Act is intended to prohibit the application of special requirements through land-use regulations, restrictive covenants, and conditional or special use permits that have the effect of limiting the ability of such individuals to live in the residence of their choice in the community.⁷⁵

The FHA, unlike Title II, does not directly identify public entities as being subject to its non-discrimination requirements or set out who may be sued for discrimination. The FHA casts a broad net by stating, “it shall be unlawful” to discriminate against individuals with handicaps.⁷⁶

2. Are Persons with Alcoholism and Drug Dependence Protected Against Discrimination

The ADA and FHA provide essentially the same scope of coverage for individuals with alcohol and drug dependence problems, albeit with slightly different statutory language.

⁷⁴ *City of Edmonds v. Oxford House, Inc.*, 514 U.S. 725 (1995).

⁷⁵ H.R. Rep. No. 100-711, 100th Cong. 2d Sess. 24 (1988), *reprinted in* 1988 U.S.C.C.A.N. 2173, 2185.

⁷⁶ *See Hemisphere Building Co., Inc. v. Village of Richton Park*, 171 F.3d 437 (7th Cir. 1999).

a. Title II

Title II extends discrimination protection to “qualified individuals with disabilities.” The ADA’s definition of “disability” is a three-pronged definition modeled directly after the Rehabilitation Act definition. It covers an individual who has “a physical or mental impairment that substantially limits one or more of the major life activities of such individual,” “a record of such an impairment;” or being “regarded as having such an impairment.”⁷⁷ Thus, individuals who have current disabling condition, a condition that was disabling in the past, or are perceived erroneously as having a disabling condition are protected against discrimination. While the statute itself does not define the terms “physical or mental impairment,” “major life activity” or “substantially limits,” the DOJ Title II regulations provide guidance, and the Supreme Court has further refined, and, as some commentators would argue, restricted the scope of those terms.⁷⁸

A “physical or mental impairment” is any physiological disorder or condition that affects any of

⁷⁷ 42 U.S.C. § 12102(3); 28 C.F.R. § 35.104 (2003). The statutory definition applies to all three titles of the ADA (employment, public entities and public accommodations) and no single federal agency was given statutory authority to define that term. The Equal Employment Opportunity Commission has defined the term in its regulations and the Department of Justice had done so in both the public entity and public accommodations regulations.

⁷⁸ Aviam Soifer, *Disabling the ADA: Essences, Better Angels, and Unprincipled Neutrality Claims*, 44 WILLIAM AND MARY L. REV. 1285 (2003); Kiren Dosanjh Zucker, *The Meaning of Life: Defining “Major Life Activities” Under the Americans With Disabilities Act*, 86 MARQ. L. REV. 957 (2003); Cheryl L. Anderson, “*Deserving Disabilities*”: *Why the Definition of Disability Under the Americans With Disabilities Act Should Be Revised to Eliminate the Substantial Limitation Requirement*, 65 MO. L. REV. 83 (2000); Ruth Colker, *The Americans With Disabilities Act: A Windfall for Defendants*, 34 HARV. C.R.-C.L. L. REV. 99 (1998); Steven S. Locke, *The Incredible Shrinking Protected Class: Redefining the Scope of Disability Under the Americans With Disabilities Act*, 68 U. COLO. L. REV. 107 (1997); and Argun M. Ulgen, Comment, *From Household Bathrooms to the Workplace: Bringing the Americans With Disabilities Act Back to Where It Belongs: An Analysis of Toyota Motor Manufacturing v. Williams*, 30 FORDHAM URB. L.J. 761 (2003).

the body systems and any mental or psychological disorder.⁷⁹ The Title II regulations provide a non-inclusive list of impairments and explicitly include “alcoholism” and “drug addiction” in that list.⁸⁰ In addition, the Title II regulations define “major life activities” as “functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”⁸¹ The wild card in the analysis is the amorphous term “substantially limiting.” The DOJ’s interpretive guidance states that an individual is substantially limited when the “individual’s important life activities are restricted as to the conditions, manner, or duration under which they can be performed in comparison to most people.”⁸² The Supreme Court ratcheted up the threshold for meeting this standard in *Toyota Motor Manufacturing v. Williams*, holding that an individual is substantially limited only if the impairment prevents or severely restricts his or her ability to perform a major life activity and the impact is permanent or long-term.⁸³

79 28 C.F.R. § 35.104 (2003).

80 28 C.F.R. § 35.104 (2003).

81 28 C.F.R. § 35.104 (2003). The Supreme Court expanded that list in *Bragdon v. Abbott*, 524 U.S. 624 (1998), holding that reproduction is a major life activity. The Court reexamined the issue in *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*, 534 U.S. 184, 197 (2002), and held that major life activities are those that are of central importance to most people’s daily lives.

82 28 C.F.R. § 35 App. A, Substantial Limitation of a Major Life Activity (2003).

83 *Toyota Motor Manufacturing, supra*, 534 U.S. at 198. In 1999, the Supreme Court made clear in *Sutton v. United Airlines, Inc.*, 527 U.S. 471 (1999) and *Albertsons Inc. v. Kirkingburg*, 527 U.S. 555 (1999), that the disability determination must be made on an individualized, case-by-case basis that examines the effect of the impairment on the particular individual rather than on the general characteristics of a particular condition. Moreover, to the extent an individual’s impairment is corrected by medications, modified behavior or corrective devices, the individual does not satisfy the first prong of the definition of disability.

Individuals who suffer from the impairments of alcoholism and drug dependence must satisfy the above standards to assert protection under the ADA, but face one significant gap in coverage. The law excludes from protection individuals who currently engage in the illegal use of drugs if the public entity acts on the basis of such use.⁸⁴ The term “drug” is defined to cover only a controlled substance, as defined under the Controlled Substances Act,⁸⁵ and, thus, individuals with current alcohol problems who do not engage in the illegal use of drugs are not excluded from protection as an individual with a disability by virtue of their alcohol use.⁸⁶ Similarly, individuals who take controlled substances under

84 42 U.S. C. § 12210 provides in relevant part:

(a) *In general*

[T]he term “individual with a disability” does not include an individual who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use.

(b) *Rules of Construction*

Nothing in subsection (a) shall be construed to exclude as an individual with a disability an individual who –

(1) has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use;

(2) is participating in a supervised rehabilitation program and is no longer engaging in such use; or

(3) is erroneously regarded as engaging in such use, but is not engaging in such use

85 42 U.S.C. § 12210 provides in pertinent part:

(d) “Illegal use of drugs” defined

(1) *In general*

The term “illegal use of drugs” means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act [21 U.S.C. 801 et seq.]. Such term does not include the use of a drug taken under supervision by a licensed healthcare professional, or other uses authorized by the Controlled Substance Act or other provisions of Federal law.

(2) *Drugs*

The term “drug” means a controlled substance, as defined in schedules I through V of section 202 of the Controlled Substances Act [21 U.S.C. 812].

86 See Department of Justice discussion at 28 C.F.R. § 35, App. A, § 35.131 *Illegal Use of Drug* (2003).

the supervision of a licensed health care professional or as authorized by the Controlled Substances Act are also not deemed to be engaged in the illegal use of drugs. Accordingly, individuals with alcohol or drug dependence who have been rehabilitated or are participating in an alcohol or drug treatment program, including methadone maintenance programs, are covered under the definition of disability, as long as they do not currently engage in the illegal use of drugs. In addition, individuals who are erroneously perceived as engaging in current drug use are also protected.⁸⁷

There is one important exception to the exclusion of persons who currently use drugs illegally: an individual cannot be denied health services or services provided in connection with drug rehabilitation on the basis of his or her current use of drugs if the individual is otherwise entitled to such services.⁸⁸ Congress wisely included this provision to ensure that individuals with current drug

87 The Department of Justice explained the distinction that Congress had drawn in excluding individuals who engage in the illegal use of drugs from the definition of “individual with a disability. “Congress intended to deny protection to people who engage in the illegal use of drugs, whether or not they are addicted, but to provide protection to addicts so long as they are not currently using drugs.” 28 C.F.R. § 35, App. A, § 35.131 *Illegal Use of Drug* (2003). Thus, protections extend to persons who are participating in treatment programs, those who have been rehabilitated and those erroneously regarded as engaging in the illegal use of drugs. *Id.* For a discussion of the legislative history of the drug provisions, see R. Burgdorf, *Drugs and Alcohol*, in *DISABILITY DISCRIMINATION IN EMPLOYMENT LAW* (BNA 1995).

88 42 U.S.C. § 12210(c) provides:

(c) Health and other services

Notwithstanding subsection (a) of this section and section 12211(b)(3) of this title, an individual shall not be denied health services, or services provided in connection with drug rehabilitation, on the basis of the current illegal use of drugs if the individual is otherwise entitled to such services.

The Title II regulations provide that, “[a] public entity shall not deny health services, or services provided in connection with drug rehabilitation, to an individual on the basis of that individual’s current illegal use of drugs” 28 C.F.R. § 35.131(b)(1) (2003).

problems could receive health care services, including drug treatment, that are essential to recover from drug dependence.⁸⁹ Without such protection, individuals who are seeking treatment for an active drug problem could be prevented from challenging discriminatory practices that prevent them from getting treatment. In the zoning context, this arguably means that even an individual who has a current drug problem would have standing to challenge a zoning standard that interferes with the establishment of an alcohol or drug program. Drug treatment programs could also use this provision to defend claims that they are not protected under the ADA⁹⁰ based on the current drug use of some clients who are in the early stages of recovery.⁹¹

89 As the Department of Justice explained in the preamble to the Title II regulations, “Congress clearly intended to prohibit exclusion from drug treatment programs of the very individuals who need such programs because of their use of drugs. . . .” 28 C.F.R. § 35, App. A § 35.131 (2003).

90 The Title II regulations provide that “[a] public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.” 28 C.F.R. §35.130(g) (2003). This provision ensures that entities that provide services to individuals with disabilities, such as health care services, are not subjected to discrimination because of their professional association with their clients. 28 C.F.R. § 35, App. A 3§ 5.130 General Prohibitions Against Discrimination (2003).

Accordingly, courts have held in Title II zoning discrimination cases, that drug treatment programs have standing to challenge discriminatory zoning decisions. *See MX Group, Inc.*, 293 F.3d at 332-35; *Innovative Health Systems*, 117 F.3d at 47-48; and *Tsombanidis*, 180 F. Supp.2d at 280 (landlord of property rented by umbrella organization for Oxford Houses).

91 Courts have generally rejected claims that current drug use by some clients disqualifies the treatment program from protection under the Act, without relying on §12210(c). The Second Circuit in *Innovative Health Systems* noted that “the program indisputably does not tolerate drug use by its participants. An inevitable, small percentage of failures should not defeat the rights of the majority of participants in the rehabilitation program who are drug-free and therefore disabled under [Title II].” 117 F.3d at 48. The District Court for the Northern District of California in *Bay Area Addiction Research and Treatment, Inc. v. City of Antioch*, in an order granting preliminary injunction, declined to resolve whether §12210(c) would enable persons who currently used drugs to challenge a zoning ordinance, finding that the rights of the named plaintiffs, who abstained from drug use, would not be affected by persons in the

Courts that have undertaken a close analysis of whether individuals with alcohol and drug dependence are covered in the Title II context under the *Toyota Motor Manufacturing* and *Sutton* standards have concluded that individuals who participate in alcohol and drug treatment and reside in group recovery homes are protected against discrimination.⁹² The Second Circuit, for example, in *Regional Economic Community Action Program, Inc. v. City of Middletown*⁹³ concluded that future clients of a halfway house were substantially limited in their ability to live independently and to care for themselves based on statutorily established eligibility criteria for admission to a halfway house.⁹⁴ Those criteria limited admission to individuals who were unable to abstain from alcohol and, thus, care for

treatment program who continued to use. 2000 WL 33716782 (Mar. 16, 2000). This provision may have relieved courts in Title II cases related to health care or treatment services of the difficult task of attaching time frames to and cabining the term “current.” The Title II regulations define the term as “illegal use of drugs that occurred recently enough to justify a reasonable belief that a person’s drug use is a real and ongoing problem.” 28 C.F.R. § 35.104 (2003).

92 Unlike Title I employment discrimination cases, the coverage issue in Title II cases is often conceded, even with the strict coverage standard. *See, e.g., Habit Management, Inc. v. City of Lynn*, 235 F. Supp.2d 28, 29 (D. Mass. 2002) (clients of a methadone treatment program are recovering drug addicts, who “Lynn concedes are “qualified individuals with disabilities”); *Smith-Berch, Inc.*, 68 F. Supp.2d at 617 (“defendants do not dispute that WMI’s anticipated clientele – individuals with opiate addiction who require methadone therapy to aid in their recovery – are disabled individuals covered by the ADA.”); and *Project Life, Inc.* 1998 WL 1119864 * 1 (D. Md.) (“there is no dispute that . . . an individual recovering from substance abuse is an individual with a disability under the ADA”).

93 294 F.3d 35 (2nd Cir. 2002).

94 Several courts have dealt with the inherent dilemma of satisfying the individualized standard of coverage when a program has been barred from siting and, thus, is without actual patients to demonstrate a substantially limiting impairment. In *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*, the Second Circuit noted that the concern about varying intensities of symptoms was obviated because all residents had to meet statutorily defined levels of impairment to reside in the halfway house. 294 F.3d at 48, n.3. The Sixth Circuit in *MX Group, Inc.* held that, where a program has been foreclosed from opening based on the clients it intended to serve, it would defy reason to require an individualized determination based on an actual client. 293 F.3d at 336.

themselves, without continued services in a structured living environment and would require such services for three to nine months (thereby satisfying the long-term duration requirement). The Court also concluded, without analysis, that future clients would qualify under the second prong of the disability definition because they have a record of a substantially limiting impairment. The Sixth Circuit concluded that future clients of a methadone treatment program would be covered under all three prongs of the disability definition. They are substantially limited in their ability to work, parent and function, and those limitations are not ameliorated or rendered transitory by the medication as the recovery process could take years and is often fraught with relapse.⁹⁵ The court also found that potential clients of a methadone program had a record of a substantially limiting impairment because they were required to provide documentary proof of one year of narcotic or opiate addiction to be admitted and would, during that one-year period, be unable to work or function. Finally, the “regarded-as” prong was satisfied because the program had been denied a zoning permit based on the stereotypical, but unfounded, fear that future clients would continue drug use and would attract drug activity to the area, thereby being perceived as being limited in productive social functioning based on their alleged criminality.⁹⁶

⁹⁵ See also *Bay Area Addiction Research and Treatment, Inc.*, 2000 WL 33716782, at 6 (evidence existed that even with the mitigating effect of methadone treatment, recovery is a process that can take weeks, months or years after individuals enter treatment, during which time they continue to be substantially limited in their ability to work and raise families. Methadone treatment itself imposes substantial limitations on the patients’ lives because they must visit a clinic daily for medication, which affects the individual’s choice of residence and work, participate in counseling, and undergo random drug testing and intensive scrutiny.)

⁹⁶ 293 F.3d at 342; and *Bay Area Addiction Research and Treatment, Inc.*, 2000 WL 33716782, at 11-12 (fear that clients of methadone program would continue to use drugs and engage in crime demonstrated that individuals were substantially limited in ability to interact with others, work and

The final hurdle to asserting protection under Title II, is demonstrating that the individual with a disability is “qualified” to participate in the service, program or activity; i.e. meets the essential eligibility requirements for participation in the public entity’s program or activity, either with or without reasonable modifications of rules, policies or procedures.⁹⁷ An individual who presents a “direct threat” to the health or safety of others is not “qualified.” “Direct threat” is defined in the preamble of the Title II regulations as:

a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids The determination that a person poses a direct threat to the health or safety of others may not be based on generalizations or stereotypes about the effects of a particular disability. It must be based on an individualized assessment, based on reasonable judgment that relies on current medical evidence or on the best available objective evidence, to determine: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.⁹⁸

The risk at issue must not only be real, but also “significant.”⁹⁹ The Ninth Circuit articulated the direct threat standard in the context of a methadone treatment program’s zoning discrimination challenge in *Bay Area Addiction Research and Treatment, Inc.* It explained that a significant risk to health and safety includes “severe and likely harms to the community that are directly associated with the operation of the methadone clinic . . . [and] may include a reasonable likelihood of a significant increase in crime.

refrain from criminal activity.)

97 42 U.S.C. 12131(2) defines “qualified individual with a disability,” in relevant part, as: “an individual with a disability who, with or without reasonable modifications to rules policies, or practices . . . meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

98 28 C.F.R. § 35, App. A § 35.104 Definitions (2003).

99 *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998).

. . . [I]t is not enough that individuals pose a hypothetical or presumed risk. Instead, the evidence must establish that an individual does, in fact, pose a significant risk.”¹⁰⁰ While public entities often raise this issue as a rationale for imposing special requirements on the siting of drug and alcohol treatment services,¹⁰¹ courts that have examined the factual basis for such a claim have concluded uniformly that individuals who are participating in alcohol or drug treatment services do not present a “direct threat.”¹⁰²

b. The Fair Housing Act

In addition to the ADA, individuals who are in treatment or are in recovery from alcohol or drug dependence (as well as those erroneously perceived as current drug users) are covered under the FHA’s definition of “handicap,” as long as they are not currently using drugs illegally.¹⁰³ Individuals with

¹⁰⁰ *Bay Area Addiction Research and Treatment, Inc.*, 179 F.3d at 736-37.

¹⁰¹ *See supra* text accompanying note 38.

¹⁰² *Behavioral Health Services, Inc.*, 2003 WL 21750852 * 7 (women’s residential treatment program will not constitute a direct threat to the health or safety of other individuals or result in substantial physical damage to the property of others); *MX Group, Inc.*, 293 F.3d at 342 (ample evidence that plaintiff’s other methadone program operated without incident of criminal activity and that “methadone clinics present no more problems in the way of drug trafficking and diversion than other facilities that deal with lawfully administered drugs, such as hospitals and pharmacies.”); *Tsombanidis v. City of West Haven*, 180 F. Supp.2d at 289 (no evidence that allowing a group home for recovering alcoholics and drug dependent persons to operate in a single-family district would jeopardize the public health, safety, or welfare of neighbors or would diminish property values in the neighborhood); *Bay Area Addiction Research and Treatment, Inc.*, 2000 WL 33716782, at 13-19 (extensive evidence that the location of a methadone program in a residential neighborhood does not significantly increase the risk of crime in the neighborhood, including police records that reflected no criminal activity in the area of the clinic that was directly attributable to the clinic); *See also Smith-Berch, Inc.*, 68 F. Supp.2d at 617-18; and *Oxford House-C v. City of St. Louis*, 843 F. Supp. 1556, 1570 (E.D. Mo. 1994) (in case brought under the Fair Housing Act, “[S]tudies have . . . shown that the presence of group homes has not had an impact on crime, safety, traffic, utilities, noise, or parking.”).

¹⁰³ 42 U.S.C. § 3602(h) provides:

‘Handicap’ means, with respect to a person –

alcohol dependence who do not use drugs illegally are also protected like any other individual with a disability, as the FHA also defines “drug” to be a controlled substance,¹⁰⁴ distinguishing between legal and illegal drug use. An individual’s “current use” may be a more significant barrier to challenging zoning discrimination in residence-based treatment or supportive services under the FHA than under the ADA (to the extent Title II protections are not asserted), as the FHA does not protect persons with “current” illegal drug use from discrimination in the receipt of health services or treatment. In several FHA cases brought on behalf of individuals in recovery, the courts have made clear that anyone who resides in a recovery home or transitional house will not be protected against discrimination if he or she uses drugs illegally.¹⁰⁵ Courts have, however, readily extended protection to individuals with histories

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- (1) a physical or mental impairment which substantially limits one or more of such person’s major life activities,
 - (2) a record of such an impairment,
 - (3) being regarded as having such an impairment,
- but such term does not include current, illegal use of or addiction to a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)).

The FHA, unlike the ADA, does not provide explicit coverage for individuals who are participating in or have completed treatment or are otherwise rehabilitated, but the legislative history makes clear that Congress did not intend to exclude individuals who “have recovered from an addiction [sic] or are participating in a treatment program or a self-help group such as narcotics Anonymous.” H.R. Rpt. 100-711 (1988), U.S.C.C.A.N. 2173, 2183. Congress explained that, “[j]ust like any other person with a disability, such as cancer or tuberculosis, former drug-dependent persons do not pose a threat to a dwelling or its inhabitants simply on the basis of status. Depriving such individuals of housing, or evicting them, would constitute irrational discrimination that may seriously jeopardize their continued recovery.” *Id.*

104 42 U.S.C. § 3602(h).

105 *Oxford House, Inc. v. Township of Cherry Hill*, 799 F. Supp. 450, 460 (D.N.J. 1992); *Oxford House-Evergreen v. City of Plainfield*, 769 F. Supp. 1329, 1342 (D. N.J. 1991). In addition, to address community opposition to services for persons with histories of drug dependence, entities have implemented clear policies that require the immediate eviction of individuals who use drugs illegally.

of alcohol and drug dependence, including those who continue to participate in treatment.¹⁰⁶

The FHA explicitly excludes one additional group of individuals from protection: those who have been convicted of the illegal manufacture or distribution of a controlled substance.¹⁰⁷ While a conviction record does not satisfy the definition of “handicap” and, thus, would not provide a basis for challenging a zoning decision, this defense could be used to exclude from residential treatment services individuals whose conviction record is associated with their underlying drug dependence – a fairly common relationship.¹⁰⁸ The ADA, which does not contain this exclusion, should fill in the gap to avoid

Oxford House, Inc. v. Township of Cherry Hill, 799 F. Supp. at 453 (Oxford House policy requires individuals who resume alcohol or drug use to leave the house); *Support Ministries for Persons With AIDS, Inc. v. Cit of Waterford, N.Y.*, 808 F. Supp. 120, 127 (N.D.N.Y. 1992) (adult day care facility for persons with AIDS would implement drug testing policy to ensure no-drug use policy followed and residents required to sign a contract adhering to policy and face eviction for violation); *Baxter v. City of Belleville, Ill.*, 720 F. Supp. 720, 733 (S.D. Ill. 1989) (any current illegal drug user would be denied admission to residence for persons with AIDS).

¹⁰⁶ See *United States v. Southern Management Corp.*, 955 F.2d 914, 917-23 (4th Cir. 1992); *Elliot v. City of Athens*, 960 F.2d at 977 n.2 (11th Cir. 1992); *Tsombanidis*, 129 F. Supp.2d at 147-48; *Corporation of the Episcopal Church in Utah v. West Valley City*, 119 F. Supp.2d 1215, 1219 (D. Utah 2000); *Project Life, Inc.*, 1998 WL 1119864 at * 2; and *Oxford House, Inc. v. Township of Cherry Hill*, 799 F. Supp. at 459-60 (D.N.J. 1992). As with many Title II zoning cases, few courts conduct a detailed analysis of whether the individuals in treatment for alcohol or drug dependence are substantially limited in a major life activity. Those that have examined the impact on functionality have concluded that these impairments disrupt personal relationships and impair one’s ability to advance in education and employment and that these impairments continue through at least the early stages of recovery. *Oxford House, Inc. v. Township of Cherry Hill*, 799 F. Supp. at 460. The Fourth Circuit in *Southern Management Corp.* concluded that individuals who were prohibited from residing in an apartment complex satisfied the “regarded as” prong, because they were denied the opportunity to obtain an apartment – a major life activity – as a result of the management company’s perception that they would be undesirable tenants. 955 F.2d at 919.

¹⁰⁷ 42 U.S.C. § 3607(d)(4).

¹⁰⁸ At least one city that fought the siting of a group recovery home in a residential neighborhood has used this exception to assert that the residents were not protected under the FHA. The court rejected as

this result to the extent there is evidence that the tenants' alcohol and drug dependence was also a motivating factor in the zoning decision.

The behavior of tenants is also subject to scrutiny under the FHA via a provision that parallels the ADA's "qualification" requirement. The FHA bars protection for any individual who presents a "direct threat" to the health or safety of other individuals."¹⁰⁹ The "direct threat" analysis outlined above also applies under the FHA. The legislative history to this provision explains that "[a]ny claim that an individual's tenancy poses a direct threat and a substantial risk of harm must be established on the basis of a history of overt acts or current conduct. Generalized assumption, subjective fears, and speculation are insufficient to prove the requisite direct threat to others."¹¹⁰ Moreover, as with Title II, entities are required to make reasonable accommodations that could eliminate the risk.

too speculative the city's argument that the future residents of a group recovery home would have convictions for drug distribution or manufacturing and, thus, not be protected under the Act. *Oxford House-Evergreen*, 769 F. Supp. at 1342-43.

109 Section 3604(f)(9) states:

Nothing in this subsection requires that a dwelling be made available to an individual whose tenancy would constitute a direct threat to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others.

110 H.R. Rep. No. 711, 100th Cong., 2d Sess. (1988), *reprinted in* 1988 U.S.C.C.A.N. 2173, 2190. *Cf. Talley v. Lane*, 13 F.3d 1031, 1034 (7th Cir. 1994) (FHA permits public housing authority to establish tenant selection criteria to determine if applicant is eligible for housing and to consider conviction history; public housing authority had discretion to find that individual with history of property and assaultive crimes, allegedly related to former drug use, would be a direct threat to other tenants).

3. What Actions Constitute Discrimination

a. Title II

Title II does not set out practices that constitute discrimination, but the Department of Justice Title II regulations identify a number of practices that constitute discrimination. Practices that are imposed with the intent to discriminate on the basis of disability as well as those that have the effect of discriminating violate Title II.¹¹¹ The standards most relevant to zoning discrimination challenges include the following. In providing any service, a public entity is prohibited from: (1) denying a qualified individual with a disability “the opportunity to participate in or benefit from the . . . service;” (2) affording “an opportunity to participate in or benefit from the . . . service that is not equal to that afforded others;” (3) providing a “service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;” or (4) otherwise limiting “the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the . . . service.”¹¹² A public entity is also prohibited from utilizing criteria or methods of administration that “have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability”¹¹³ Finally, a public entity is prohibited from imposing eligibility criteria “that screen out . . . an individual with a disability or any class of individuals with

¹¹¹ The Supreme Court recently affirmed in a Title I employment discrimination case involving an individual with a history of alcohol and drug dependence that the ADA prohibits practices that have a discriminatory purpose as well as those with a discriminatory effect. *Raytheon Co. v. Hernandez*, 124 S. Ct. 513, 519-20 (2003).

¹¹² 28 C.F.R. § 35.130(b)(1)(i), (ii), (iii), and (vii) (2003).

¹¹³ 28 C.F.R. § 35.130(b)(3)(i) (2003).

disabilities from fully and equally enjoying any service . . . unless such criteria can be shown to be necessary for the provision of the service. . . .”¹¹⁴ The Title II regulations also impose an affirmative duty on public entities officials to (1) “administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities”¹¹⁵ and (2) “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability. . . .”¹¹⁶

b. The FHA

As with Title II, the Department of Housing and Urban Development has promulgated sweeping regulations to enforce the FHA’s disability provision by invalidating practices that have either the intent or effect of discriminating on the basis of disability. In addition to restating the statutory prohibitions against denying or making a dwelling unavailable because of handicap,¹¹⁷ the FHA regulations make it unlawful to refuse to “make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford [such person] equal opportunity to use and enjoy a dwelling. . . .”¹¹⁸ The FHA regulations also prohibit steering practices that, because of handicap, “restrict the choices of a person . . . in . . . seeking, negotiating for, buying or renting a dwelling . . . or . .

¹¹⁴ 28 C.F.R. § 35.130(b)(8) (2003).

¹¹⁵ 28 C.F.R. § 35.130(d) (2003).

¹¹⁶ 28 C.F.R. § 35.130(b)(7) (2003).

¹¹⁷ 24 C.F.R. § 100.202(a) and (b) (2003).

¹¹⁸ 24 C.F.R. § 100.204(a) (2003).

. discourage or obstruct choices in a community, neighborhood or development.”¹¹⁹ Among the prohibited steering practices are those that discourage any person from purchasing or renting a dwelling because of handicap and those that communicate to any prospective purchaser that he or she would not be comfortable or compatible with existing residents because of handicap.¹²⁰

4. Proving Discrimination

Protected individuals can prove zoning discrimination under Title II and the FHA in any of four ways: they may demonstrate that officials adopted or implemented zoning standards that are facially discriminatory; intended to discriminate (disparate treatment); have a discriminatory effect (disparate impact) on the basis of disability; or that officials violated their reasonable accommodation obligation by failing to modify a facially neutral zoning practice or standard in order to avoid discrimination on the basis of disability or to permit an equal opportunity to use and enjoy a dwelling.¹²¹

¹¹⁹ 24 C.F.R. § 100.70(a) (2003).

¹²⁰ 24 C.F.R. § 100.70(c)(1) and (3) (2003).

¹²¹ The strategic advantage to a plaintiff in alleging and proving an intentional discrimination claim under Title II is that compensatory damages are available as a remedy. *Ferguson v. City of Phoenix*, 157 F.3d 668 (9th Cir. 1998), *cert. denied*, 526 U.S. 1159 (1999); *Bartlett v. New York State Bd. Of Law Examiners*, 156 F.3d 321, 331 (2nd Cir. 1998), *vacated in part on other grounds*, 527 U.S. 1031 (1999); and *Tyler v. City of Manhattan*, 118 F.3d 1400 (10th Cir. 1997). *But see Discovery House, Inc. v. Consolidated City of Indianapolis*, 319 F.3d 277 (7th Cir. 2003) (reversal of \$1 million jury award to drug treatment program that successfully challenged denial of zoning permit in state court; injunctive relief alone is afforded under Title II remedy provision). Injunctive relief is available to remedy both disparate impact and disparate treatment violations and reasonable accommodations violations. *See, e.g., First Step, Inc. v. City of New London*, 247 F. Supp.2d 135, 156-57 (D. Conn. 2003) (intentional discrimination); *Behavioral Health Services, Inc. v. City of Gardena*, 2003 WL 21750852 * 11 (C.D. Cal.) (failure to provide reasonable accommodation); and *MX Group, Inc.*, 196 F. Supp.2d at 921 (facially discriminatory zoning ordinance). Punitive damages are not available, under Title II, against a municipality. *Barnes v. Gorman*, 536 U.S. 181 (2002).

a. Facial Discrimination

A zoning ordinance is facially invalid if it imposes on a protected group unique zoning requirements that are not tailored to carry out a legitimate governmental interest.¹²² For example, some local jurisdictions have responded to the proposed establishment of treatment programs by enacting emergency ordinances that prohibit the program from locating within a certain distance of a residential neighborhood or school or impose unique occupancy or notification requirements on the entity. To the extent such restrictions have not served a legitimate governmental interest, courts have invalidated them as facially discriminatory.¹²³ The same standard has been applied under the FHA.¹²⁴

Under the Fair Housing Act, compensatory damages are available if a court finds either discriminatory intent or effect or the failure to accommodate. Punitive damages and injunctive relief are also available. The Act provides: “if the court finds that a discriminatory housing practice has occurred or is about to occur, the court may award . . . actual and punitive damages, and . . . may grant as relief, as the court deems appropriate, any permanent or temporary injunction, temporary restraining order, or other order . . .” 42 U.S.C. § 3613(c)(1). See *Samaritan Inns, Inc. v. District of Columbia*, 114 F.3d 1227, 1239 (D.C. Cir. 1997) (punitive damages against city officials); *Smith & Lee Assoc., Inc. v. City of Taylor*, 102 F.3d 781, 798 (6th Cir. 1996) (failure to accommodate); *Support Ministries v. Village of Waterford, N.Y.*, 808 F. Supp. 120, 139-40 (N.D.N.Y. 1992) (intentional discrimination); and *United States v. Village of Marshall, Wis.*, 787 F. Supp. 880, 880-81 (W.D. WI. 1991) (failure to accommodate). *But see, Behavioral Health Services, Inc.*, 2003 WL 21750852 (compensatory damages denied for violation of FHA reasonable accommodation requirement).

122 Some courts analyze facially discriminatory standards as a separate theory of discrimination, while others subsume the analysis under the disparate treatment/discriminatory intent standard. See cases cited at note 123. The Courts in *Hispanic Counseling Center, Inc. v. Incorporated Village of Hempstead*, 237 F.Supp.2d 284 (E.D.N.Y. 2002) and *Sunrise Development, Inc. v. Town of Huntington, N.Y.*, 62 F. Supp.2d 762, 774 (E.D.N.Y. 1999) analyzed facially discriminatory ordinances under the disparate treatment standard, while the courts in the other cases have relied upon the facial discrimination analysis. One court has distinguished these two theories insofar as the motive of the decision maker is irrelevant in establishing a facial discrimination claim, but is a key consideration in an intentional discrimination claim. *Marriott Senior Living Services, Inc. v. Springfield Township*, 78 F. Supp.2d 376, 388 (E.D. Pa. 1999).

123 See e.g., *MX Group, Inc.*, 106 F. Supp. 2d at 917-18, 920, *aff'd*, 293 F.3d at 345 (ordinance

b. Intentional Discrimination (Disparate Treatment)

A locality intentionally discriminates against protected individuals if its zoning decision is “motivated, at least in part, by an unjustified consideration of the disabled status of individuals who would be affected by the decision.”¹²⁵ It is not necessary to prove that officials are motivated by a dislike for, or animosity against, individuals with alcohol or drug dependence.¹²⁶ Nor is it necessary to

imposing on methadone treatment programs maximum occupancy requirement of one person per 200 square feet of floor area discriminatory on its face and violative of the ADA); *Habit Management, Inc.*, 235 F.Supp.2d at 29 (ordinance prohibiting the establishment of a methadone clinic within two miles of a school is invalid on its face); *Hispanic Counseling Center, Inc.*, 237 F.Supp.2d at 296 (facially discriminatory zoning ordinance that barred substance abuse treatment facilities from all business districts preliminarily enjoined); *Bay Area Addiction Research and Treatment, Inc.*, 2000 WL 33716782 (facially discriminatory ordinance that prohibited methadone treatment program from locating within 500 feet of a residential use preliminarily enjoined); and *Potomac Group Home Corp. v. Montgomery County, Md.*, 823 F. Supp. 1285 (D.Md. 1993) (county licensure law that required group homes for persons with disabilities to notify prospective neighbors of intention to locate in community and to provide information about clients to be served and opportunity for continual input was facially discriminatory and served no legitimate governmental interest).

¹²⁴ See, e.g., *Larkin v. State of Michigan Dept. of Social Services*, 89 F.3d 285 (6th Cir. 1996) (state licensing law that required notification to neighbors of proposed adult foster care facility and imposed distance requirement on such facilities facially invalid); *Horizon House Developmental Services, Inc. v. Township of Upper Southampton*, 804 F. Supp. 683 (E.D. Pa. 1992), *aff'd*, 995 F.2d 217 (3rd Cir. 1993) (ordinances that imposed distance requirement for “family care home for disabled persons” facially invalid); *Potomac Group Home Corp. v. Montgomery County, Md.*, 823 F. Supp. 1285 (D. Md. 1993) (licensure regulation for group homes for individuals with mental illness that required notification of intention to site in neighborhood facially invalid); *Marbrunak, Inc. v. City of Stow, Ohio*, 974 F.2d 43 (6th Cir. 1992) (ordinance that imposed stringent safety requirements on homes for persons with developmental disabilities facially invalid as it did not tailor the safety requirements to the particular disability at issue).

¹²⁵ *Bryant Woods Inn, Inc. v. Howard County, Md.*, 911 F. Supp. 918, 929 (FHA); see also *Pathways Psychosocial v. Town of Leonardtown*, 133 F. Supp.2d 772, 781-82 (Title II); *Tsombanidis*, 129 F. Supp.2d at 151, *aff'd*, 352 F.3d at 579-80.

¹²⁶ *Bryant Woods Inn, Inc.*, 911 F. Supp. at 929; *Innovative Health Systems, Inc.*, 931 F. Supp. at 241 (“To prevail on their [Title II] claim of discriminatory treatment, the plaintiffs are not required to show

prove that city officials were motivated solely, primarily, or even predominantly by the disability of treatment program or group home clients.¹²⁷ Courts in both Title II and FHA cases apply the *Arlington Heights* factors¹²⁸ to evaluate both the direct and circumstantial evidence of intent to determine whether the disability of a treatment program's clients was a motivating factor in the implementation of its zoning practices. Statements from officials involved in the decision-making process as well as the public are also important evidence of intent. Even where the official decision-makers do not express discriminatory views, "a decision made in the context of strong, discriminatory opposition becomes

the defendants were motivated by some purposeful, malicious desire to discriminate against drug and alcohol-dependent people."); compare *Regional Economic Community Action Program, Inc. v. City of Middleton*, 294 F.3d 35, 49 (2002), *cert. denied*, 537 U.S. 813 (2002), in which the Second Circuit stated that evidence of animus against a protected group was necessary to establish a prima facie case under the FHA and the ADA. The Court noted that plaintiffs must present evidence that "animus against the protected group was a significant factor in the position taken by the municipal decision-makers themselves or by those to whom the decision-makers were knowingly responsive." *Id.* Other Circuit Courts have defined the standard of proof for intentional discrimination under the FHA as requiring proof that the jurisdiction would have approved a zoning request "but for discriminatory animus toward the handicapped." *Smith & Lee Assoc., Inc.*, 102 F.3d at 790 (plaintiffs must show that "discriminatory purpose was a motivating factor" in the city's decision).

¹²⁷ *Innovative Health Systems*, 931 F. Supp. at 241 (Title II); *Stewart B. McKinney Foundation, Inc. v. Town Plan and Zoning Commission of Fairfield, Conn.*, 790 F. Supp. 1197, 1211 (D. Conn. 1992) (FHA); compare *Regional Economic Community Action Program, Inc.*, 294 F.3d at 49 ("a significant factor" but not the "sole" factor as required under Section 504 of the Rehabilitation Act).

¹²⁸ The Supreme Court in *Arlington Heights v. Metropolitan Housing Corp.*, 429 U.S. 252, 266-68 (1977), identified the following factors as useful in evaluating whether a decision was motivated by a discriminatory intent: (1) the discriminatory impact of the governmental decision; (2) the decision's historical background; (3) the specific sequence of events leading up to the challenged decision; (4) departures from the normal procedural sequence; (5) departures from normal substantive criteria; and (6) legislative or administrative history including contemporaneous statements by members of the decision-making body. Evidence need not be provided for each factor to prove discriminatory intent. See *Stewart B. McKinney Foundation, Inc.*, 790 F. Supp. at 1211 (FHA); *Pathways Psychosocial*, 133 F. Supp.2d at 781-82, and cases cited therein.

tainted with discriminatory intent even if the decision makers personally have no strong views on the matter.”¹²⁹ Evidence of discriminatory animus has been found to exist where officials and community members base their opposition on stereotypical fears of increased crime and decreased property values that are not supported by facts; complaints about over-concentration of human service programs in a particular area; bias against individuals who require drug treatment or a particular modality of treatment; and emotional reactions rather than facts.¹³⁰

129 *Innovative Health Systems*, 117 F.3d at 49, and cases cited therein; *City of Cuyahoga Falls, Ohio v. Buckeye Community Hope Foundation*, 123 S.Ct. 1389, 1394-95 (Statements made by decision makers or citizens who sponsored referendum during deliberation over a referendum may constitute relevant evidence of discriminatory intent in a challenge to an ultimately enacted initiative. But discriminatory intent by City officials not found as “the City did not enact the referendum and therefore cannot be said to have given effect to voters’ allegedly discriminatory motives for supporting the petition.”); *Regional Economic Community Action Program, Inc.*, 294 F.3d at 49 (discriminatory intent can be established by showing animus was a factor in either the decision-maker’s action or “by those to whom the decision-makers were knowingly responsive.”); *Project Life*, 139 F. Supp.2d 703, 711, *aff’d*, 46 Fed. Appx. 147, 2002 WL 2012545 (4th Cir. 2002) (state engaged in intentional discrimination in violation of the FHA when it refused to enter a lease agreement with a drug treatment program based on the opposition of local officials to have the program in “their backyard” and the state’s illegal acquiescence to that desire; state officials “acquiesced to community pressure to keep the [program] out of the community because of discriminatory animus toward the disabled population that Project Life would serve.”); *Community Housing Trust v. Dept. of Consumer and Regulatory Affairs*, 257 F. Supp.2d 208, 227-28 (same in context of housing for persons with mental illness).

130 See, e.g., *Regional Economic Opportunity Action Program, Inc.*, 294 F.3d at 49-50 (complaints by city and planning officials that city has taken more than its share of human services programs and is over-concentrated with half-way houses satisfied prima facie case of intentional discrimination); *Innovative Health Services*, 931 F. Supp. at 243 (complaints that alcohol and drug program would affect residents’ quality of life, security, tranquility and value of their property); *Sunrise Development, Inc.*, 62 F. Supp.2d at 775 (community complaints that presence of persons with disabilities lowers property values and drains community services); *Support Ministries v. Village of Waterford, N.Y.*, 808 F. Supp. 120, 135 (N.D.N.Y. 1992) (village official’s complaint that he does not want persons who have come out of drug rehabilitation in a house close to a playground or in the village); cf *Behavioral Health Services, Inc.*, 2003 WL 21750852, * 6-7 (discriminatory animus not proven even though some city officials and contractors used stereotypes about alcoholics and drug addicts in opposing issuance of a conditional use permit for a residential treatment program and many citizens opposed the program based

Courts apply the *McDonnell Douglas Corp. v. Green*¹³¹ burden-shifting analysis in determining whether intentional discrimination has been established under the ADA and FHA. If the plaintiff establishes a prima facie case of discrimination under the *Arlington Heights* standard, the burden shifts to the locality to provide a legitimate, non-discriminatory reason for the decision. To the extent the defendant meets that burden, the plaintiff must prove intentional discrimination on the basis of disability.¹³²

The Second Circuit applied this standard in *Innovative Health Systems v. City of White Plains*, in which an out-patient alcohol and drug treatment program claimed that the City had engaged in intentional discrimination by denying it a building permit to locate in a business zone.¹³³ The Second Circuit affirmed the lower court's issuance of a preliminary injunction, concluding that Innovative Health Systems (IHS) would prevail on the merits. The court relied on evidence that the city had departed from both substantive and procedural norms in denying the building permit and that zoning officials, while not expressing discriminatory views about individuals with alcohol and drug dependence, had acted in the context of strong, discriminatory opposition from the community and had been tainted by those views.

on fears and stereotypes, as the Planning Commission and City Council based their denial of the permit on the program's impact on city services, non-compatibility with surrounding area and population density.)

¹³¹ 411 U.S. 792 (1973).

¹³² *Regional Economic Community Action Program, Inc.*, 294 F.3d at 49; and *Smith & Lee Assoc., Inc.*, 102 F.3d at 791 (once plaintiff shows defendants were motivated at least in part by discriminatory animus, burden shifts to defendants to prove it would have made the same decision even if it had not been motivated by an unlawful purpose).

¹³³ 117 F.3d 37 (2d Cir. 1997).

The events surrounding the denial of the permit demonstrated the City's discriminatory decision-making. When IHS applied for a building permit, the city's building commissioner determined that it met the zoning code's classification of a business or professional office and was entitled to locate in the business zone. The decision was met with intense opposition from prospective neighbors, who claimed that the program fell within the classification of a "hospital or sanitarium," which was not permitted in the zone. The city attorney affirmed the building commissioner's interpretation, and distinguished IHS's operation from that of a "hospital or sanitarium." Two prospective neighbors appealed the decision to the Zoning Board of Appeals, and, at the hearing on the appeal, community members voiced strong opposition to the program, focusing primarily on unsubstantiated fears of crime and lower property values. The board of appeals reversed the decision of the building commissioner, without issuing a written resolution, as required under the zoning code, addressing the commissioner's interpretation, which was entitled to deference, providing a rationale for classifying the program as a "hospital or sanitarium," or distinguishing the program's services from that of mental health providers who were already operating in the same area.

The Second Circuit rejected the city's assertion that denial of the building permit was not motivated by discrimination, and concluded that "there is little evidence in the record to support the [board of zoning appeal's] decision on any ground other than the need to alleviate the intense political pressure from the surrounding community brought on by the prospect of drug- and alcohol-addicted neighbors."¹³⁴ The Court found that the board's decision was highly suspect because it had ignored the zoning code's requirements for the classification of "hospital or sanitarium," and did not explain why it

¹³⁴ *Id.* at 49.

had declined to follow the building commissioner or city attorney’s interpretation of those requirements. Moreover, it did not explain why the treatment program was not a permissible use while other providers of mental health services were. The city, according to the Court, also failed to provide support for the decision when challenged in the Title II action. According to the court, “the lack of a credible justification for the zoning decision raises an additional inference that the decision was based on impermissible factors, namely the chemical-dependent status of IHS’s clients.”¹³⁵

c. Discriminatory Effect (Disparate Impact)

The third form of discrimination – disparate impact – generally applies to zoning practices and standards that, while neutral on their face, have a disproportionate impact on individuals with disabilities. Some courts have applied a disparate impact analysis where a zoning practice or decision targets a protected class and, thus, lacks facial neutrality,¹³⁶ while others have rejected the viability of a disparate impact claim in such cases to the extent they do not challenge a neutral zoning standard that is

¹³⁵ *Id.*

¹³⁶ *See, e.g., Behavioral Health Services, Inc.*, 2003 WL 21750852, * 6 (denial of conditional use permit to a drug treatment program did not constitute intentional discrimination, but city’s rationale for denial treated the program’s clients differently from others on basis of disability); *Tsombanidis*, 129 F. Supp. 2d at 151-53 and 155-59; and 180 F. Supp.2d at 289-291 (disparate treatment and impact analyses applicable in challenging city’s classification of group recovery home as a “boarding house” rather than a “family,” which resulted in the imposition of more stringent building and fire safety standards on group home than on other residences); *Smith-Berch, Inc.*, 68 F.Supp.2d at 621-622, (disparate impact analysis applied to invalidate a zoning practice that required methadone treatment programs alone to participate in a hearing process to gain zoning approval); *Sunrise Development, Inc.*, 62 F. Supp.2d at 776 (disparate impact analysis applied in addition to disparate treatment analysis where local ordinance imposed more burdensome zoning standards on residential care facilities for the elderly alone); and *Potomac Group Home Corp.*, 823 F. Supp. at 1297 (disparate impact analysis applied to invalidate a hearing process that was selectively enforced on group homes for elderly individuals).

also applied to a similarly situated group.¹³⁷

Courts have articulated the standard for proving disparate impact claims under the ADA and FHA in slightly different, yet analogous, terms. Under Title II, a zoning practice has a discriminatory effect if it imposes a disproportionate burden on a protected class of individuals with disabilities and the public entity cannot demonstrate that the practice is necessary to the zoning scheme and that the disproportionate burden cannot be eliminated by a reasonable modification.¹³⁸ Thus, for example, in *Smith-Berch, Inc. v. Baltimore County, Md.*, the District Court invalidated a public hearing requirement

137 See, e.g., *Regional Economic Community Action Program, Inc.*, 294 F.3d at 52-53 (disparate impact claim dismissed where challenge is to a single specific adverse zoning decision rather than a challenge to a facially neutral policy or practice); *Gamble v. City of Escondido*, 104 F.3d 300, 306-07 (9th Cir. 1997) (disparate impact claim under FHA not established where no evidence that permit denial practices disproportionately affect group living for persons with disabilities as opposed to other kinds of group living); *Pathways Psychosocial*, 133 F. Supp.2d at 788-89 (challenge to zoning decision regarding the zoning designation of mental health program failed to state disparate impact claim as it did not challenge a facially neutral policy); *Corporation of the Episcopal Church in Utah*, 119 F. Supp.2d at 1220 (disparate impact claim not available to challenge denial of building permit for a residential drug treatment program in a residential zone where no similarly situated group living facility would have been permitted in the zone). This line of reasoning is unnecessarily restrictive, as nothing in the framework of the ADA or FHA requires an individual with a disability to prove discriminatory intent in a case that challenges the application of a zoning standard. As noted above, Title II and the FHA and their respective regulations bar policies and practices that have either the purpose or effect of discriminating on the basis of disability. Moreover, in many cases there is no bright line demarcation between cases of disparate treatment and impact, as evidence of discriminatory intent is relevant to both analyses. While a party need not provide evidence of discriminatory intent to prevail on a disparate impact claim, such evidence is useful in establishing such a claim. See *Huntington Branch, NAACP v. Town of Huntington*, 844 F.2d 926 (2d Cir. 1988), *aff'd*, 488 U.S. 15 (1988).

138 *Smith-Berch, Inc.*, 115 F. Supp.2d at 523. This standard is derived from the Title II regulatory provision that prohibits the use of eligibility criteria that screen out or “tend to screen out” an individual with a disability from “fully and equally enjoying any service, program or activity, unless such criteria can be shown to be necessary for the provision of the service, program or activity being offered.” 28 C.F.R. § 35.130(b)(8) (2003). The interpretive guidance to this provision explains that the purpose of this standard is to invalidate policies or criteria that indirectly prevent or limit the ability of persons with disabilities to participate. 28 C.F.R. § 35, App. A (2003).

that was imposed on methadone treatment programs that sought to locate in Baltimore County, finding that it had a disparate impact under Title II. The county required methadone treatment programs to participate in a hearing process to demonstrate that they satisfied the zoning code definition of “medical office,” while all other drug treatment programs and medical practices were permitted to locate as of right as a “medical office” without participating in a hearing. The court found that, while public expression is an important part of zoning laws, the county’s requirement imposed a disproportionate burden on a class of protected individuals – opiate addicts who require methadone to aid in their recovery – because no other entity that provided drug treatment or general medical care was required to participate in a hearing to locate in a business district. The county had not met its burden of proving that the hearing requirement was necessary to its zoning scheme because the county’s own zoning officials had construed methadone programs to fit within the zoning code’s definition of “medical office,” and, thus, had determined that they were entitled to locate like any other general medical office. The court did not reach the issue of whether a reasonable modification could mitigate the disproportionate burden because the hearing requirement itself was not necessary.¹³⁹

The disparate impact standard under the FHA also examines the disproportionate burden of the zoning standard, governmental interest in the standard and the existence of alternative practices that

139 *Smith-Berch, Inc.*, 115 F. Supp.2d at 523-24. See *infra* discussion at Part IV for a detailed discussion of the *Smith-Berch* litigation. See also *Potomac Group Home Corp.*, 823 F. Supp. at 1297-99 (public hearing requirement imposed on groups homes seeking licensure had a disparate impact in violation of the FHA; hearing disproportionately affected protected class as no other group of non-disabled individuals was subjected to public scrutiny and the hearing process facilitated the expression of prejudices and gave weight to them in the regulatory process; defendant failed to demonstrate a legitimate interest in the hearing requirement as licensure applications were in some circumstances reviewed without a public hearing and the members of the review boards did not possess expertise on licensure issues, and legitimate information could be gathered in a less discriminatory fashion).

would mitigate the burden. A plaintiff establishes a *prima facie* case by demonstrating that the challenged standard actually or predictably results in a greater adverse impact on a protected group than on others. The burden then shifts to the defendant to prove that its actions furthered a legitimate, bona fide governmental interest and that no alternative would serve that interest with a less discriminatory effect. Some courts evaluate two other factors in determining whether a standard has a discriminatory effect: evidence of discriminatory intent on the part of the defendant and evidence of whether plaintiffs are seeking to require the defendant to eliminate an obstacle to housing or to affirmatively build housing.¹⁴⁰

This standard was applied, for example, by the federal district court for New Jersey in issuing a preliminary injunction in favor of a group recovery home that had been denied a certificate of occupancy in a single family district because it did not meet the definition of “family” under the locality’s zoning code. Individuals related by blood or marriage were presumed to meet the definition of “family” and automatically granted an occupancy certificate, while groups of unrelated individuals were required to participate in a public hearing and demonstrate that they met indicia of “permanence and stability” to qualify as a “family.” The court found that the locality’s standard had an adverse impact on individuals protected under the FHA, as it imposed more stringent requirements on groups of unrelated individuals who, because of their disability, were more likely to require a group home setting in a residential neighborhood to facilitate their recovery. The locality defended its standard as serving the legitimate

¹⁴⁰ *Tsombanidis*, 180 F. Supp.2d at 575, citing *Huntington Branch, NAACP*, 844 F.2d at 934-36; *Lapid-Laurel v. Zoning Board of Adjustment of the Township of Scotch Plains*, 284 F.3d 442, 466-67 (3rd Cir. 2002). The Second Circuit in *Tsombanidis* held that statistical evidence or some analytical mechanism is required to demonstrate a disproportionate impact on the protected class in comparison to a similarly situated group that is not affected by the policy. 352 F.3d at 575-77.

governmental interest of ensuring that the requisite “permanency and stability” existed, which the state’s highest court had held was a legitimate consideration. The Court rejected this justification, finding that the locality had failed to follow state law in making this determination. Instead of applying a functional test, capable of being met by either related or unrelated persons, the locality automatically denied an occupancy certificate based on the group’s unrelated status. The court also found that the locality had not demonstrated that no less restrictive alternative existed. According to the court, a waiver of the single family requirement would impose no administrative or financial burden and would not result in a fundamental change in the neighborhood.¹⁴¹

d. Reasonable Accommodation Obligation

The fourth theory for challenging zoning standards that bar services for individuals with disabilities is the failure to satisfy the reasonable accommodation requirement. As noted above, both Title II and the FHA impose an affirmative obligation on public entities to modify standards, rules, services, practices and procedures to prevent discrimination on the basis of disability and to afford persons with disabilities an equal opportunity to enjoy and use housing.¹⁴² The parameters of this requirement and the standards for proving a violation have been fleshed out substantially since the enactment of these provisions.¹⁴³ Several Supreme Court cases that have examined the requirement in

¹⁴¹ *Oxford House, Inc. v. Township of Cherry Hill*, 799 F. Supp. at 461-62.

¹⁴² See *supra* text accompanying notes 115 and 118.

¹⁴³ As described below, courts in Title II and FHA cases generally agree that a requested modification/accommodation must satisfy three criteria: it must be reasonable, necessary and not require a fundamental alteration of the program at issue. See *PGA Tour v. Martin*, 532 U.S. 661, fn.38 (2001). This standard has evolved from earlier cases in which the courts paid little attention to the first two criteria and focused almost exclusively on the fundamental alteration factor. See, e.g., *Hovsons, Inc.*

the Title I (employment discrimination) and Title III (public accommodations) contexts provide significant guidance for understanding the scope of this obligation in the zoning context.¹⁴⁴

First, as a general matter, the Supreme Court has made clear that the reasonable accommodation requirement will, in some instances, require a public entity to waive a rule or standard that would not be waived for a non-disabled individual. The Supreme Court explained in *U.S. Airways v. Barnett* that:

The Act requires preferences in the form of “reasonable accommodations” that are needed for those with disabilities to obtain the *same* . . . opportunities that those without disabilities automatically enjoy. By definition any special “accommodation” requires the [entity] to treat an [individual] with a disability differently, i.e., preferentially. And the fact that the difference in

v. Township of Brick, 89 F.3d 1096 (3rd Cir. 1996); *Turning Point, Inc. v. City of Caldwell*, 74 F.3d 941, 945 (9th Cir. 1996) (failure to eliminate annual review of a Special Use Permit violated accommodation obligation under FHA because no persuasive justification for requirement existed and city’s power to abate nuisances can address any problems that arise). Indeed, the Section 504 regulation that enforces the reasonable accommodation requirement under the Rehabilitation Act and was the precursor to the Title II regulation does not include the “necessary” factor as an element of the standard. It provides:

A recipient shall make reasonable accommodations to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program.

28 C.F.R. § 41.53 (2003).

144 Title III standards are relevant to Title II reasonable accommodations claims, as the legislative history directed the Attorney General, when drafting the regulation, to incorporate the specific requirements of Title III into the Title II regulations to the extent they do not conflict with the regulations implementing Section 504. 28 C.F.R. Part 35, App. A at 525 (2003). The Supreme Court has also examined the reasonable accommodation requirement in the Title II context of deinstitutionalization of individuals with mental illness, focusing primarily on what modification would be deemed “reasonable” in that specific context. In *Olmstead v. L.C. (“Zimring”)*, 527 U.S. 581 (1999), the Supreme Court ruled that in evaluating whether the placement of an individual in a community-based program was reasonable or constituted a fundamental alteration, a public entity was entitled to consider the resources available to it to serve all individuals with the mental illness and its obligation to maintain a range of facilities. This type of resource analysis has limited applicability in determining what is either “reasonable” or a “fundamental alteration” in the zoning context.

treatment violates an [entity's] disability-neutral rule cannot by itself place the accommodation beyond the Act's potential reach. . . . The simple fact that an accommodation would provide a "preference" in the sense that it would permit [an individual] with a disability to violate a rule that others must obey – cannot, *in and of itself*, automatically show that the accommodation is not reasonable.¹⁴⁵

Second, *Barnett* confirmed that the accommodation obligation reaches rules that create barriers because of an individual's disability as well as rules that are not disability-based and create barriers to persons regardless of disability.¹⁴⁶ Thus, the reasonable accommodation requirement in the zoning context will require a public entity to modify some neutral zoning standards that operate to exclude persons with disabilities but have no relationship to the disability itself.¹⁴⁷

¹⁴⁵ 535 U.S. 391, 397 (2002).

¹⁴⁶ See discussion in *Giebeler v. M & B Assoc.*, 343 F.3d 1143, 1150-51 (9th Cir. 2003) (waiver of landlord's rental policy that forbid cosigners was a reasonable accommodation to enable an individual with AIDS who could not otherwise afford the apartment, even though the rule applied to all prospective tenants). In *Barnett*, the requested accommodation involved a waiver of a seniority system that affected the entire workforce, not just those with disabilities. While the waiver was not deemed reasonable in the particular case, the Court indicated that a waiver of a seniority system could be reasonable under some circumstances. The *Barnett* standard implicitly overrules the Seventh Circuit holding in *Hemisphere Building Company, Inc.*, 171 F.3d at 440, that the duty to accommodate is limited to rules and policies that hurt persons with disabilities "by reason of their handicap, rather than that hurt them solely by virtue of what they have in common with other people, such as a limited amount of money to spend on housing." But see *Good Shepherd Manor Foundation, Inc. v. City of Momence*, 323 F.3d 557, 561 (7th Cir. 2003) (post-*Barnett* case affirming *Village of Richton Park* standard without mentioning *Barnett*).

¹⁴⁷ This standard has been established consistently in zoning cases. For example, in *Hovsons, Inc. v. Township of Brick*, *supra* n. 143, the Third Circuit ruled that a nursing home was entitled to a waiver of the zoning code provision that barred all such facilities from residential areas, and rejected the locality's contention that authorization to locate in a hospital zone, as permitted under its zoning code, satisfied its accommodation obligation. This standard has also been applied in cases in which a group home for persons with disabilities seeks to locate in a single-family residence zone as a "family" but does not meet the locality's "family" definition (either because it is a group of unrelated individuals or because it exceeds a cap on the number of unrelated individuals who may reside together as a "family") and is,

The reasonable accommodation obligation requires a public entity to make “an individualized inquiry . . . to determine whether a specific modification for a particular person’s disability would be reasonable under the circumstances as well as necessary for that person, and yet at the same time not work a fundamental alteration.”¹⁴⁸ To prevail on a reasonable accommodation claim, the plaintiff must make an initial showing that the proposed accommodation is “reasonable” and “necessary” to prevent discrimination on the basis of disability or provide an equal opportunity to enjoy housing. After establishing a prima facie case, the burden shifts to the locality to demonstrate that the accommodation would fundamentally alter its zoning scheme or impose an undue administrative or financial burden.¹⁴⁹

thus, subject to other requirements to locate in that residence zone. While the “family” definition would also bar group living by unrelated individuals who are not disabled, courts have waived the standard for group homes for individuals with disabilities, concluding that they could not reside in a residential neighborhood without a therapeutic living environment of a group home and that a specific number of residents in excess of the cap is needed to cover costs. *See, e.g., Smith & Lee Associates*, 102 F.3d at 795-96; *ReMed Recovery Care Centers v. Township of Williston, Chester County, Pa.*, 36 F. Supp.2d 676 (E.D. Pa. 1999) (waiver of cap on number of unrelated people permitted to live in single-family residence district required for group home for persons with brain damage to enable it to operate); *Oxford House, Inc. v. Township of Cherry Hill*, 799 F. Supp. at 462-63 (evidence supports waiver of requirement that a group of unrelated individuals must demonstrate indicia of “family” to locate in single-family residence district). Similarly, in *Corporation of the Episcopal Church in Utah*, 119 F. Supp.2d at 1221-22, the district court held that a locality was required to provide a reasonable accommodation to a drug treatment program that sought to locate a residential treatment program for seventeen individuals in a single-family residence district even though the zoning code prohibited such use in the zone and also barred similar services for non-disabled individuals. *But see Forest City Daly Housing, Inc. v. Town of North Hempstead*, 175 F.3d 144 (2nd Cir. 1999) (denial of special use permit to developer to build an assisted living facility in a business zone did not violate reasonable accommodation requirement because comparable residences for persons without disabilities were not permitted in the zone).

¹⁴⁸ *PGA Tour v. Martin*, 532 U.S. at 688.

¹⁴⁹ *Barnett*, 535 U.S. at 402 (“once the plaintiff has made [the showing that an accommodation is reasonable on its face] the defendant . . . then must show special (typically case-specific) circumstances that demonstrate undue hardship in the particular circumstances.” *See also Oconomowoc Residential*

The initial showing of reasonableness, according to the Supreme Court in *Barnett*, requires proof that the proposed accommodation “seems reasonable on its face, *i.e.* ordinarily or in the run of cases.”¹⁵⁰ Thus, for example, the federal district court in *Tsombanidis v. City of West Haven*, found that a request to waive the zoning code’s limitation on the number of unrelated persons who could reside in a single family residence was reasonable to enable seven individuals in recovery to live in a single-family neighborhood. The request was reasonable, according to the court, because the group recovery home operated in a manner similar to a single family residence and the zoning code imposed no limitation on the number of related people who may live together in a single-family neighborhood.¹⁵¹

The “necessary” standard requires the plaintiff to demonstrate a causal connection or direct linkage between the requested modification and the ability to obtain an equal opportunity to use and enjoy a dwelling or avoid discrimination in zoning practices.¹⁵² Thus, the court in *Tsombanidis*

Programs, Inc. v. City of Milwaukee, 300 F.3d 775, 783 (7th Cir. 2002); *Geibeler*, 343 F.3d at 1155-58; and *Hovsons Inc.*, 89 F.3d at 1104. This formulation gives meaning to both the terms “reasonable” and “undue hardship” rather than collapsing the two into a single inquiry that determines the reasonableness of a requested accommodation based on whether it would impose an undue financial or administrative burden. See, e.g., *Smith & Lee Assoc.*, 102 F.3d at 795; *Wisconsin Correctional Service v. City of Milwaukee*, 173 F. Supp.2d 842, 855 (E.D. Wis. 2001). This formulation also eliminates confusion as to which party bears the ultimate burden of proof on the issue. See *Barnett* at 401-402. *Barnett* implicitly overrules the Fourth and Fifth Circuit rulings in *Bryant Woods Inn, Inc. v. Howard County, Md.*, 124 F.3d 597, 603-04 (4th Cir. 1997) and *Elderhaven, Inc. v. City of Lubbock*, 98 F.3d 175,178 (5th Cir. 1996), which held that the plaintiff bears the ultimate burden of proof on whether an accommodation is reasonable.

¹⁵⁰ *Barnett*, 535 U.S. at 401. As noted above, the proof for demonstrating “reasonableness” is different from the proof for demonstrating “undue burden” or “fundamental alteration.”

¹⁵¹ *Tsombanidis*, 180 F.Supp.2d at 291, *aff’d*, 352 F3d at 580.

¹⁵² Courts have explained this requirement in varying terms. See, e.g., *Geibeler*, 343 F.3d at 1155 (plaintiff must show that “but for the accommodation, they likely will be denied an equal opportunity to

concluded that lifting the cap on the number of unrelated people who could reside together in a single-family district was necessary because persons in recovery need to live in group homes located in single-family neighborhoods removed from areas where alcohol and drugs are readily available. Without the waiver of the cap, persons in recovery would be denied the opportunity to live in a group home because a certain number of residents is needed to make the group home model functionally successful and economically feasible.¹⁵³ Similarly, the court in *Oconomowoc Residential Programs, Inc. v. City of Milwaukee*, found that a waiver of an ordinance that barred community living arrangements for persons with disabilities from locating within 2,500 feet of one another was necessary to permit individuals to move from an institution to a community-based setting. According to the court, the distance requirement precluded new group homes from locating in most areas of the city, thereby preventing individuals who require supportive living from residing in almost all residential neighborhoods.¹⁵⁴

Finally, the “fundamental alteration or undue burden” standard focuses on the hardship to the

enjoy the housing of their choice”); *Behavioral Health Services, Inc.*, 2003 WL 21750852, * 7 (accommodation is necessary if it will “ameliorate the effects of the disability of the participants.”); *Oconomowoc*, 300 F.3d at 784 (the necessity standards requires a showing that without the required accommodation the individual with a disability will be denied the equal opportunity to reside in a residential neighborhood); and *Bryant Woods Inn*, 124 F.3d at 604 (plaintiff must show a “direct linkage between the proposed accommodation and the ‘equal opportunity’ to be provided [I]f the proposed accommodation provides no direct amelioration of a disability’s effect, it cannot be said to be ‘necessary.’”).

¹⁵³ *Tsombanidis*, 180 F.Supp.2d at 290; see also *ReMed Recovery Care Centers*, 36 F. Supp.2d at 685 (necessity to lift cap on number of unrelated persons living in a single family residence demonstrated where group home for persons with brain injuries could not operate financially without additional residents and additional residents provided social and staffing benefits); but see *Bryant Woods Inn*, 124 F.3d at 605 (expansion of group home for elderly persons from 8 to 15 persons was not necessary to provide therapeutic environment or to be financially viable).

¹⁵⁴ *Oconomowoc*, 300 F.3d at 787.

public entity in modifying its policy or practice. The Supreme Court explained in *PGA Tour v. Martin* that a fundamental alteration would occur if the requested modification would either alter an essential aspect of the activity at issue (even if it affected everyone equally) or provide to the individual with a disability an advantage over others so as to fundamentally alter the character of the activity.¹⁵⁵ In the zoning context, courts evaluate how the accommodation would affect the jurisdiction’s zoning scheme, administrative services and finances, or the particular neighborhood in which an entity seeks to locate.¹⁵⁶ Courts have examined, for example, whether a proposed change would unduly burden municipal services, police or emergency services, traffic or street parking, and population density in a particular neighborhood. In evaluating this evidence, courts require specific evidence of an adverse impact, rather than speculation or anecdotal evidence.¹⁵⁷

¹⁵⁵ *PGA Tour, Inc.*, 532 U.S. at 690. The Supreme Court applied this same formulation under Section 504 in its first decision on the reasonable accommodation requirement, *Southeastern Community College v. Davis*, 442 U.S. 397, 413-14 (1979). In *Davis*, the Court ruled that the modification requested by a nursing student who was deaf – assignment of a full time, personal supervisor when attending patients and elimination of clinical courses from required curriculum – would constitute a fundamental alteration in the nursing program because it compromised the essential requirements and purpose of the program. See also *Alexander v. Choate*, 469 U.S. 304, 307-08 (1985) (requiring state Medicaid officials to evaluate all proposed changes in benefits to determine whether state’s goals could be met without disproportionately disadvantaging persons with handicaps would impose administrative costs well beyond what is required under *Davis*).

¹⁵⁶ While neither the FHA nor Title II regulations mention the “undue burden” standard, 28 C.F.R. § 35.130(b)(7) (2003), it has been read into the reasonable accommodation requirement under both laws, and financial burdens are taken into consideration as part of the analysis. See, e.g., *Olmstead v. Zimring*, 527 U.S. at 606, n. 16; and *United States v. California Mobile Park Mgmt. Co.*, 29 F.3d 1413, 1417 (9th Cir. 1994).

¹⁵⁷ See, e.g., *Oconomowoc*, 300 F.3d at 785-786 (allegations that group home for persons with brain injuries and development disabilities will generate more police calls and impose greater burden on emergency services is too speculative to constitute evidence of undue financial and administrative burden and is based primarily on anecdotal evidence from the opponents of the group home).

Thus, for example, the federal district court in *Behavioral Health Services, Inc. v. City of Gardena*, concluded that the city had failed to demonstrate that issuing a conditional use permit to an organization that sought to remodel an abandoned hospital to provide residential alcohol and drug treatment services to women would constitute an undue administrative or financial burden or fundamentally alter the nature of the neighborhood. The court rejected the city's claim that the heavy density of the project would make it incompatible with the surrounding neighborhood or impose additional administrative burdens. According to the court, since the building already existed in the neighborhood, the presence of the treatment program would not fundamentally alter the community's appearance. Moreover, since the participants would be spending most of their time on the site itself, they would not be driving to and from the program on a regular basis. The court also noted that the zone itself did not have a density requirement and permitted people to come and go freely without any limitations on their numbers. The court also rejected the city's assertion that the program would impose additional burdens on a neighborhood park. The court reasoned that the level of use by program participants would not differ from that of visitors to a hospital or people working at or using the building for another commercial purpose.¹⁵⁸

The court in *Oconomowoc* applied a similar fact-specific analysis in rejecting the city's claim that undue financial and administrative burden would result from traffic risks, and lack of sidewalks in the proposed site and the possibility that residents would not be properly supervised based on the defendant's problematic history of running similar group homes in other locations. According to the

¹⁵⁸ *Behavioral Health Services, Inc.*, 2003 WL 21750852, * 6-7.

court, the city had failed to demonstrate the nature or quantity of burden that the proposed facility would impose at the site at issue in the case based on the provider's past operational problems. Claims that program would generate the need for more emergency services also were not based on factual evidence that would distinguish the proposed home from any other neighborhood residences. Finally, the city's assertion that clustering group homes would result in disproportionate costs to emergency services did not, according to the court, explain how those costs would be mitigated by adhering to the distance requirement.¹⁵⁹

Similarly, the court in *Tsombanidis* ruled that the city had failed to demonstrate that lifting a cap on the number of unrelated people who could reside in a single-family neighborhood would impose any "undue hardship" or "substantial burden." According to the court, there was virtually no cost to permitting seven individuals to reside in a group recovery home, as there was no evidence that the residents would impose greater administrative or financial burdens regarding the use of city or emergency services. Speculation on the part of residents about the risks of having persons in recovery as neighbors was not borne out by any proof of a real threat to safety. The court also found that, since the group home operated much like any other single-family residence, the accommodation would neither fundamentally alter the nature of the neighborhood nor effect a fundamental change in the city's zoning code.¹⁶⁰

¹⁵⁹ *Oconomowoc*, 300 F.3d at 786.

¹⁶⁰ *Tsombanidis*, 180 F.Supp.2d at 291, *aff'd*, 352 F.3d at 580; *See also ReMed Recovery Care Centers*, 36 F. Supp.2d at 684-85 (permitting three additional persons to reside in group home would not fundamentally alter zoning laws or impose undue administrative or financial burden as home would operate like any other family in the neighborhood, generate comparable amount of traffic, and look the same as other buildings; no evidence of greater financial or administrative burden).

As a procedural matter, a growing number of courts require an individual who seeks a modification of a facially neutral standard or policy to make a formal request of the public entity before filing a Title II or FHA action alleging a violation of the law, even if this requires the entity to go through an administrative hearing to obtain the modification. Courts have increasingly concluded that an accommodation claim is not ripe unless the public entity has been given an opportunity to consider and rule on the request.¹⁶¹ Thus, even though Title II and the FHA do not require an individual with a disability to exhaust administrative remedies before filing a claim,¹⁶² an individual will likely have to participate in the locality's administrative process to formally seek a modification of a policy or practice, to the extent such a process exists and is required of all entities that seek waivers of a zoning standard and is not a futile process for obtaining relief. Courts have also made clear, however, that a locality does not satisfy its reasonable accommodation obligation by simply providing a process for seeking a

¹⁶¹ See, e.g., *Oxford House-C v. City of St. Louis*, 77 F.3d 249 (8th Cir. 1996) (group home must seek variance to operate with more than eight individuals in a residential zone before reasonable accommodation claim under FHA is ripe; process would not be futile); *U.S. v. Village of Palatine, Ill.*, 37 F.3d 1230, 1233-34 (7th Cir. 1994) (group recovery home must seek special use approval through a hearing before reasonable accommodation claim under FHA is ripe; requirement is imposed on all entities and seeking approval is not futile); *Tsombanidis*, 120 F. Supp.2d at 159-61, *aff'd*, 352F.3d at 578-79 (group recovery home must seek special use permit, an exemption or variance from city and fire marshal before reasonable accommodation claim under ADA and FHA is ripe; process would not be futile); *Marriott Senior Living Services, Inc.*, 78 F. Supp.2d 376, 380(1999) (reasonable accommodation claim not ripe where housing provider did not present final plan to locality to afford it an opportunity to consider request for an accommodation); *Oxford House, Inc. v. City of Virginia Beach, Virginia*, 825 F. Supp. 1251, 1264 (E.D. Va. 1993) (FHA claims not ripe until group home applies for conditional use permits to exceed the cap on number of unrelated people permitted to reside in residential zone).

¹⁶² 42 U.S.C. § 12133 (Title II provides for the same procedural rights as are available under Section 504) and 28 C.F.R. § 35.172(b); and 42 U.S.C. § 3613(B)(2) (2003).

waiver.¹⁶³

B. Summary

These civil rights protections hold the promise that fair and non-discriminatory zoning standards will exist for those in need of drug treatment services. They also provide the tools to challenge state and local zoning practices that inhibit the establishment of drug treatment services when that promise is not honored. The challenge, however, is to create the political will to implement the non-discrimination standards on behalf of individuals who, as a group (if not individually), are unpopular and not organized politically, and, thus, obviate the need for litigation to enforce those rights. An examination of zoning practices in two communities offers an insight into the complexity of this problem and the starting point for identifying potential solutions.

Part IV: Public–Private Partnerships to Bar Drug Treatment Services

The establishment of most health care services rarely evokes bitter zoning battles. Typically, a medical practice locates an appropriate office, usually in a residential, office or business zone depending upon the land use classifications and zoning districts under the locality’s zoning code, and with little fanfare opens its doors for business. As demonstrated in the previous discussion, drug and alcohol treatment providers often do not enter communities with the same ease. Some localities specifically define alcohol and drug treatment as a distinct land use in their zoning codes and impose special requirements – notification and public hearing, spacing or distance limitations and conditional use standards – not required of other medical services. Other localities may classify alcohol and drug services like other medical services but then respond to community opposition to a proposed program by

¹⁶³ *Oconomowoc*, 300 F.3d at 785 (“the right to appeal to [the board of zoning appeals] is not in and of itself an accommodation.”)

taking official action to bar those services: reinterpreting zoning standards; enacting emergency zoning ordinances that change the ground rules; and applying intense pressure to abandon a site. Vocal opponents can forge strong alliances with local officials who, while bound by their oath of office to represent all constituents and uphold laws prohibiting discrimination, either share the sentiments of the opposition or see political advantage in doing so. Establishing drug treatment programs becomes a political “third rail” in some communities.

The zoning practices in Baltimore County and Baltimore City, Maryland demonstrate this dynamic. Both jurisdictions impose burdensome zoning standards on alcohol and drug treatment programs that are not required of other medical services, including notification and hearing procedures and, in the case of Baltimore City, community approval. Some residents have used these procedures to galvanize community opposition, building on fear and stereotype rather than a factual examination of the quality of the proposed service. Officials retain to these discriminatory standards to appease community opposition even when treatment programs have demonstrated that they operate harmoniously in and serve the community.

The stories that follow are typical of events that are taking place throughout the country.¹⁶⁴ Efforts by programs to meet the demand for treatment services are met by fairly standard concerns and fears on

164 One commentator has observed in the context of developing affordable housing that a “solid core of concerns” surface in all communities in which developers seek to establish housing. Opponents are generally concerned about who will be living in the housing, tenants’ behavior, such as potential criminal activity and loitering, effect on property values, appearance and density of the proposed housing, land use issues such as parking and traffic, and process. The opposition’s tactics, which are similarly predictable, include: distributing flyers; holding community meetings to organize against the development; demanding meetings with the developer; lobbying local officials; getting the media involved; and holding public hearings. Tim Iglesias, *Managing Local Opposition to Affordable Housing: A New Approach to NIMBY*, 12 J. OF AFFORDABLE HOUSING, 78, 82 (Fall 2002).

the part of communities. Political leaders then respond by adopting special requirements that give communities notification of proposed programs and an opportunity to mount opposition, heighten public scrutiny through a hearing processes or bar programs entirely from communities¹⁶⁵

165 In some states, officials are now looking to statewide zoning legislation to bar treatment services. For example, the Virginia General Assembly in its 2004 session adopted a bill, Senate Bill 607, that would prohibit the siting of methadone treatment programs within a half-mile of schools and state-licensed day care centers and require notification to local jurisdictions of licensure applications. See text at <http://legis.state.va.us>. This and other bills were filed in response to community opposition to several proposed methadone programs. A newspaper account of the legislation noted that, while opponents of such treatment programs cite the peril they pose to children, no actual incidents of criminal activity or improper behavior had ever occurred at schools that are presently located within blocks of methadone programs. *Legislation Would All But Bar Drug Clinics*, THE ROANOKE TIMES, Jan. 18, 2004, at B1; *Drug czar pans bill limiting methadone clinics*, ROANOKE.COM, March 12, 2004. Several bills were also introduced in the 2004 session of the Maryland General Assembly: House Bill 1244 and Senate Bill 474 would authorize methadone treatment programs to locate under the same zoning standards as a health care practitioner's office that provides outpatient treatment and would prohibit the application of special exceptions, conditional use permits or procedures to methadone programs if such requirements are not imposed on a health care practitioner's office; and House Bill 1115 and Senate Bill 761 would authorize licensed halfway houses for persons with alcohol and drug problems to locate in single and multi-family residential zones on the same basis as other residences of similar density without being subject to special exceptions, conditional use permits or procedures that are not also imposed on all other residences. See text at <http://www.mlis.us.md>.

The California legislature considered a number of bills from the mid to late 1990's relating to residential care and treatment facilities for individuals with disabilities. The proposals were introduced in response to perceived "over-concentration" of residential services in particular areas and put forth a number of predictable options, including moratoriums on new residential services in specific counties, expansion of distance requirements, municipal approval of particular types of facilities that serve persons with criminal records. In an effort to comprehensively address these issues, the legislature enacted in 1997 a resolution that established a Care Facilities Task Force that was asked to study the issues related to the integration and dispersal of residential care facilities, state licensure requirements, and local government oversight and to make recommendations regarding state regulation of residential care and treatment facilities, taking into consideration Fair Housing Act standards. The recommendations of the Task Force are reported in Senate Health and Human Services Committee, "Report to the Legislature and the Governor, Senate Concurrent Resolution 27, Residential Care and Treatment Facilities (January 31, 1998) (hereafter California Task Force Recommendations). Those recommendations have never been implemented. Telephone Interview with Task Force Member Susan Blacksher (February 10, 2004).

A. Baltimore County, Maryland: Exclusion of Methadone Maintenance Treatment

In the spring of 1998, the co-owners of a methadone maintenance treatment program,¹⁶⁶ White Marsh Institute, undertook to challenge the denial of zoning approval for their proposed program in Baltimore County, Maryland.¹⁶⁷ White Marsh Institute had located what its principals believed to be the perfect site for a methadone treatment program – a commercial zone at the intersection of several major transportation arteries with no nearby residential properties -- but was denied zoning approval to open. One of the owners had tried unsuccessfully in 1993 to establish a methadone treatment program in Baltimore County and thus suspected a pattern of discrimination against individuals with drug dependence who required methadone to treat their opiate dependence. The facts soon revealed that, indeed, Baltimore County had a long-standing practice of excluding methadone treatment programs.¹⁶⁸

¹⁶⁶ Methadone maintenance treatment is the most thoroughly researched drug treatment modality, but remains the most controversial and misunderstood. Methadone is a synthetic narcotic that is used to treat chronic pain, frequently associated with cancer, and is also useful in opiate dependence treatment. In the treatment of opiate dependence, methadone is used in two ways. It is prescribed to withdraw an individual from opiates by gradually decreasing doses of methadone over a relatively short period of time. Methadone is also prescribed as a maintenance treatment whereby a patient is given increasing doses over several weeks to reach the point of tolerance and is then stabilized at an appropriate dose for an indefinite period of time. At the stabilized dose, the patient does not feel a euphoric effect from the medication, does not experience withdrawal symptoms, and cannot achieve a euphoric effect by taking other opiates, because methadone creates a cross-tolerance or “blockade” to such drugs. As a result, the patient is totally functional and not sedated, and one’s efforts to get “high” by using heroin or ingesting additional amounts of methadone are futile. THE FEDERAL REGULATION OF METHADONE TREATMENT, *supra* n. 5, at 194. Methadone maintenance treatment is widely accepted as the most effective treatment for opiate dependence. *Id.* at 30-31, 37.

¹⁶⁷ I was an attorney with the Legal Action Center, a public interest law firm specializing in drug, alcohol, AIDS, and criminal justice issues that was retained by White Marsh Institute with respect to this matter.

¹⁶⁸ The factual information outlined in this section is referenced in the two published opinions in *Smith-Berch, Inc. v. Baltimore County, Md.*, 68 F. Supp.2d 602 (D. Md. 1999) and 115 F. Supp.2d 520 (D. Md.

A predictable pattern of official activity had unfolded each time a methadone treatment program sought to locate in the County: County officials sought State intervention to halt or slow down the siting; they facilitated community opposition behind the scenes; and they imposed, through administrative practices or legislation, burdensome standards that resulted in the exclusion of programs. This strategy began to take shape in 1989 when County officials faced bitter community opposition to the opening of a satellite office for its one publicly-funded methadone treatment program. County officials closed the program just two weeks after it had opened. Faced with the prospect of this or other programs trying to open, County officials established a procedure that required the State Department of Health and Mental Hygiene to give them the right to approve proposed methadone programs prior to the State licensing such a program. The process was designed to give County officials notice of all proposed programs¹⁶⁹ and to provide them the opportunity to inform the community, which, in turn, predictably organized opposition. The County adopted this procedure because methadone treatment programs fit within the definition of a “medical office,” under the Baltimore County Zoning Code (B.C.Z.R.), a use permitted to locate “as of right” in an area zoned for commercial businesses.¹⁷⁰ The

2000). All documents are on file with the Legal Action Center, 236 Massachusetts Ave., N.E. Suite 505 Washington, D.C. 20002.

¹⁶⁹ By the late 1990’s, the state was somewhat of an unwilling partner in this arrangement. State regulations require alcohol and drug treatment programs to comply with local zoning requirements as a condition of state certification. MD. REGS CODE tit. 10, § 10.47.01.05 (2003).

¹⁷⁰ Section 101 of the B.C.Z.R. defines “medical office” as a “place for the treatment of outpatients by one or more medical practitioners. The term does not include a veterinarian’s office, medical clinic, ambulatory care center, diagnostic center, birthing center or dialysis satellite unit. The term does not include ambulatory surgical facilities.” The County permitted all non-methadone treatment programs to locate “as of right” as a medical office in business and commercial zones. Under the B.C.Z.R., the medical services that were excluded from the definition of “medical office” were included in the

pre-approval requirement provided the opportunity for administrative and political intervention, which was not available under the County's own zoning code.

In 1993, when several methadone treatment programs attempted to open in the County, the County Council decided not to rely on the pre-approval process alone. It passed a resolution asking the County's Planning Board to consider proposing amendments to the zoning code that would define methadone clinics and restrict them from inappropriate zones. Amendments were never proposed, however, as the County's Planning Office advised against the revision based on legal advice from the county attorney. Its report noted that methadone clinics fall under the definition of "medical office" and that it would be very difficult legally to require separate standards for methadone clinics as compared to medical offices. As a result, no changes were made to the county's zoning code.

In 1997, with renewed efforts by several methadone programs to locate in the County, including White Marsh Institute, the County Council took several additional steps to prevent their operation. It again passed a resolution asking the Baltimore County Planning Board to propose amendments to the county zoning regulations that would define methadone clinics and drug treatment centers and specify zones in which such programs could locate. The County Executive then asked the Secretary for the State Department of Health and Mental Hygiene to suspend the certification process for all methadone programs that sought to locate in the County until the County Council considered these amendments. Finally, the County voted to impose a moratorium on all new methadone programs pending the enactment of legislation. While no such legislation was introduced or enacted at that time, the County

definition of "medical clinic." Methadone treatment programs did not fall within this definition. This distinction became important in 2002 when the County sought to legislate where methadone treatment programs could site.

never lost interest in legislating in this area. Five years later, after litigation, it succeeded in doing so in response to renewed efforts to provide methadone treatment.

The denial of zoning approval for White Marsh Institute was notable because the co-owners had over thirty-five years of experience in providing methadone treatment in Maryland and enjoyed a reputation among the State's regulators of running top-notch programs. Years of experience had taught them to take great care in locating an office in the County, avoiding all sites that could generate community opposition. Their proposed site was located in a small shopping mall in a heavy commercial zone, surrounded by a sanitary landfill¹⁷¹ and other businesses. The closest residential area was over a mile away.

Before signing a five-year lease for the office space, White Marsh Institute sought and received clearance from the Baltimore County Health Department official designated under the County's pre-approval policy. It also won the acceptance of neighboring businesses in the shopping mall. But the program ran into problems as soon as it sought an operating license from the County. The County zoning office informed the program's owners that the County had a "special policy" for methadone clinics that required it to participate in a public hearing that would determine whether it qualified as a "community care center."¹⁷² No mention was made of the "medical office" provision or that medical

171 The fact that the treatment program would be located next to a sanitary landfill was not lost on the community. At least one program opponent protested that the community already had "the dump" and should not be "dumped" upon again. While alcohol and drug treatment programs are in no way analogous to waste disposal sites and other uses that are traditionally deemed to be LULU's – locally undesirable land use -- communities often rank these services as having the same level of unacceptability. *See supra* note 38.

¹⁷² Section 101 of the B.C.Z.R. defines "community care center" as:

A small-scale facility, sponsored or operated by a private, charitable organization or a public

offices, including drug treatment programs that do not dispense methadone, locate as of right in business zones without a hearing process.

Strong opposition erupted when certain community members learned about the proposed methadone program. Some civic associations and state and local elected officials voiced their opposition, all of which was based on the fact that individuals with drug problems would be served. Opponents expressed the purely speculative concern that the program's clients would engage in criminal activity in the neighborhood. The community and elected officials also put pressure on the owners of the building to revoke the lease. The Institute's co-owners responded to these concerns by holding a community meeting, responding to concerns about security, clientele and methadone treatment and by repeatedly inviting elected officials and the community to visit their existing methadone programs in other communities in Maryland. Those efforts were futile.

A public hearing was held in September 1997 to determine whether White Marsh Institute could locate at the site as either a "medical office" or "community care center." In October 1997, the Zoning Commissioner denied White Marsh Institute the right to locate. The decision stated that community organizations and local elected officials opposed the siting solely because of animus toward the clients who would be served and the fear that they would be a threat to the neighborhood. White Marsh

agency, and licensed by the Maryland State Department of Health and Mental Hygiene, or the Maryland State Department of Social Services, for the housing, counseling, supervision, or rehabilitation of alcoholics, or drug abusers, or of physically or mentally (including emotionally) handicapped or abused individuals who are not subject to incarceration or in need of hospitalization.

As a for-profit entity, White Marsh Institute did not fit within this definition.

Institute was forced to surrender its five-year lease as a result of the Zoning Commission's decision. Community backlash was so fierce, that the owner of the mall posted a sign stating that no treatment program was located on the premises.

In June 1998, White Marsh Institute filed suit in the federal District Court of Maryland, *Smith-Berch, Inc. v. Baltimore County, Md.*, challenging the denial of zoning approval under Title II of the Americans With Disabilities Act (ADA). One year later, the District Court denied the County's motion to dismiss,¹⁷³ finding that the County's special methadone policy imposed a disproportionate burden on individuals with disabilities and would violate Title II unless the County could show that its policy was necessary to carry out its zoning scheme. The parties entered settlement negotiations shortly thereafter, resolved the monetary claim, and agreed that the federal District Court would resolve the request for injunctive relief based on cross motions for summary judgment on the question of whether the County violated the ADA by requiring Plaintiff to submit to a public hearing to determine whether a methadone treatment program could operate in the County rather than permitting it to locate as a medical office as a matter of right.

In July 2000, the Court granted Plaintiff's motion for summary judgment.¹⁷⁴ It ruled that the County had violated Title II because its public hearing and special exception requirements imposed a disproportionate burden on individuals with disabilities and the hearing requirement was not necessary

¹⁷³ *Smith-Berch, Inc. v. Baltimore County, MD*, 68 F. Supp.2d 602 (D. Md. 1999).

¹⁷⁴ The relief requested in plaintiff's motion for summary judgment was carefully crafted in an effort to prevent the county from enacting a new zoning ordinance that would impose discriminatory standards on methadone programs. Thus, in addition to requesting a declaration that the county's practice violated the ADA, plaintiff also sought an injunction prohibiting the county from treating methadone programs differently from medical offices for purposes of zoning.

to its zoning scheme. The Court relied on evidence demonstrating that the County had consistently construed methadone treatment programs to fit under the zoning code's definition of "medical office" and that its own attorney had advised that applying different standards to methadone treatment programs was not justifiable legally. The Court concluded that the County could not impose a hearing requirement on methadone treatment programs when that same requirement was not imposed on medical offices and other drug treatment programs.¹⁷⁵

The victory did not magically change the hearts or minds of the community or County officials. Beginning in January 2001, the program searched for over a year, throughout the County, for an appropriate building that would rent office space to a treatment program. At least one large commercial property owner stated that it would not rent space to a drug treatment program, but many more simply did not return calls after learning the nature of the business. In February 2002, the program finally located a landlord willing to rent office space, and agreed to begin lease negotiations in April.

Those negotiations never took place. On April 1, 2002, the County Council introduced legislation, Bill No. 39-02, to amend the County's zoning code with regard to methadone treatment programs and all other drug treatment services. The landlord backed out of the negotiations.

The events surrounding the introduction of Bill 39-02 were a rerun of the preceding decade. Two proposed methadone treatment programs, neither of which was associated with White Marsh Institute, had rented offices within several blocks of each other and were going through the state and federal licensure process. When residents in the community learned of the proposed programs, some

¹⁷⁵ *Smith-Berch, Inc.*, 115 F. Supp.2d 520 (D. Md. 2000).

objected vociferously.¹⁷⁶ County Council members and state legislators responded, first, by appealing to State officials to regulate the siting of methadone treatment programs. When State officials refused to do so, the County Council introduced Bill No. 39-02¹⁷⁷ and passed it on an expedited basis two weeks later.¹⁷⁸

Bill 39-02 vitiated the *Smith-Berch* relief and, indeed, imposed more burdensome zoning

¹⁷⁶ The community's opposition was covered widely in the press: *Two Drug Clinics Posed for Pikesville*, OWINGS MILLS TIMES, March 13, 2002; *Pikesville Residents Gear Up to Fight Two Proposed Methadone Clinics*, BALTIMORE JEWISH TIMES, March 14, 2002; *Protesters Crash Clinic Open House*, OWINGS MILLS TIMES, March 19, 2002; *A Bitter Battle*, BALTIMORE JEWISH TIMES, March 20, 2002; *County Pulls Back Use Permit for Pikesville Methadone Clinic*, BALTIMORE SUN, March 22, 2002; *Council Bill Would Ban Certain Medical Clinics*, OWINGS MILLS TIMES, April 2, 2002; *Bill Would Block Drug Clinics Near Residences*, BALTIMORE SUN, April 2, 2002; *Council Measure Would Ban Some Medical Clinics in Residential Areas*, TOWSON TIMES, April 3, 2002; *Clinics Foresee Legal Battles*, BALTIMORE SUN, April 22, 2002.

¹⁷⁷ The Legal Action Center, counsel to White Marsh Institute in the *Smith-Berch* litigation, testified before the County Council on Bill No. 39-02, informing the County that the Bill violated the Court's summary judgment order. The testimony urged the County to abandon legislative efforts that discriminated against individuals in need of alcohol and drug treatment. Testimony on file with the author.

¹⁷⁸ The legislation was handled on an expedited basis because both programs were close to completing the licensure process. The state licensure process requires proof that the programs are zoned properly, and under the *Smith-Berch* decision, both programs were permitted to locate in a business zone as of right. Thus, to bar the programs from opening, County officials had to amend the zoning standard before the programs completed the licensure process. Bill 39-02 imposed the new zoning standards on any program that was established after April 1, 2002 and provided a six-month grace period to comply with the new standards to any program that was established and operating after April 1, 2002 and before the effective date of the legislation (which turned out to be April 16, 2002). One program opened its doors for operation the day the legislation was passed and just hours before it was signed by the County Executive. The County asked the State to revoke the program's license, asserting that it was not "operating" before the enactment of the legislation, and, thus, not properly zoned. When the State refused to do so, the County filed a zoning enforcement action to enjoin its operation. The second program had not gotten far enough along in the licensure process to take advantage of the *Smith-Berch* zoning standard.

requirements on treatment programs than had previously existed. Under the legislation, all alcohol and drug treatment programs are required to participate in a public hearing and obtain a special exception to locate in any business or office zone. The ordinance also prohibits these providers from locating within 750 feet of a residentially zoned property line and imposes enhanced parking requirements -- two requirements not imposed on other medical services. The ordinance permits treatment programs to locate as of right only in manufacturing zones.¹⁷⁹

Four years after the commencement of litigation, the program was back in court¹⁸⁰ and, more important, was no closer to providing methadone treatment to county residents. The likelihood of

179 The County Council attempted to sidestep the Court's injunction to treat methadone programs like medical offices by imposing these same requirements on a small segment of other medical providers -- "freestanding ambulatory care facilities." These facilities are defined under Maryland law to include any ambulatory surgical facility, freestanding endoscopy facility, freestanding facility utilizing major medical equipment, kidney dialysis center, or freestanding birthing center that is not owned or operated by a hospital. Until the enactment of Bill No. 39-02, the County's zoning code defined these providers as "medical clinics," not "medical offices." Bill No. 39-02 did not amend the definition of "medical office" and did not impose these new restrictions on any "medical office;" they continue to locate "as of right" in business zones and are not subject to distance or enhanced parking requirements. Thus, the County had again treated methadone treatment programs differently than all other medical offices, contrary to the Court's order in *Smith-Berch, Inc.*, and had reimposed the same zoning practices -- a public hearing and special exception requirement -- that the court had ruled violated the ADA.

180 In May 2002, counsel for Smith-Berch filed a contempt motion asking the Court to find the County in contempt of its July 2000 summary judgment order and to enjoin the enforcement of Bill No. 39-02. In August 2002, the district court enjoined Baltimore County from enforcing the new ordinance as it applied to methadone treatment programs. *Smith-Berch, Inc. v. Baltimore County, Md.*, 216 F.Supp.2d 537 (D. Md. 2002). The County appealed the decision, asserting that the lower court had lacked jurisdiction to entertain the contempt motion. In May 2003, the Fourth Circuit, without reaching the merits of the underlying ADA claim, reversed the lower court and held that because the District Court's July 2000 order did not specify the injunctive relief that it sought to issue, as required under Rule 65(d) Fed. R. Civ. P., the Court lacked jurisdiction to enjoin the implementation of the new zoning ordinance. The validity of Bill No. 39-02 is now the subject of litigation in *Helping Hand Inc. v. Baltimore County, Md.*, CCB-02-2568 (D. Md.) and *START, Inc. v. Baltimore County*, No. CCB-03-2051 (D. Md.).

finding a landlord who would be willing to rent office space to any methadone treatment program was slim and the prospect of unmitigated opposition by the County and some community members great.

The Baltimore County experience provides one model for addressing zoning discrimination against individuals with disabilities. It focused exclusively on litigation to enforce federal civil rights. The “win the battle, but lose the war” result raises the question of whether other legal and non-legal strategies should be pursued in these emotionally and politically charged and complex situations. An equally discriminatory zoning policy in the neighboring jurisdiction of Baltimore City presents a good case study to test that question and to identify other approaches to expand access to treatment services.

B. Baltimore City: Legislating the Location of Alcohol and Drug Services

Perhaps no city in the United States is more closely identified with drug addiction than Baltimore, Maryland. Books, movies, television series¹⁸¹ and headline news¹⁸² have graphically depicted the desperate lives of individuals addicted to drugs and the devastation of entire communities because of drug-related crime and an economy based on the drug trade. The Mayor of Baltimore, Martin O’Malley, has called drug addiction “the crisis that is killing our city,”¹⁸³ and city residents deem drug abuse to be

181 *E.g.*, DAVID SIMON & EDWARD BURNS, *THE CORNER* (1998) and the Home Box Office miniseries of the same title; DAVID SIMON, *HOMICIDE: A YEAR ON THE KILLING STREETS* (1993) inspired the television series, *Homicide: Life on the Streets*.

182 In the fall of 2002, the country was shocked by the firebombing deaths of Angela and Carnell Dawson Sr. and their four young children in Baltimore’s Oliver community. The family was allegedly targeted because Mrs. Dawson confronted drug dealers on her block and reported them to police. *O’Malley has proper focus: on city’s ills, not boosterism*, BALTIMORE SUN, Nov. 25, 2002; *Arson victim is remembered as ‘full of life,’* BALTIMORE SUN, Nov. 1, 2002; *Acknowledging ‘our debt to this family,’* BALTIMORE SUN, Oct. 25, 2002.

183 Grand Jury Charge, Grand Jury for the Circuit Court for Baltimore City, January Term 2003. Judge Althea Handy charged the January 2003 Grand Jury with investigating the available alcohol and drug treatment options and the ways in which the criminal justice system could better serve defendants with

the city's Number One health problem.¹⁸⁴ An estimated 58,000 adults in Baltimore City – approximately 10% of the city's adult population – are addicted to drugs and in need of treatment.¹⁸⁵ In 2003, roughly 25,000 were treated in the City's publicly funded treatment system.¹⁸⁶ While the City has tripled the number of treatment slots since 1996,¹⁸⁷ its current treatment capacity serves only one in three city residents who need such care.¹⁸⁸ As drug treatment becomes accepted as the most cost-

drug problems.

184 BALTIMORE NEIGHBORHOOD INDICATORS ALLIANCE, *VITAL SIGNS FOR BALTIMORE NEIGHBORHOODS: MEASURING BALTIMORE'S PROGRESS TOWARD STRONG NEIGHBORHOODS AND A THRIVING CITY* 13 (2002) (hereafter *Vital Signs*).

185 G. S. YACoubIAN *ET AL.*, CENTER FOR SUBSTANCE ABUSE RESEARCH, *ESTIMATING THE NEED FOR SUBSTANCE ABUSE TREATMENT IN MARYLAND: AN UPDATE OF REUTER ET AL. (1998)* 18 (2002). This is 20% of the statewide adult population (roughly 286, 000 people) who are in need of treatment. *Id.*

The criminal justice costs of untreated drug dependence in Baltimore City are staggering. Half of the persons charged with felony crimes in Baltimore City in 2001 were charged with felony narcotics crimes. An estimated 70% of all cases heard in the Baltimore City Circuit Court were directly or indirectly related to drug abuse. Approximately 90% of the homicides in the city are drug-related. The costs to the city in crime alone are estimated to be over \$3 billion. Charge Committee Report, Grand Jury for the Circuit Court for Baltimore City, January Term 2003 at 1 (hereafter *Grand Jury Report*) at 1-2.

186 Baltimore Substance Abuse Systems, Inc.

187 The city agency that administers the alcohol and drug treatment system gets fifty calls each day from persons seeking drug treatment. The City's budget for alcohol and drug treatment services has grown from \$14 million in 1995 to \$60 million in 2003. Executive Director, Baltimore Substance Abuse Systems, Inc., Speech (Apr. 29, 2003).

188 All sectors of the City, from business to government to medical to religious to legal, have recognized the need to dramatically increase the availability of treatment to address the City's drug problem, and the City and State have made increased funding for treatment services a higher priority since the mid-1990's. *DRUG STRATEGIES, SMART STEPS: TREATING BALTIMORE'S DRUG PROBLEM* 8-10 (2000). The January 2003 term Grand Jury Charge Committee endorsed this public health approach. The Grand Jury, echoing the views of experts around the country who have studied the effectiveness of the national response to drug dependence, concluded that the City cannot arrest its way out of the drug

effective means of enhancing public safety,¹⁸⁹ the need for treatment slots will increase even more.

The symbolic importance of drug treatment was driven home by the Mayor in the summer of 2003 when he selected a new residential treatment program – the first of its kind to be established in the city in thirty years¹⁹⁰ -- as the location for announcing his reelection bid. His campaign sign – Treating Addiction, Reducing Crime – was a powerful endorsement of treatment as critical to the City’s rejuvenation.¹⁹¹ The story that was not told at that event, however, was the City Health Department’s

epidemic and that treatment and alternative sentencing practices offer a more effective and cost-effective way to create safer and healthier communities. Grand Jury Report at 14-15. The Grand Jury specifically recommended that the City: (1) establish a continuum of care for substance abusers that would provide treatment and a range of supportive services, preferably in a residential setting; (2) divert non-violent drug offenders to a “continuum of care” rather than incarceration; (3) use criminal citations rather than arrests for offenders who are buying drugs for personal use; and (4) reexamine regulated or licensed distribution of drugs to individuals for personal use. Grand Jury Report at 4-14.

189 The City’s treatment expansion is thought to have contributed to a reduction in violent crime in the City. From 1999 to 2001, violent crime dropped 24% and robberies decreased 28%. After a decade of more than 300 homicides each year, the number of homicides dropped to 261 in 2000 and 259 in 2001. STEPS TO SUCCESS, *supra* n. 25, at 6. The trends in drug-related health problems have dramatically improved with the expansion of treatment services. The number of drug-related emergency room visits for cocaine and heroin problems fell by 19% in 2001, the largest drop among cities in the United States, *see data at* <http://www.DrugAbuseStatistics.SAMHSA.gov>. The number of overdose deaths in Baltimore dropped from 343 in 1999 to 334 in 2000 and 306 in 2001. DANA LEHDER ET AL., CENTER FOR SUBSTANCE ABUSE RESEARCH ALCOHOL AND DRUG-RELATED OVERDOSE DEATHS IN MARYLAND 7 (2002), *at* <http://www.dewsonline.org/dews/pubs/me11-02.pdf> (last visited Feb. 17, 2004). In addition, the rate of syphilis dropped significantly during the period 1999 to 2001. MARYLAND DEPT. OF HEALTH AND MENTAL HYGIENE, DIVISION OF SEXUALLY TRANSMITTED DISEASES, *at* http://edcp.org/pdf/P&S_1993-2002.pdf. (last visited Feb. 17, 2004).

190 BALTIMORE SUN, June 24, 2003. Providing drug treatment is one component of the Mayor’s two-pronged approach to fighting crime. Creating a persistent police presence to ward off drug dealers is the other component.

191 One must question, however, whether the seemingly inextricable linking of treatment to crime further promotes the stigmatized view of treatment.

struggle to get zoning approval to site this treatment program.¹⁹² Like all other drug treatment providers in Baltimore, the Health Department was required to obtain the enactment of a city ordinance – a conditional use ordinance -- authorizing the siting of the program. This involved obtaining community approval for the program, submitting extensive information to the city’s Planning Department, and participating in two separate public hearings before the Planning Commission and the City Council; a process that took over eight months to complete.¹⁹³

In a City that has, from all appearances, bought into the concept of drug addiction as a treatable disease, it has surrendered to the political nature of drug control by adopting a zoning policy that places a premium on public sentiment, rather than objective facts about the magnitude of the need for treatment and quality of services. It also relies upon elected officials to introduce and support legislation (the conditional use ordinance) that, if unpopular with vocal constituents, could harm one’s political career.

192 The City does not own or operate this or other treatment programs, but the Health Department took the unusual step of purchasing the building and obtaining zoning approval before awarding a bid for the operation of the program. The treatment program, Gaudenzia Baltimore, is located in the Park Heights community, which is located in the City’s zip code that had the second largest number of people served by drug treatment programs in 2001 and the second largest number of diagnosed AIDS cases for the period 1981-2002. VITAL SIGNS, *supra* n. 184, at 38-39.

193 The Health Department staff person who marshaled the project through the process described it as a “bureaucratic nightmare.” The City attorney’s office took several months to determine the proper zoning process for a residential treatment program. Once the conditional ordinance process was commenced, the Planning Department could not adequately describe the information that needed to be provided and then sought information that was not available because of the unique nature of the project. Obtaining community approval was time consuming because of the multiple neighborhood associations that had to be consulted on the project. Finally, approval required the seemingly repetitive process of public notice and a public hearing before two different city authorities. The staff person concluded that the effort takes sophistication, political connections and an ability to navigate an unhelpful bureaucracy – skills that some providers do not have. Telephone Interview with Baltimore City Health Department Staff (June 27, 2001).

While zoning matters often pull public officials into the political fray, the underlying standard for siting treatment programs turns the process itself into a political contest. In the current environment, the standard is nothing less than hostile to the establishment of treatment programs.

1. Baltimore City Zoning Standards
 - a. Conditional Use Ordinance (CO)

Under the Baltimore City Zoning Code, a provider who seeks to establish an outpatient treatment program¹⁹⁴ or a residential program serving more than eight individuals¹⁹⁵ is required to obtain a

194 Non-residential treatment services are covered under the zoning classification “substance abuse treatment center” and defined as:

a facility that provides and represents or advertises itself as providing:

- (1) nonresidential counseling, treatment, care, medication or rehabilitation for individuals who show the effects of substance abuse; or
- (2) transportation of individuals for the purpose of substance abuse treatment, care, medication, or rehabilitation.

BALTIMORE MD. ZONING CODE, COMPACT EDITION, TITLE 1 § 1-194 (2000). Non-residential treatment programs include a variety of out-patient counseling services (both intensive and non-intensive) and medication assisted treatment (such as methadone treatment), all of which must be certified by the State to operate. See MD. CODE ANN., HEALTH-GEN. I § 8-403 (b) (2003); and MD. REGS. CODE tit. 10, § 10.47.03.01 (2003).

195 Residential treatment programs are covered under the term “homes for non-bedridden alcoholics or homeless persons,” which is not defined in the code, or the term “family.” The zoning code defines “family” to include a group of not more than four (4) unrelated people living together as a single housekeeping unit (BALTIMORE MD. ZONING CODE, *supra* n. 192), but the City Planning Department has, since mid 2002, permitted groups of eight (8) unrelated people to live together under the definition of “family.” Residential services include halfway houses and intermediate care facilities, which must be certified by the State to operate. See MD. REGS. CODE tit. 10, §§ 10.47.02.06, 10.47.02.07, and 10.47.02.08 (2003) In addition, group recovery homes, which provide a clean and sober living environment for persons (some of whom have participated in or continue to participate in treatment) as well as non-therapeutic support services, are not licensed by the State. These housing services fill an important gap in the continuum of care for individuals who have begun their recovery but are either homeless or want to avoid returning to a drug-using home environment. Group recovery homes with up

conditional use ordinance to locate in any part of the city.¹⁹⁶ A conditional use ordinance (hereafter CO) is zoning legislation that is enacted through the municipal legislative process. The program is required to have a city council member sponsor the conditional use bill, post notice of the requested authorization after the bill has been introduced in the City Council, and then submit detailed information about the proposed site and its operation to the City’s Planning Department, which makes recommendations to the Planning Commission about whether it should support the legislation.¹⁹⁷ During this review process, the

to eight individuals can locate under the definition of “family,” which are permitted to locate “as of right” without going through a zoning process. Larger group homes are required to locate under the term “homes for non-bedridden alcoholics and homeless persons” and must obtain a conditional use ordinance.

¹⁹⁶ The conditional use ordinance requirement for alcohol and drug services is also included in the city code provision that regulates health facilities. The provision prohibits the establishment of any home for the rehabilitation of non-bedridden alcoholics or substance abuse treatment center “unless authorized by an ordinance of the Mayor and City Council of Baltimore.” BALTIMORE CITY REV. CODE, HEALTH, HE § 3-101. A violation of this requirement can result in the issuance of an order by the Health Commissioner to discontinue all operations within ten days of the order. HE § 3-104. Providers that fail to comply with such an order are guilty of a misdemeanor and can be fined up to \$1,000 for each day of operation. HE § 3-107.

¹⁹⁷ Under the zoning code, the City Council is required to refer the bill to the Board of Municipal and Zoning Appeals (BMZA), the Planning Commission and any other relevant agency for their written reports and recommendations. The agencies are required to submit their recommendations to the City Council within 100 days of introduction of the bill. BALTIMORE MD. ZONING CODE, COMPACT EDITION, TITLE 16 §§ 16-203, 301, and 302 (2000).

The Planning Commission’s recommendations (as well as the BMZA’s) are to be based on a number of zoning considerations including: (1) the nature of the proposed site, including size and shape; (2) resulting traffic pattern and adequacy of off-street parking; (3) nature of the surrounding area and extent to which the proposed use might impair its development; (4) proximity of other places of public gathering, such as churches and schools; (5) accessibility of fire and police protection; (6) accessibility of light and air; (7) type and location of adequate utilities, access roads, drainage and other necessary facilities; (8) preservation of historic and cultural landmarks; (9) provisions of the City Master Plan; (10) provisions of any applicable Urban Renewal Plan; (11) all applicable requirements of the zoning code; (12) the intent and purpose of the zoning code; and (13) any other matter of interest to the general public. BALTIMORE MD. ZONING CODE, COMPACT EDITION, TITLE 14 § 14-205. Section 16-304

Planning Department also ascertains community sentiment about the proposed program by identifying neighborhood associations that the program is required to meet with and get community approval from.¹⁹⁸ The community approval requirement is not contained in the CO provision of the zoning code, but it is the linchpin of the siting process for alcohol and drug treatment programs. Failure to obtain community approval or to agree to “conditions” requested by the community¹⁹⁹ during that process will kill the legislation.

Upon completing its review, the Planning Department prepares a report for the Planning Commission, which, in turn, hears the proposal at a public hearing. The same neighborhood associations that were consulted previously are notified of the hearing and given an opportunity to

of the Zoning Code incorporates these considerations for a CO. While these considerations guide the Planning Department’s information gathering process, the Planning Commission report does not address these issues directly.

198 This information is based on extensive interviews of alcohol and drug treatment providers that the author conducted from June 2001 through January 2002 and September 2002 to May 2003. Treatment programs have been identified by numbers to protect their privacy. Interview notes are on file with the author.

Telephone Interview with Baltimore City Health Department Staff (June 27, 2001); Personal Interview with Director of Program 1 (June 28, 2001); Telephone Interview with Director of Program 6 (Jan. 8, 2002); Telephone Interview with Director of Program 18 (Jan. 7, 2002); Telephone Interview with Contracts and Development Officer of Program 15 (May 20, 2003).

199 Treatment providers have been required to limit the number of clients who will be served as a condition of obtaining a favorable recommendation. Telephone Interview with Director of Program 1 (July 20, 2001); Personal Interview with Director of Program 16 (June 28, 2001); Telephone Interview with President of the Board of Directors of Program 13 (July 27, 2001). The Planning Department uses the zoning process to deal with programmatic issues and to evaluate whether the proposed facility will create problems for the neighbors. Telephone Interview with former Division Manager, Current Planning, Baltimore City Planning Department (September 5, 2001). Thus, a program’s operating hours, plans for where clients may congregate and smoke and the movement of clients in and out of the facility are scrutinized. Telephone Interview with Baltimore City Health Department Staff (June 27, 2001); Telephone Interview with Director of Program 1 (July 20, 2001).

testify. Once the reports have been filed with the City Council, the Council's Land Use Committee must also conduct a hearing on the bill. The public is again provided notice of the hearing and given an opportunity to testify. Following the hearing, the Council votes on the bill, and, if passed, sends it to the Mayor for signature. As a legislative process, there is no right to appeal the Council's rejection of the bill or the Mayor's refusal to sign the legislation.

The CO process is imposed on land uses that are controversial²⁰⁰ and is designed to make officials "listen to the community" and "help clean up the community."²⁰¹ The power of the community in determining the outcome of the CO process was demonstrated by the public flailing of one well respected, out-patient treatment program that had served the city for over 30 years. The Director of the program, hoping to provide a permanent home for her non-profit program, had purchased and renovated a building several blocks from the site it had occupied for ten years. In the summer of 2002, she moved her program into the building without first obtaining a CO.²⁰² The new office sat on the perimeter of an upper income, predominantly white community that is separated by a major road from a lower-income, predominately African-American community. The African-American community from which the

200 For example, other land uses that are required to obtain a CO include: adult entertainment, adult book stores, community correction centers, incinerators, parole and probation offices; racetracks, recyclable materials recovery centers, and stadiums. Convalescent and nursing homes are the only other land use that is required to obtain a CO to locate in every zoning district in the city. BALTIMORE MD. ZONING CODE, COMPACT EDITION, Chart (2000).

201 Telephone Interview with former Division Manager, Current Planning Division, Baltimore City Planning Department (Sept. 5, 2001).

202 The program operated two out-patient programs and four halfway houses in different locations throughout the city, but had never obtained a CO previously. Telephone Interview, Director of Program 6 (Jan. 7, 2002).

program had moved wholeheartedly supported the treatment program. While the provider thought that the new location, which was half a block from the major artery, was located in that same community, she had, in fact, entered an entirely different racial and socio-economic community. A single neighbor's complaints to zoning officials about music and cigarette smoke coming from the program's parking lot triggered an investigation that revealed the program's failure to obtain a CO. The City Health Department abruptly closed the program pending compliance with that process.

The program's director, in an effort to win public support, held an open house to answer questions and inform residents about the program's services and unblemished track record.²⁰³ The meeting turned into an angry indictment of the program, characterized by stereotypical fears about the clients.²⁰⁴ The community, insulted that it had not been consulted before the program had moved in, voiced unsubstantiated concerns about increased crime and lower property values. Some speculated about the program serving sexual predators, inebriated individuals roaming the neighborhood, and unspecified, yet seemingly predictable, disruptions to the neighborhood. Others warned that the substantial tax base that was represented by those in the room did not have to remain in the city and that the program was simply

203 The meeting was held on September 17, 2002. Notes from that meeting are on file with the author. Prior to the meeting, the neighborhood association submitted a list of over 50 questions to the Health Department. A copy of those questions is also on file with the author.

204 The Director provided a profile of her clients, who typically were employed, entered treatment either through Drug Court referrals, school or self- referrals and traveled to the program by bus. The program did not accept individuals with violent criminal records, but only those with non-violent, drug-related crimes. The program, like other publicly funded programs in Baltimore City, is required to reserve a certain number of treatment slots for individuals referred from the criminal justice system. Indeed, one of the residents who participated in the meeting, but lent no vocal support, was a local judge who had referred criminal defendants to the program. The program routinely monitors clients for drug use through standard drug testing protocols and refers clients who continue to use drugs while enrolled in the program to detoxification services.

in the “wrong neighborhood” and should be located where “these people lived.” The City’s Health Commissioner, who participated in the community meeting, acknowledged the good treatment outcomes that the program had achieved consistently, but berated the program’s director for undermining the City’s progress in expanding treatment by ignoring the CO process. He assured residents repeatedly that the City would not permit the program to locate in the community if they did not want it there. Following this cue, the neighborhood association voted to oppose the program rather than negotiate “conditions” under which the program could operate. The director abandoned her effort to obtain a CO, being advised by the City’s Planning Department that the bill would go nowhere without support of the Health Department. The director put the building on the market and returned to its previous location.²⁰⁵

No other health care service is subjected to this process when seeking to locate in any zoning district in the City.²⁰⁶ Outpatient medical services are permitted to locate as of right in certain business

205 The outcome of this zoning battle can best be understood as a socio-economic and racial clash with the politically powerful prevailing. At the same time, programs face the same opposition in some neighborhoods whose residents and community leaders are engaged in the CO process from the start, and whose residents are lower-income individuals who, when seeking care for addiction, would access such services at non-profit treatment programs. This has been driven home to one of the City’s most respected residential treatment providers that sought to expand an existing halfway house program for women on a one-acre plot in a predominately African-American, multi-family dwelling neighborhood. The provider met with community leaders to discuss its plans as funding-raising progressed and invited them to visit its residential treatment program. The community association rejected the program’s offer, noting that it did not want additional treatment services in the neighborhood. The provider hired an outside consultant to “sell” the program to the community, but was awaiting the introduction of a bill almost one-year into that process. Telephone Interview, Contracts and Development Officer of Program 15 (May 20, 2003).

206 Hospitals are required to obtain a CO to locate in particular residence and business districts, but are also permitted to locate “as of right” without going through any zoning process in residence districts with higher density dwellings and several business districts. BALTIMORE MD. ZONING CODE, COMPACT EDITION, Chart (2000).

and industrial districts and a mixed office and residence district under two land use categories.²⁰⁷ Out-patient mental health services and psychiatric rehabilitation programs, which provide many of the same types of counseling services as alcohol and drug treatment programs and serve persons with dual diagnoses of mental health and substance abuse, locate as of right in many zoning districts in the City under the “office” land use category. Residential services for persons with mental illness also locate as of right, pursuant to a state law that preempts local standards for group homes.²⁰⁸ Thus, drug and alcohol treatment services must comply with far more burdensome zoning standards than other similarly situated health services.

i. Origin of the Conditional Ordinance Process

The CO process is the legacy of zoning discrimination against persons who sought alcohol treatment in the mid-1950’s. Not unlike current practices, the City incarcerated, rather than treated, alcoholics at that time, and private entities attempted to provide alternatives by establishing recovery homes. Zoning officials attempted to shut down the homes operated by one of these organizations, the Flynn Christian Fellowship Houses, Inc., but sparked a three-year legal and legislative battle that

207 The “office” use, an undefined term in the zoning code, permits business, professional and governmental offices with no sales or bulk storage to locate as of right in the office-residence district and five business districts. BALTIMORE MD. ZONING CODE, COMPACT EDITION, Chart (2000). The “clinic: medical or dental” use is defined as “a building the principal use of which is for offices of physicians or dentists for the examination and treatment of people on an out-patient basis.” BALTIMORE MD. ZONING CODE, COMPACT EDITION, TITLE 1 § 1-126 (2000).

208 Licensed group homes for persons with mental illness that have up to eight residents are permitted to locate as of right in any residential zone. Group homes with nine to sixteen residents are permitted to locate as of right in any multi-family zoning district. MD. CODE ANN., HEALTH-GEN. I §§ 10-514 and 10-518 (2003). State law also prohibits the application of any special exception, conditional use permit or procedure to these group homes that differs from those that are applied to single-family or multi-family dwellings. HEALTH-GEN. I § 10-518(b)(3) (2003).

culminated in the enactment of the CO process.

Beginning in 1958, Flynn Houses proposed, but could not win approval of, zoning legislation that would have permitted the recovery homes to operate either as of right or with the approval of the Board of Municipal and Zoning Appeals (BMZA) in residential neighborhoods.²⁰⁹ In 1962, however, the City Council approved legislation that, for the first time and over the objections of the BMZA, authorized the City Council to grant a conditional use to “homes for non-bedridden alcoholics and for the care and custody of homeless persons.”²¹⁰ The new standard permitted neighborhoods to vote on whether a recovery home could locate in their area.

In 1971, when the City adopted its Zoning Code, it required a conditional use ordinance for “homes for non-bedridden alcoholics and homeless persons.” One year later, the City added the land use “drug abuse rehabilitation and treatment centers” and adopted the conditional use ordinance process for all drug and alcohol treatment programs (both out-patient and residential). City officials were quite explicit in 1972 that they were adopting the CO practice so that communities could bar treatment programs from their neighborhoods because of the fear that they would attract drug addicts and the crime associated with those individuals.²¹¹

209 The legislative history reveals that the Planning Commission objected to a proposal that the recovery homes locate “as of right” in residential districts because the “homes . . . could result in misuses which would be a serious nuisance to adjoining residential properties.” The Commission noted that the location of such homes “should be subject to individual consideration and controls, guides and standards” Journal, City Council of Baltimore, Nov. 16, 1959, at 537.

210 Journal, City Council of Baltimore, Jan. 29, 1962, at 1126.

211 The Planning Commission advised at the time that the CO process was appropriate because it permitted the City Council to impose conditions and restrictions on the establishment, location, construction, maintenance and operation of the programs to “reduce or minimize any effect of such use

The zoning code standard for residential and out-patient treatment programs has remained the same since 1972, with only one significant modification. In 1994, the City Council adopted a definition for the term “drug abuse rehabilitation and treatment centers” to ensure that treatment programs would not evade the CO process. The legislation was offered in response to public opposition to one particular methadone treatment program that bussed clients to a program in a neighboring county for treatment. The community complained about loitering, littering and property damage by clients who were not supervised while waiting for the bus.²¹² City officials discovered that the program had not gone through the CO process, but had located as of right in a business district as a medical office. The Director of the Planning Commission approved of the legislation, which defined what constituted a treatment program, to ensure that “proper review and community input” occurs prior to permitting the use in any neighborhood.²¹³

The history demonstrates that, at every critical juncture, City officials adopted its zoning

upon other properties in the neighborhood.” Journal, City Council of Baltimore, Jan. 24, 1972, at 348-49. The Planning Department noted that the public hearing would ensure community input (*Id.* at 349), and the City’s Commissioner of Health predicted the tenor of community input:

The primary problem involved with drug abuse rehabilitation centers is their location. Rightly so, many communities do not want such a center in their neighborhood because of the fear that it will attract drug addicts and the crime associated with such addicts to their areas. The best way that this problem can be handled is through zoning where both the City Council and the Zoning Commission can hold public hearings to determine where such a center can or cannot be located.

Journal, City of Baltimore, Apr. 17, 1972, at 432.

212 Planning Commission Staff Report on City Council Bill # 951, Nov. 3, 1994; City Council Hearing Notes, Nov. 9, 1994.

213 Charles C. Graves III, Planning Commission Staff Report on City Council Bill # 951, Nov. 3, 1994.

standards in response to public concerns and bias against individuals who needed alcohol and drug services. The city also adopted standards that would ensure the greatest level of regulation and community control in the siting process.

b. Conditional Use Board Process

In contrast to the CO process, the City zoning code also provides for a second conditional use process, referred to as the conditional use board (CB) process, that is a traditional administrative (not political) process. The process is generally required for land uses that seek to locate in a zoning district for which they are not permitted as of right.²¹⁴ The process is more streamlined than the CO with less agency involvement and scrutiny, fewer layers of review and significantly less deference to the community. The decision-maker in the process, the Board of Municipal and Zoning Appeals (BMZA), is an appointed body and, thus, not subject to the same political influences and considerations as the City Council. The whole process can be completed within two months.

In evaluating an application for a CB, the BMZA conducts a hearing for which the public is given notice through posting and an opportunity to present its views. Community approval, however, is neither sought nor required. To approve a conditional use, the BMZA must find that the use will not be detrimental to or endanger the public and the authorization is consistent with the purpose and intent of the zoning code.²¹⁵ In practice, the BMZA presumes that the applicant meets the required findings

214 For example, a medical and dental clinic is permitted to locate in the office-residence district if it obtains a CB and physicians and dentists may open an office in several residence districts with a CB. Consumer-run programs that provide social and recreational services for persons with mental illness are permitted to locate in any residence district or the office-residence district with a CB. BALTIMORE MD. ZONING CODE, COMPACT EDITION, Chart (2000).

215 BALTIMORE MD. ZONING CODE, COMPACT EDITION, TITLE 14 § 14-204 (2000).

unless demonstrated otherwise. Applicants may appeal an adverse BMZA decision to the courts.²¹⁶

2. Impact of the Conditional Ordinance Process on Establishing Treatment Programs

The foiled efforts to establish treatment programs described above are not isolated cases. The CO process has prevented and delayed the establishment of many treatment programs in Baltimore. The impact of the CO process, like its purpose and history, is critical to evaluating its legality.

Treatment providers have responded to the CO process in three ways – adopting both the concealment and resistance strategies to a stigmatizing procedure.²¹⁷ First, some providers have located without going through the conditional ordinance and approval processes, at times with the tacit approval and guidance of zoning officials. Providers have avoided the process through: (1) the intervention of landlords both with and without informal community approval,²¹⁸ (2) structuring residential services to

²¹⁶ BALTIMORE MD. ZONING CODE, COMPACT EDITION, TITLE 14 § 17-302 (2000).

²¹⁷ *See supra* note 198.

²¹⁸ For example, one publicly-funded program that provides a range of out-patient alcohol and drug services as well as mental health and primary medical care was told that it could not move into a particular building because the community already had the maximum number of social service organizations it could support. The program was prepared to back out of the plan, but the landlord facilitated a meeting with the neighborhood association, which then approved the siting of the program. The provider did not go through the CO process at that time, but upon returning to a previous location five years later was required to do so. Telephone Interview with Executive Director of Program 1 (July 20, 2001). A second out-patient program opened with the approval of the landlord who indicated that the program could open as a medical office as long as no medications were being dispensed. Telephone Interview with Director of Program 2 (Jan. 8, 2001). A third program had the same experience – siting upon the landlord's confirmation that the building was properly zoned for an out-patient drug treatment program – only to learn several years later when the program sought to expand its services that a CO was required. When the neighborhood association learned that the program provided alcohol and drug treatment services, it complained to zoning enforcement officials who threatened to close the program for failing to have a CO. The neighborhood association ultimately voted in favor of the program remaining in its location on the condition that it remove its sign, not expand its services and operate

fit under the definition of “family” and relying on the Fair Housing Act’s non-discrimination standards;²¹⁹ and (3) locating under the “office” use, at times by not identifying that they provide alcohol or drug services.²²⁰ While some providers were not aware of the CO requirement, others consciously avoided the process because of the community approval requirement.²²¹ This has resulted in an

under a “don’t ask, don’t tell” policy. Personal Interview with Director of Program 3 (June 28, 2001).

219 Halfway houses and group recovery homes have located under the “family” designation, rather than the “homes for non-bedridden alcoholics” use, and have exceeded the four-person cap on unrelated individuals even before the Planning Department lifted that cap to eight persons in 2002. (see *supra* note 195.) For example, a six-month residential program for twelve women and children located in two adjacent townhouses under the designation of “family” with the approval of the landlord alone. Telephone Interview with Director of Program 4 (June 2001). Housing and zoning officials have advised a number of group home providers whose homes serve five to twelve persons without going through the CO process, asserting that federal anti-discrimination statutes protect individuals with disabilities that seek to live together. Telephone Interview with Executive Director of Program 5 (Aug. 3, 2001); Telephone Interview with Executive Director of Program 6 (Jan. 7, 2002); Telephone Interview Executive Director of Program 7 (Jan., 8, 2002).

220 For example, one program, which provides both mental health and alcohol and drug treatment, sought to relocate after one neighborhood association asked city zoning officials to close the program. While the zoning office refused to close the program, it would not permit the program to expand its services and advised it to be as invisible as possible and not advertise its services. When the program found a new location, the zoning office advised the program to operate as of right as a mental health clinic and did not require it to go through the CO process. Telephone Interview with Director of Program 8 (July 18, 2001). Similarly, the Director of Program 6 opened a second out-patient counseling program in a shopping mall without going through the CO process based on the guidance of a City Council member and city planner. Both advised that the CO process could be avoided if the application for an occupancy permit omitted information about alcohol and drug treatment services. Telephone Interview with Director of the Program 6 (Jan. 8, 2002).

221 When one state certified halfway house, that had been in operation since 1972, moved to a new location in the late 1990’s, the director decided not to seek a CO because he had attended a neighborhood association meeting in which some residents expressed the view that the area had enough drug treatment and did not want more. Afraid to approach the neighborhood for fear of stirring up opposition, the director maintains a low profile and does not engage the community. Telephone Interview with Director of Program 9 (January 7, 2002).

inconsistent application of the zoning standard.

Second, some providers have structured their out-patient and residential services to avoid going through the conditional use ordinance and community approval processes.²²² They have chosen this course because of the complex and time-consuming nature of the ordinance process²²³ as well as the real and perceived difficulty in obtaining community approval. This has resulted in programs limiting the

222 For example, a crisis intervention center for individuals with mental health and alcohol and drug problems provides detoxification services to individuals in an apartment building. Patients undergoing detoxification live in individual apartments, with two people per apartment, to fit under the zoning code's definition of "family." The program would like to have a free-standing center with comprehensive services, but has been deterred by the prospect of having to obtain community approval. Personal and Telephone Interviews with Director of Program 10 (June 28 and July 19, 2001).

A methadone treatment program has resorted to providing treatment through mobile units that dispense medication at three different sites in the City in order to avoid obtaining community approval. While the mobile units make care more accessible, clients must go to a second location to obtain counseling and medical examinations. The arrangement also creates numerous operational and staffing problems: the program's vans, medication and counseling services are in three different locations; alternative dosing arrangements must be made when the vans break down or are snowed-in; and nursing staff are difficult to retain in a mobile treatment program. The program would like to consolidate its services in one location but is certain that it could not obtain community approval for a new fixed site location. Telephone Interview with Executive Director of Program 11 (Aug. 2, 2001). Ironically, the program, which was created as a mobile service to avoid the CO process, faced the prospect of having to obtain a CO when it sought to deal creatively with an aging fleet of vans. To extend the life of the van generators, the program decided to install a utility pole in the church parking lot from which it operates so that it could use an external power source to provide heat and air conditioning. Zoning officials initially informed the program that it would be deemed a fixed site if it plugged the van into the external power source, and, thus, be required to obtain a CO. The program resolved the problem by having the church install the utility pole in its name. Telephone Interview with Executive Director of Program 11 (September 30, 2002). This situation highlights the administrative and fiscal drain the CO process imposes on providers that seek nothing more than to provide a medical service.

223 One treatment program opted to cap the number of women it would serve in its halfway house because of the time and effort involved in obtaining a CO. Rather than establish two halfway houses for six women each, it opted to limit the capacity in each to four women. Telephone Interview with Executive Director and Program Manager of Program 12 (January 7, 2002).

number of individuals who will receive care, choosing not to expand capacity and providing less coordinated services.

Third, some providers have undertaken the ordinance and approval processes, but have spent significant time and resources garnering support from multiple neighborhood associations, developing detailed information for city zoning officials, negotiating with city officials based on community input, and participating in duplicative hearings.²²⁴ This lengthy process, which hinges on community approval, adversely affects all alcohol and drug providers and their clients by exposing them to intense public scrutiny and, at times, discriminatory animus. Some providers have not succeeded in obtaining approval because of community opposition to the clients who will be served,²²⁵ while others have experienced significant delays and increased costs in establishing or relocating services.²²⁶

224 *See supra* note 193. When Program 16, a methadone treatment program that has operated in the city since 1971, sought to relocate in the mid-1990s, the process took nine (9) months.

225 For example, one of the City's oldest methadone treatment programs had considered moving its program in the late 1990's and started seeking the support of the neighborhood associations. The community objected to the methadone treatment modality, so the Director decided to back off. Telephone Interview with Director of Program 13 (July 20, 2001). A well established residential treatment provider in Maryland spent over three years looking for a site for a women's residential treatment program and going through the zoning process. It lost two potential sites because of neighborhood opposition. At one community meeting, a council member expressed the view that the neighborhood had enough non-profits and drug treatment and did not want another. The program's representative concluded that the biggest impediment to establishing treatment services was winning community and council support: vocal opponents go to council members who then erect barriers. Telephone Interview with staff person of Program 14 (Aug. 17, 2001).

226 One outpatient treatment program worked with the community associations for two years before receiving community approval. The community turned a deaf ear to the program initially because one resident had intentionally circulated false information that the program would be a methadone treatment program. The Director finally won community approval through a long education process that included inviting all interested persons to visit her existing program on an unannounced basis to observe the program. Telephone Interview with Director of Program 6 (Jan. 7, 2002). It took a primary health care

Because of the influence of neighborhood associations, some programs have invested significant resources into maintaining community relations. Program personnel become active members in neighborhood associations to demonstrate their support for and involvement in the community and to address the community's concerns about the program.²²⁷ They also foster community support by serving the residents of the community, often on a priority basis even if capacity is limited, and by using the program's resources to enhance the neighborhood. Programs, for example, sponsor youth programs and other training services, conduct prevention programs in neighborhood schools, and hire staff from the neighborhood.²²⁸ Some have also implemented policies and procedures to ensure that the programs do not negatively affect the community, such as non-loitering policies.²²⁹

Indeed, some treatment providers believe that the implementation of formal "agreements" for community engagement could be the basis for eliminating the CO process itself. Rejecting the

facility that provides treatment services five months to win community approval when it sought to **return** to a previous location. In going to the community, the program learned that, because of its low profile, many had not known that a drug treatment program had operated in the location years earlier. Telephone Interview with Director of Program 1 (July 20, 2001). Another long-standing, well-respected residential program has been forced to retain the services of a community development organization to win community approval for the expansion of an existing halfway house program. The program went to the community association early in the planning process to discuss its plans and thought that approval would be forthcoming only to be informed that the community simply wasn't interested in the program expanding its services. Telephone Interview with Contract and Development Officer of Program 15 (May 20, 2003).

227 One methadone treatment program has had a staff person working for eight years full time on community development issues. Personal Interview with Director of Program 16 (June 28, 2001).

228 Personal Interview with Director of Program 17 (June 28, 2001); Telephone Interview with Director of Program 6 (January 7, 2002); Telephone Interview with Director of Program 5 (August 3, 2001).

229 Personal Interview with Director of Program 16 (June 28, 2001); Telephone Interview with Director of Program 13 (July 20, 2001).

stereotypical view that treatment programs and their clients impose a burden on communities, these providers have crafted a set of “good neighbor practices” that are intended to promote a cooperative relationship between the provider and the community’s residents. The “good neighbor practices” focus on three goals: education, community building, and program responsiveness.

The “good neighbor practices” seek to promote education about alcohol and drug treatment generally and the program’s services specifically through a number of concrete actions: participation in community association meetings and activities; inclusion of community members on the program’s advisory committee or appropriate boards; and sponsorship of on-going education programs about addiction and treatment services for community residents.

They promote community building by working with neighborhood associations to improve the quality of life in the community. Those strategies include: offering employment to qualified residents; providing administrative support to community associations and participating in their neighborhood activities; giving priority to residents who want to enroll in the program; working with the community to educate city officials about the need for police presence to curb drug-related criminal activity; and serving as a liaison to city officials to seek city intervention to address community-based problems that are perceived to be related to the treatment program but are beyond the control of the program.²³⁰

Finally, the good neighbor practices identify a number of strategies to demonstrate the program’s responsiveness as a “neighbor” and commitment to quality care, including: identification of contacts

²³⁰ For example, treatment providers, like other residents in a community, are not equipped to stop drug dealing that occurs in the neighborhood or disperse persons who are not enrolled in a program but are loitering in the area. Programs can, however, intervene by informing city officials that law enforcement or other city agencies are needed to address these problems.

within the program to address community concerns about the program's operation; commitment to meet or exceed state regulations on staffing levels to ensure quality treatment; and adoption of a formal process to address issues that arise between the community and the program, including mediation if the problem cannot be resolved informally. Programs that are new to a neighborhood are advised to demonstrate their responsiveness by providing information about the program to the leadership of the community association and by identifying how the program plans to adhere to the good neighbor practices.²³¹ From the program's perspective, adoption of such measures would help integrate the program into the community and give communities a good partner in addressing their problems, which the CO process fails to do.

3. Legality of the Conditional Ordinance Process

Litigation has been visibly missing from the strategies programs have adopted to respond to the CO requirement. Yet, a strong case can be made that Baltimore's zoning standards are both intentionally discriminatory and have a discriminatory effect. The City has imposed the CO requirement and the underlying community approval process on all alcohol and drug treatment programs and some group recovery homes in order to ensure heightened scrutiny of proposed services and to give communities the right to reject the siting of such services because of their clients. The City's zoning practices also have the effect of discriminating on the basis of disability: alcohol and drug services are singled out and required to comply with a process that imposes unreasonable burdens – intense public scrutiny and approval and a lengthy and costly review process – and the practices are not necessary to the City's zoning scheme.

²³¹ The "good neighbor practices" are on file with the author.

a. Disparate Treatment

An analysis of the direct and circumstantial evidence of the city's intent in adopting the CO process, under the *Arlington Heights* standard, leaves little doubt that the process was adopted precisely because of official concern about the individuals who would be served by the treatment programs.

1. Historical Background

The historical background of the CO process and the events leading up to the City's adoption of that process for treatment programs in its zoning code provide compelling proof of the City's discriminatory intent. The CO process was devised in the early 1960's specifically to address the siting of recovery homes for alcoholics. After Flynn Houses fought the BMZA's efforts to shut down its recovery homes in residential neighborhoods, the City Council created the CO process to bypass the BMZA. While the CO process was designed to facilitate the operation of recovery programs, it was nonetheless grounded exclusively in a consideration of the clients who would be served by the program and was facially discriminatory insofar as it only applied to persons with alcohol problems.²³² Moreover, the process did not place group recovery homes on an equal footing with other medical or residential uses. The City refused to adopt legislation proposed by Flynn Houses that would have permitted recovery homes to locate as of right as an accessory use in residential areas or with the approval of the BMZA – the existing zoning practices. It instead devised a new, more subjective zoning standard, including a public hearing process that was certain to give voice to community bias. In what

²³² A benign purpose does not save a practice from challenge under either the ADA or FHA. “[A] purportedly benign purpose of a facially discriminating ordinance is irrelevant to a determination of the lawfulness of the legislation.” *Potomac Group Home Corp.*, 823 F. Supp. at 1296; *see also Larkin v. State of Michigan Dept. of Social Services*, 89 F.3d 285, 290 (6th Cir. 1996).

amounts to a departure from substantive criteria, the Council adopted the process over the objections of the BMZA, which asserted that the City Council did not have statutory authority to grant a use exception.²³³

2. Discriminatory Views of Decision-makers

In 1972, when the City amended its zoning code to add the use category of “drug abuse rehabilitation and treatment centers” and to apply the CO process to such use, the legislative history reveals that City officials highlighted the negative stereotypes of clients who require treatment services and implemented a process that would facilitate the exclusion of treatment programs based on those stereotypes. The Commissioner of Health stated at that time that many communities do not want treatment programs “because of the fear that [such programs] will attract drug addicts and the crime associated with such addicts to their areas.” The CO process addressed this issue, according to the Health Commissioner, because it enabled both the City Council and Zoning Commission to hold public hearings to determine where a treatment center could, and could not, locate. The Zoning Commission endorsed the CO process because it allowed the City Council to tightly regulate all aspects of a proposed treatment program, including the “establishment, location, construction, maintenance and operation,” and ensured community input on these issues as well.²³⁴

Courts have relied on similar historical evidence and contemporaneous events and statements of discriminatory intent to invalidate zoning practices targeted at individuals with alcohol and drug dependence. For example, the Sixth Circuit Court of Appeals in *MX Group, Inc. v. City of Covington*

²³³ See *supra* text accompanying notes 209 and 210.

²³⁴ See *supra* text accompanying note 211.

affirmed the lower court's conclusion that city officials violated Title II when, in response to a methadone program seeking to locate in the city, they enacted an ordinance that excluded all such programs from the city. According to the district court, "[t]he action by the City was a panicked reaction to public hysteria based on stereotypes concerning [the program's] clients, who are either 'persons with disabilities' or regarded as such."²³⁵ Similarly, the Ninth Circuit Court of Appeals concluded in *Bay Area Addiction Research and Treatment Inc. v. City of Antioch* that a zoning ordinance that prohibited methadone programs from locating within 500 feet of any residential property, enacted in response to community opposition to a proposed program siting close to a residential area, discriminated on its face against individuals with disabilities under Title II.²³⁶ Finally, the federal district court in *Easter Seal Society v. Township of North Bergen* concluded that town officials acted with discriminatory intent under the FHA when they amended the town's zoning code to require a conditional use for community residences for the developmentally disabled to locate in residential zones, rather than continue the practice of permitting such facilities to locate as of right. According to the court, the zoning provision was passed in response to strong community and official opposition to the proposed siting of a home for individuals with psychiatric disorders and drug dependence and imposed onerous requirements on community residence programs.²³⁷

The CO requirement continues to serve the same discriminatory purpose it did when first created. City zoning officials readily acknowledge that it is intended to make city officials "listen to the

²³⁵ 106 F. Supp.2d at 920, *aff'd*, 293 F.3d 326 (6th Cir. 2002).

²³⁶ 179 F.3d at 734-35.

²³⁷ 798 F. Supp. 228, 234 and 236 (D.N.J. 1992).

community” and “help clean up the community.” The centerpiece of the process for treatment services – the community approval requirement (a standard not provided for explicitly in the Zoning Code) – assures that community views will not only be considered in the decision making process, but indeed, will be the single most important factor. City Council members have made community approval a prerequisite for their support of a prospective treatment program, and the experience of programs demonstrates that the Planning Department requires such approval to proceed with the Planning Commission’s hearing and recommendation. When complaints from the community are lodged against existing programs that have not obtained a CO, zoning decisions have been based exclusively on whether the neighborhood association has agreed to have the program remain in the community.²³⁸ Predictably, some community input is not based on legitimate, factual concerns, but rather stereotypical fears about increased crime and decreased property values that are not supported by the facts. A vocal minority can effectively derail a proposed program by communicating objections to council members.

Courts have held in analogous situations that a jurisdiction engages in intentional discrimination when it embraces a community approval process that encourages decisions to be made on the basis of stereotypical fears about and bias against individuals who require alcohol and drug services, the City has engaged in intentional discrimination. City officials have “a duty not to allow illegal prejudices of the majority to influence the decision-making process. . . . [I]f an official act is performed simply in order to appease the discriminatory viewpoints of private parties, that act itself becomes tainted with discriminatory intent even if the decision maker personally has no strong views on the matter.”²³⁹

²³⁸ See *supra* text accompanying note 201 and notes 204 and 205.

²³⁹ *Association of Relatives & Friends of AIDS Patients v. Regulations & Permits Admin.*, 740 F. Supp.

Courts have, accordingly, invalidated as facially discriminatory community notification requirements that require entities serving persons with disabilities to inform neighbors of their intention to locate in a community – much less obtain their approval.

For example, the Sixth Circuit in *Larkin v. State of Michigan Dept. of Social Services* held that a state licensure requirement for adult foster care facilities that required notification to residents whose properties were within 1500 feet of a proposed facility violated the FHA. The court ruled that the requirement was facially discriminatory because it applied only to adult care facilities, thus singling out for regulation services for individuals with disabilities. Moreover, according to the court, the state had not demonstrated that its justification for notification – to promote integration and deinstitutionalization – would be advanced by a notification requirement. To the contrary, notification would “more likely have quite the opposite effect, as it would facilitate the organized opposition to the home, and animosity towards its residents.”²⁴⁰ The court also noted that the State had not demonstrated that the needs of individuals with disabilities would warrant such notice.²⁴¹

Similarly, the federal district for Maryland in *Potomac Group Home, Corp. v. Montgomery County, Md.*, invalidated, under the FHA, a community notification requirement that required proposed

95, 104 (D.P.R. 1990). See also *Innovative Health Systems, Inc.*, 117 F.3d at 49 (“[A] decision made in the context of strong, discriminatory opposition becomes tainted with discriminatory intent even if the decision makers personally have no strong views on the matter.”); *Project Life, Inc.*, 139 F. Supp.2d at 711 (denial of berth to proposed alcohol and drug treatment program violated FHA because State officials “acquiesced to community pressure to keep the [program] out of the community because of discriminatory animus toward the disabled population that Project Life would serve”); and *Smith-Berch, Inc.*, 68 F. Supp.2d at 625, quoting *Project Life*.

²⁴⁰ *Larkin*, 89 F.3d at 292.

²⁴¹ *Id.*

group homes for elderly individuals to inform communities of their intention to site and provided an opportunity to submit on-going comments about the compatibility of the group home with the neighborhood.²⁴² According to the court, the neighbor notification rule:

necessarily assume[s] that people with disabilities are different from people without disabilities and must take special steps to “become a part of the community.” This requirement is equally as offensive as would be a rule that a minority family must give notification and invite comment before moving into a predominantly white neighborhood. . . . [N]otices of this sort galvanize neighbors in their opposition to the homes.²⁴³

The court found that the very purpose of the notification – to allow community input on the compatibility of the group home within the community – revealed its discriminatory purpose. The court also ruled that the community notification process violated the FHA even if a group home is ultimately permitted to locate, since the FHA is intended to prohibit discriminatory processes as well as exclusionary decisions. The process itself generates an outpouring of hostile reactions from neighbors and the resulting stigma, according to the court, is not easily erased.²⁴⁴

Baltimore’s community approval requirement goes far beyond notification requirements as it gives primacy to the views of the community in the zoning process. No other similar health care entity must take these special steps, and there is no evidence that community approval has any relationship to “cleaning up” a community or that the needs of persons with alcohol and drug problems warrant an approval requirement. Even if a program ultimately wins community approval, it and its clients likely

²⁴² *Potomac Group Home, Corp.*, 823 F. Supp. at 1296-97; *see also Township of West Orange v. Whitman*, 8 F. Supp.2d 408, 424-426 (E.D. Mich. 1998).

²⁴³ *Id.* at 1296.

²⁴⁴ *Id.* at 1297.

will have been subjected to heightened scrutiny in the process and will be forced to live with the resulting stigma. The Fourth Circuit in *Project Life, Inc. v. Glendenning* cited an identical community approval requirement in affirming a district court decision that the state violated the ADA by refusing to rent a berth to a drug treatment program so that it could establish a residential program on a former ship. The Court noted that state officials delayed the rental in response to pressure from state legislators whose districts included the location of the berth and required the program to obtain support from the surrounding community – a requirement that had never been imposed on any other potential tenant at the location.²⁴⁵

3. Discriminatory Effect

In addition to being adopted and perpetuated for a discriminatory purpose, the CO and community approval requirement also has a discriminatory effect. First, the process singles out a specific class of protected individuals for special treatment and imposes a more burdensome and lengthy process for establishing services. Courts have consistently found that the imposition of special procedures on individuals with disabilities has a discriminatory effect.²⁴⁶ One of the key components of these special requirements is that they expose individuals with disabilities and the facilities that serve

²⁴⁵ *Project Life, Inc.*, 46 Fed. Appx. 147, 150, 2002 WL 2012545 **1.

²⁴⁶ *Smith-Berch, Inc.*, 68 F. Supp.2d at 621 (county's special methadone policy that required methadone programs to undergo a public hearing rather than locate as of right as a medical office had a disproportionate burden on a protected class of individuals because no other medical facility was required to undergo that process); and *Sunrise Development Corp.*, 62 F. Supp.2d at 774 (city ordinance that required congregate care facilities for senior citizens to obtain a zoning change to locate in a residential neighborhood, rather than a special use exception as previously required, had a discriminatory effect; these facilities were singled out as requiring a zoning change, while other uses that could be as offensive to a residential character were permitted to locate with a special use exception).

them to public scrutiny while other similarly situated individuals and facilities do not suffer the same indignity. This factor has also led some courts to find a discriminatory effect.²⁴⁷

A second discriminatory effect is that the community approval requirement limits the sites that are available for treatment programs and group homes in the community and, ultimately, treatment capacity. Treatment programs avoid selecting sites in communities that are certain to mount significant opposition and often are excluded from those that can. Courts have ruled that the imposition of requirements that make it more difficult for individuals with disabilities to live where they choose has a discriminatory effect under the FHA and ADA.²⁴⁸ This principle is equally applicable to non-residential services under the ADA based on the Title II regulatory requirement that services for individuals with

²⁴⁷ *Stewart B. McKinney Foundation*, 790 F. Supp. at 1219 (requirement that a proposed home for individuals with HIV obtain a special exception, which required a public hearing, has a discriminatory effect because it holds the future tenants up to public scrutiny in a way that non-HIV infected persons would not be); and *Ardmore, Inc. v. City of Akron, Ohio*, 1990 WL 385236 at * 5 (N.D. Ohio 1990) (ordinance that required residential group home for adults with mental retardation to obtain a conditional use permit and submit to public hearing had a discriminatory effect because FHA protects right of individuals with disabilities to procure housing in the community without being singled out for discriminatory public scrutiny).

Some courts have not invalidated a hearing process that is applied uniformly to all individuals regardless of disability, even if persons with disabilities may be exposed to invasive public scrutiny. *See Oxford House, Inc. v. City of Virginia Beach*, 825 F. Supp. at 1262-64 (distinguishing cases in which public hearing requirement is imposed on persons with disabilities alone from those in which “participation [in the public components of zoning decisions] is required of all citizens whether or not they are handicapped.”); *cf. Smith-Berch, Inc.*, 115 F. Supp.2d at 523-24 (“a public hearing requirement does not of itself establish an actionable violation of the ADA,” but disproportionate burden exists when county “has only allowed the public to express its opinion on methadone clinics and not on other medical offices . . .”).

²⁴⁸ *See Sunrise Development, Inc.*, 62 F. Supp.2d at 774 (requiring congregate care facility to obtain a zoning change had a discriminatory effect under both the FHA and ADA; the procedure would make it more difficult for the residents of those facilities to live in the residential neighborhood of their choice).

disabilities be provided in the most integrated setting appropriate to the needs of the particular individuals.²⁴⁹ The community approval requirement²⁴⁹ operates much like a distance requirement, which essentially imposes a quota on the number of persons with disabilities who can reside or be served in a particular area. As discussed in Part III, courts have almost uniformly invalidated distance requirements as facially invalid, with some finding no adequate justification for imposing a quota on the presence of persons with disabilities.²⁵⁰

The third discriminatory effect of the CO process is that it results in delay in establishing alcohol and drug services. In contrast to other medical services that locate as of right in certain districts, treatment services that succeed in obtaining community approval must find a sponsor for legislation, go through an extensive administrative review process, participate in two hearings and then obtain passage of an ordinance. This results in substantial delay in providing health care to vulnerable persons and investment of scarce resources to complete the process. Courts have readily concluded that procedures that impose additional burdens and delay on the establishment of services for individuals with disabilities have a discriminatory effect.²⁵¹

The factors taken together demonstrate that the CO and community approval processes

²⁴⁹ 28 C.F.R. § 35.130 (d) (2003).

²⁵⁰ See, e.g., *Larkin v. State of Michigan Dept. of Social Services*, 89 F.3d at 291; and *Horizon House Developmental Services, Inc.*, 804 F. Supp. at 695.

²⁵¹ See, e.g., *Sunrise Development, Inc.*, 62 F. Supp.2d at 669 and 676 (process for obtaining a zoning change was significantly more costly and lengthy than obtaining a special use permit – thirty-three months compared to sixty-two days, respectively – and, therefore, had a discriminatory effect); *Stewart B. McKinney Foundation*, 790 F. Supp. at 1220 (special exception requirement, which included submission of various site and architectural plans and fire and health reports and a hearing, had a discriminatory effect; it had the potential of being burdensome, controversial, unpleasant and expensive).

intentionally discriminate against individuals with alcohol and drug dependence and the programs that serve them.

b. Disparate Impact

The CO process is also subject to challenge under a disparate impact theory. The discussion above clearly demonstrates that the CO process imposes a disproportion burden on alcohol and drug treatment services. The remaining questions in the disparate impact analysis are whether the standard is necessary to carry out the City's zoning scheme, and, if so, whether modifications can be made that would mitigate the disproportionate burden.

The City would be hard-pressed to demonstrate that the CO requirement is necessary to its zoning scheme. A significant number of programs and group homes have located without obtaining a CO, and they have operated successfully without being subjected to exhaustive public and official scrutiny. The single justification for the CO process is that it ensures that officials will consider community views about a proposed program. This same justification has been rejected by courts, to the extent community views are obtained only with regard to services for persons with disabilities and not similarly situated services.²⁵² Hearing requirements have also been rejected in cases in which the jurisdiction has applied a hearing requirement on an *ad hoc* basis in the most controversial matters but not in other routine decisions. The likelihood that a hearing will provide a venue for the airing of biases rather than legitimate interests also undermines a finding of necessity. As the federal district court in

²⁵² *Smith-Berch, Inc.*, 115 F. Supp.3d at 523-24 (“[t]hough public expression obviously is an important part of zoning laws, . . . since the County has only allowed the public to express its opinion on methadone clinics and not on other medical offices or drug treatment facilities, the public hearing requirement . . . cannot be considered ‘necessary’ to the County’s zoning scheme”).

Potomac Group Home noted in invalidated a hearing requirement as having a discriminatory effect, “[a]lthough [county officials] themselves may not harbor prejudices . . . against the handicapped elderly, they have designed and utilized a regulatory procedure which facilitates the expression of [community] prejudices and which gives weight to such views in the process.”²⁵³

Even if the City identified a legitimate reason for evaluating a treatment program’s compliance with neutral zoning standards, it could satisfy that need through a far less burdensome process. As the court recognized in *Potomac Group Home*, if “[county officials] need information from a provider regarding its program . . . there are less formal means to obtain it,” including a non-public meeting at which experts would consult and consider the programmatic aspects of a provider’s proposed program.²⁵⁴

V. Beyond the Legal Standards: Community and Official Response to Siting Treatment Services

The foregoing analysis suggests that a litigation-based strategy would likely result in the invalidation of Baltimore’s zoning standards. The question remains, however, whether that strategy would facilitate not only the adoption of a new zoning standard that secures the *right* of treatment programs to locate on a fair basis for the long term but also would result in a more tolerant environment that promotes the establishment of new services. To answer that question two other perspectives must be considered: neighborhood associations that represent residents in the communities in which a treatment program seeks to locate and the City government which represents and serves both sets of constituents

²⁵³ *Id.* at 1297.

²⁵⁴ 823 F. Supp. at 1299.

and interests. The perspectives of these groups suggest that numerous factors far beyond the legal rights of the parties must be considered to craft an effective solution.

A. Neighborhood Perspective

Baltimore is a city of neighborhoods – over 260 neighborhoods, each with its own unique housing stock, amenities, population and values and a long tradition of civic involvement.²⁵⁵ More than 600 neighborhood associations work on issues that affect their communities, and many have a rich history of activism on drug and alcohol prevention and treatment issues.²⁵⁶ The city’s oldest citizen action organization, the Citizens Planning and Housing Association (CPHA), has been an indispensable resource for neighborhood associations who wish to tackle drug-related issues that affect their quality of life. Beginning in the late 1980’s, CPHA coordinated a coalition of neighborhood associations and other advocacy groups in a ten-year legislative and legal battle to remove alcohol and tobacco billboards from lower income, African-American neighborhoods.²⁵⁷ In the mid-1990’s, community frustration with open air drug markets mixed with fear of confronting drug dealers resulted in the development of a comprehensive community anti-drug campaign that combined the efforts of community associations, lawyers, city planners, urban designers and law enforcement to route out drug dealing sites and prevent crime. As communities were trained in how to rid their neighborhoods of open air drug markets, they

255 VITAL SIGNS, *supra* n. 184, at 1.

256 A survey conducted by the Baltimore Neighborhood Indicators Alliance that sought to identify the issues that neighborhood associations work on revealed that over half of those responding address drug-related issues frequently. VITAL SIGNS, *supra* n. 184, at 13.

257 The history of this initiative is described in M. Themba, MAKING POLICY, MAKING CHANGE: HOW COMMUNITIES ARE TAKING LAW INTO THEIR OWN HANDS 40-54 (1999).

also realized that locking people up did not stop the drug trade and that their own residents and family members desperately needed treatment services.²⁵⁸ The limited availability of drug treatment was the single most important regional issue identified by neighborhood associations attending a Neighborhood Congress convened by CPHA in the spring of 1999.²⁵⁹ As a result, CPHA and many neighborhood associations began to work with other advocacy groups to demand expanded drug treatment resources in the city and state and these efforts have helped win increased state funding for treatment.²⁶⁰

Neighborhood support for treatment, however, has not translated into support for treatment and group recovery homes in “my neighborhood,” even in some communities with vacant and boarded houses, significant drug-related crime and substantial need for treatment services. CPHA’s work has most recently evolved into dealing with NIMBY issues by bringing community groups and treatment providers together to work on strategies that will enable the two to co-exist and support one another and

258 The demand for drug treatment in the community depicted in *THE CORNER* resulted in the creation of a treatment program, Recovery in Community (RIC). In 1997, a local foundation began to meet with representatives from three neighborhoods about what was needed to counter the impact of drugs in their communities and then funded what became RIC. The program’s goals are to reduce crime and alcohol and drug use and increase employment and quality of life among the residents of its three target community neighborhoods. Recovery in Community: Program Description with Goals and Objectives, on file with author. RIC opened its doors in mid-1999 and provides out-patient counseling, acupuncture, community outreach and intervention, as well as referral services to in-patient, detoxification and methadone treatment and group recovery homes. In 2003, the program established its own group recovery home in the same neighborhood, again with significant involvement of the neighborhood associations. Telephone Interviews with Director of Recovery in Community (Oct. 31, 2001 and March 14, 2003). The program has enjoyed community support because it was designed to meet the needs of those in the neighborhood. Telephone Interview with Organizer, Outreach Southwest Association (Oct. 30, 2001).

259 Presentation by Betty Robinson, former Chief Organizer, CPHA, October 29, 2002.

260 VITAL SIGNS, *supra* n. 184, at 13.

change the NIMBY attitude.

Community conversations have identified many factors that contribute to resistance. First, providers and the communities in which they locate often do not talk to one another, resulting in a lack of understanding about drug addiction, the recovery process and the nature of treatment.²⁶¹ Limited communication also undermines the ability of qualified programs to educate the community about what constitutes qualified treatment and group home services, and to distinguish themselves from bad services that invariably exist and often begin to define “treatment” generally.²⁶² It also prevents the community from putting a human “face” on those in recovery.²⁶³ Some providers remain isolated because they

261 Dear has noted that the source of information about persons with disabilities and proposed facilities that serve those individuals affects the level of community acceptance for such facilities. In the context of mental health facilities, most people, according to Dear, receive a substantial portion of information about mental disability from the popular media. This source of information is associated with fewer acceptances of mental health facilities. Greater acceptance has been seen when individuals obtain information from informal sources, such as books, family and friends, have greater personal exposure to mental health care professionals and are well-informed about mental disability. MICHAEL DEAR ET AL., CAMPAIGN FOR NEW COMMUNITY, ACCEPTING AND REJECTING COMMUNITIES 21-22, 24 (Resource Document Series 1996). If this same pattern holds for the acceptance of alcohol and drug treatment facilities, the treatment programs’ failure to educate the community undermines acceptance. Media messages regarding drug problems certainly contribute to a narrow, frequently negative perspective of persons with this disability.

262 The significant need for housing for individuals in recovery has led to the establishment of many group recovery homes, some of which do not adhere to housing code standards or ensure drug-free environments. These entities may color the public’s perception of “drug treatment” and undermine support for state-certified treatment programs and qualified group recovery homes.

263 This is critically important because once community residents have an opportunity to interact with individuals in recovery their stereotypes are often disproved, as they realize that those individuals are no different from themselves. The author has observed the sudden softening of opinion among those resistant to group recovery homes when an individual recounts his or her history of recovery and describes the value of living in a group home setting. Personalizing recovery also challenges the racial stereotypes many hold. Many residents’ attitudes are also colored by personal experiences with family members who have struggled unsuccessfully to overcome their addiction or have inflicted great pain on

believe that they have a right under the law to locate like any other health service and that they should not be prevented from providing an important service that will ameliorate the effect of drug activities.²⁶⁴ Experience has also taught that the best – and perhaps only – way to be accepted by a neighborhood is to keep a low profile, move in quietly and then demonstrate compatibility with the neighborhood by being a “good neighbor” once established.²⁶⁵

Residents, on the other hand, have a personal investment in their neighborhoods, and are most offended by the notion that a treatment provider will come into their neighborhood without first informing them.²⁶⁶ They perceive this as disrespectful, fatal to a long-term trusting relationship and

them. Dear has observed that the degree of familiarity with and awareness of the characteristics and problems of the client group is an important factor in an individual’s acceptance of that group. The greater the understanding, the more likely an individual will tolerate the group. Dear, *supra* n. 261, at 13.

264 Presentation by Betty Robinson, former Chief Organizer, CPHA Drug Treatment Committee October 29, 2002.

265 The research identifies three types of community entry strategies: low, moderate/medium, and high profile. *See* Dear, *supra* n. 39, at 12, and articles identified therein. Community association representatives in Baltimore have candidly acknowledged that treatment providers may be better off adopting a low profile strategy -- not announcing their intention or obtaining community support prior to moving into a community. Those that have sought approval often never get sited. President, Liberty Road Community Council, CPHA Discussion (March 14, 2003). The community outreach coordinator for one neighborhood association that has worked for years with a particular recovery home noted that the recovery home would still be waiting for the association to vote on its coming into the neighborhood had it sought community support prior to opening. Community Outreach Coordinator, Garwyn Oaks Housing Resource Center, CPHA Community Conversation (May 29, 2003). At the same time, entering a community without obtaining support can back fire if the community, upon learning about the program, strongly opposes it. Subsequent attempts to gain community support often are met with accusations of deception and complaints of an irreparable breach of trust. Program 6 Community Meeting (September 17, 2002); *see* Dear, *supra* n. 39, at 12.

266 Among the key concerns of communities are programs that (1) come into the neighborhood unannounced; (2) provide services that the community perceives it does not need; and (3) are

perhaps predictive of the level of future commitment to the neighborhood.²⁶⁷ Some communities, regardless of how well a program or recovery home is run, cannot get past the perception that persons who are addicted to drugs are being brought into their neighborhood. If a neighborhood is doing well, residents may not want to risk a problem, and, if problems already exist on a particular block, residents may not want to attract more addicts for fear of increased crime and lower property values.²⁶⁸ This is particularly true if an existing group home provider or treatment program does not provide quality services or permits active drug use, loitering or trash accumulation to occur in or around the facility.²⁶⁹ Communities are also skeptical about the effectiveness of treatment services since relapse rates are high and the incidence of drug addiction in Baltimore is so great. While substantially more funds have been invested in treatment, few see the city turning the corner in reducing the number of persons with active

disconnected from the neighborhood and do not act like a homeowner. Community associations believe that they should be brought into the planning process and have their needs considered even if federal disability rights standards do not require this of providers. And they have a negative view of providers who exercise their federal rights without first engaging the community. CPHA Community Meeting (April 29, 2003).

267 Dear refers to this as the “stake” in the neighborhood or the level of commitment to the neighborhood. This factor greatly influences group attitudes about a facility. The community’s involvement in a siting decision increases as the individual’s stake rises. Dear, *supra* n. 259, at 12-13.

268 President, Patterson Park Neighborhood Association, CPHA Discussion (March 14, 2002). Some communities also point to the negative effect a troubled community may have on those who are seeking to recover. *Hollins Market Residents Say Influx of Drug Treatment Centers and Group Houses is Hurting the Neighborhood*, BALTIMORE CITY PAPER, May 14-20, 2003.

269 Treatment services are alternatively viewed as the entity that causes of all the neighborhood’s problems and as the entity that is expected to solve all the community’s problems. Thus, programs are expected to resolve a community’s drug dealing activity and loitering even when those problems are not caused by or associated with the program’s clients. Similarly, a program may not be welcome in a neighborhood, but may still be expected to provide treatment services to the neighborhood’s residents on a priority basis.

addiction or crime associated with addiction.²⁷⁰ Finally, some communities complain that they have become saturated with social services, and, thus, do not want additional vacant buildings to be occupied by recovery homes or treatment programs.²⁷¹ Many want other desperately needed services and resources to be invested in their neighborhoods, and others believe that all neighborhoods should take their “fair share” of social services.

The CO process and community approval requirement, if followed, provide a process for implementing these views and are, therefore, supported by neighborhood associations. Those neighborhoods that perceive themselves as not having a drug problem or whose socio-economic or racial make-up differs from their perception of the clients who are served by a drug treatment program use the process to exclude treatment programs.²⁷² Similarly, neighborhoods that believe they have a

270 CPHA Treatment Provider Meeting (April 22, 2003). Research has shown that a critical ratio of treated to untreated individuals in a community must be achieved before improvements at the individual patient level have a demonstrable community-wide impact. STEPS TO SUCCESS, *supra* n. 25, at 4. The slow pace at which services are expanded can, in turn, affect community support for those services. According to Dear, community support wanes when “compassion fatigue” sets in. This arises when the general public is tired of dealing with an entrenched, persistent problem and begins to despair of finding a solution. Dear, *supra* n. 261, at 15.

271 CPHA Community Meeting (April 29, 2003); *Hollins Market Residents Say Influx of Drug Treatment Centers and Group Houses is Hurting the Neighborhood*, *supra* n. 268. One community portrays itself as the “treatment/help center of the City, claiming to serve over 3,000 people daily at drug treatment centers, parole and probation centers, soup kitchens and mental health clinics. Community associations from the area complain that these services overwhelm the residents and businesses and prevent the community from being a viable neighborhood. Letter from Charles Village Community Benefits District to Department of Planning, Mar. 6, 2000 (on file with author). “Fair share” proposals raise a number of complex issues including: gathering data on the magnitude of need for a range of social services in a particular community or region; evaluating the extent to which those needs are met with existing services; and identifying the types of services that are needed to fill the gaps. This discussion is beyond the scope of this article.

272 See *supra* text accompanying notes 203-205.

disproportionate share of the city's treatment services and non-profit programs also use the process to exclude programs. At the same time, communities that have been ravaged by drug use and drug related crime, and have advocated for increased funding for treatment services, also support the community approval process. From their perspective, the process serves several purposes.

First, some believe it provides a means of quality control. Neighborhood associations have long held the view that treatment programs have little regard for the quality of life in the surrounding community. The community approval process gives residents the ability to evaluate whether the program will be well managed and determine how it will address future concerns.²⁷³

The approval process is also a tool for political control. Residents view the approval process as the only way they can have a voice in the number and type of treatment services that locate in the community. Without that process, programs have no incentive to be responsive, and a sense of hopelessness is reinforced in the community.²⁷⁴ On a different level, the approval process is viewed as providing an opportunity to identify other desperately needed services. While communities need treatment services, they have an equally compelling need for jobs, and improved housing, roads and schools.²⁷⁵ All too often, residents see treatment programs and soup kitchens coming into their

273 Telephone Interview with Director of Operation Reachout Southwest (Oct. 30, 2001). Communities also support an on going community review process to ensure quality as well as enforcement of state and local laws. CPHA Community Meeting (April 29, 2003).

274 Telephone Interview with Director of COIL, Inc.(Oct. 31, 2001).

275 For this reason, communities look to treatment programs to provide some of those resources as well. Programs are more welcome if they can offer jobs to qualified residents of the neighborhood, offer child care or health care services to residents and provide prevention education in local schools.

neighborhoods, but not investments in these other critical areas.²⁷⁶

Finally, and closely related, the process is used as a tool for community building. Community organizers are desperate to work with entities who wish to form partnerships to address the community's pressing needs. To the extent providers discuss their plans with the community and seek its recommendations before moving in, the community has reason to support the programs.²⁷⁷ These programs also tend to be more engaged in the community after they locate, by participating in community meetings, helping at events and street clean-ups and policing for drug dealing.²⁷⁸

Representatives from some community associations, with the leadership of CPHA, have translated some of the benefits they hope to gain through the CO process into a set of operating principles – community-provider partnership strategies – to guide treatment providers who seek to locate in communities. Like the “good neighbor practices” developed by treatment providers, the “partnership strategies” also fall into the general areas of education, community building, and program responsiveness and, in most aspects, overlap with the program “good neighbor practices.” In the area of education, communities want to have on-going education about drug treatment and recovery and ways the community can assist in advocating for expanded services. They want to learn about what has worked in other communities that have had good experiences with treatment programs. They would also like to have on-going communication with the program through the establishment of a program-

276 Telephone Interview with Director of Operation Reachout Southwest (October 30, 2001).

277 Telephone Interview with Director, COIL, Inc. (October. 31, 2001). Communities view a program that partners with the community to address crime, vacant homes and other problems as an asset. CPHA Community Meeting (April 29, 2003).

278 Telephone Interview with Director of Operation Reachout Southwest (October 30, 2001).

community liaison, inclusion of a community representative on the program's board, and institution of regular meetings and outreach to educate the community about available services.

In the area of community building, communities want programs to actively participate in community association meetings and neighborhood improvement activities and to work with the community and law enforcement to reduce drug dealing and other illegal activities in the vicinity of programs. Finally, in the area of responsiveness, communities want programs to adhere to the highest professional and ethical standards in providing their services; maintain "good neighbor" standards by not tolerating trash, noise, littering, substandard housing conditions or other community norms; and provide community residents with fast track access to treatment services.

Two elements of responsiveness that go beyond the provider's good neighbor practices include the communities' desire to have programs (1) solicit their concerns and input from the time a program is being considered for a particular location until it has been opened and (2) respect a community's desire for "fair share placement" and seek an alternative site if several programs already exist in the immediate vicinity.²⁷⁹

B. Baltimore City Perspective

City health and zoning officials recognize that the CO process hinders the expansion of treatment services²⁸⁰ and may violate federal anti-discrimination standards.²⁸¹ Those same officials, until recently,

279 A copy of the "community-provider partnership strategies" is on file with the author.

280 The City's Health Commissioner has noted that the lengthy process jeopardizes a provider's ability to retain funding for the proposed program while complying with the CO requirement.

281 Zoning officials have informed treatment programs that it is unlawful for a program's zoning process to be derailed by a neighborhood's refusal to provide its approval. Telephone Interview with

have been slow to change the standard.²⁸² The CO and community approval processes certainly pose both practical and political dilemmas for city officials. While circumvented in some circumstances, these processes have been embraced by neighborhood associations around the City. This poses a political dilemma for elected city officials who fear constituent opposition by proposing or agreeing to rescind the 40 year-old practice. Eliminating the approval process could also create a backlash against treatment – aligning those communities that want to exclude all treatment services with those that want more control over the services that come into their neighborhoods – that would further exacerbate siting problems.

As a practical issue, the community approval process, as well as the elaborate Planning

Director of Program 6 (Oct. 10, 2002). The City's Health Commissioner has also stated that the CO process is probably illegal and subject to suit. Program 6 Community Meeting (September 17, 2002). As of the spring 2003, the City Council member who chairs the Land Use Committee, which has jurisdiction over CO legislation, has refused to conduct the required Council hearing for proposed drug treatment services because of her concern that such procedures are unlawful under federal disability statutes. She has directed the Planning Department to craft a procedure that complies with the law. Communications with Old Goucher Neighborhood Association; External Affairs Officer for Health Care for the Homeless; and Director of Legislative Affairs, Baltimore City Health Department (May 12, 2003).

282 Thus, for example, in March 2003, the Baltimore City Planning Department proposed revising its zoning code provisions related to group homes for individuals with disabilities in order to comply with the Fair Housing Act and Americans with Disabilities Act. It would formally eliminate the CO process for group homes that serve less than nine individuals, and would permit those facilities to locate as of right in all residential districts. The proposal, however, would retain the CO process for group homes for more than nine individuals that seek to locate in areas zoned for single family dwellings as well as for congregate living facilities with seventeen or more individuals that seek to locate in any residential or business zone. Baltimore City Planning Department Comprehensive Rezoning Project: Zoning for Group Homes and Assisted Living, Draft 3-25-03. The Planning Department was prepared to introduce legislation to implement this plan in the spring of 2004, but, under new leadership, re-evaluated its position. The Director of Planning has indicated his intention to eliminate the CO process for treatment services. Telephone Conversation with Director of Baltimore City Planning Department. (February 23, 2004).

Department evaluation process, is, in part, a proxy for a quality oversight process. The zoning process is not intended to, and should not, serve this purpose; the state licensure and oversight process fills this role.²⁸³ But to the extent communities are not satisfied with the State’s oversight or they must contend with underfinanced treatment programs and unregulated transitional homes²⁸⁴ that they view as having a negative effect on their neighborhoods, they will look to the zoning process to filter out the potentially problematic providers. These issues must be addressed in crafting a workable solution.

Part VI: Comprehensive Strategies to Establish Community-Based Treatment Services

Many scholars have explored whether litigation is an effective tool to shape public policy and achieve social change and public health goals.²⁸⁵ While the establishment of community-based drug

283 All states provide oversight for alcohol and drug treatment services. In Maryland, for example, state regulations require all programs offering drug and alcohol treatment to be certified by the Office of Health Care Quality. Regulations establish standards that all programs must meet regarding governance structure, clinical, environmental, and staff requirements, patient grievance procedures, and record keeping. MD. REGS. CODE tit. 10, § 47.01.03 – 47.01.08 (2003). Certification is based on an application that demonstrates compliance with the standards, a site visit, and correction of any deficiencies that are identified. MD. REGS. CODE tit. 10, § 47.03.05 (2003).

284 Group recovery homes that provide housing but no treatment services are not subject to state licensure requirements. This lack of regulation has led some to advocate for a registration requirement for group recovery homes that are not otherwise licensed. The call for registration often arises when a group home is not properly managed, and residents in the group home as well as in surrounding dwellings are exposed to health and safety risks. Such problems can and should be addressed through traditional law enforcement and local building code enforcement. Imposing regulations on “housing” that serves persons with disabilities would arguably violate the FHA and ADA because a registration requirement would treat persons with disabilities who require a group living arrangement to reside in the community differently from other “family” settings.

285 See, e.g., GERALD N. ROSENBERG, *THE HOLLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE?* (Chicago: Univ. of Chicago Press 1991); DONALD L. HOROWITZ, *THE COURTS AND SOCIAL POLICY* (Washington, D.C.: Brookings Institution 1977); S. A. SCHEINGOLD, *THE POLITICS OF RIGHTS: LAWYERS, PUBLIC POLICY AND POLITICAL CHANGE*, (New Haven: Yale Univ. Press 1974); Peter H. Schuck, *Judging Remedies: Judicial Approaches to Housing Segregation*, 37 HARV. C.R.-C.L. L. REV.

treatment services may fall short of Rosenberg's definition of "policy change with nationwide impact,"²⁸⁶ his model for evaluating when litigation will successfully effect social change is nonetheless instructive in this context. Rosenberg maintains that three structural constraints on courts limit their ability to produce social reform unless political, social and economic conditions have become supportive of change. Those constraints are: (1) the limited nature of constitutional rights, which prevents courts from hearing or effectively acting on many significant social reform claims; (2) the judiciary's lack of independence from other branches of government; and (3) the judiciary's lack of tools to develop appropriate policies and implement decisions.²⁸⁷ Courts can overcome these constraints, according to Rosenberg, only when: (1) ample legal precedent exists to overcome the limited nature of rights; (2) the legislative branch has enacted or is seriously considering legislation relating to the reform or the executive branch supports a reform position, overcoming the judiciary's lack of independence; (3) and political and popular support exists so that those who must change their behavior to accomplish change

289 (Summer 2002); Peter D. Jacobson and Soheil Soliman, *Litigation as Public Health Policy: Theory or Reality?*, 30 J. LAW, MEDICINE & ETHICS 224 (Summer 2002); and Peter D. Jacobson and Kenneth E. Warner, *Litigation and Public Health Policy Making: The Case of Tobacco Control*, 24 J. HEALTH POL. POL'Y & LAW 769 (Aug. 1999).

286 Rosenberg includes within this category social reforms that either affect large groups of people, such as African-Americans, women or workers, or alter bureaucratic and institutional practice nationwide. ROSENBERG, *supra* n. 285, at 4. In the context of drug policy, this social reform could include efforts to decriminalize or legalize drug use. The public health strategy of dramatically expanding access to prevention and treatment, which necessitates change in a number of institutions to expand education among health care professionals, integrate alcohol and drug services into primary health care systems and modify and enhance financing streams, would also arguably fall into this definition.

287 ROSENBERG, *supra* n. 285, at 10-21.

will do so, overcoming the judiciary's lack of implementation power.²⁸⁸

Without being too formulaic, this model suggests why litigation, even if successful in establishing civil rights protections, is not the best tool to ensure that drug treatment services will be established in communities.²⁸⁹ As seen in the *Smith-Berch* litigation, ample legal precedent existed to enforce the program's right to locate in the community. The Court did little more than faithfully enforce

288 Rosenberg asserts that social reform also requires one of four conditions to exist to address the forces that may seek to prevent change: actors outside the courts must offer positive incentives, such as money or other benefits, to induce compliance; other actors must impose costs to induce compliance; market forces must operate to implement the change, bypassing recalcitrant institutions; or persons who are crucial to implementation and willing to act use the courts to provide leverage, a cover or an excuse for doing so. ROSENBERG, *supra* n. 285, at 31-36.

289 Litigation may, however, be a necessary, albeit insufficient, strategy in situations in which political institutions are unwilling to address long-standing problems. Jacobson, *supra* n. 285, *Litigation and Public Health Policy Making*, at 798; and HOROWITZ, *supra* n. 285, at 24 (noting that courts become involved in social policy matters because of the reticence of policymakers to address them, and their "occasional proclivity to push them onto the courts.") Litigation was certainly necessary to create an opportunity for methadone treatment programs to locate in Baltimore County because official opposition had blocked movement for almost a decade, notwithstanding a documented need for such treatment. See *supra* text following note 168.

This critical role of litigation has led some scholars to observe that the judiciary plays an important role in policy making at particular stages in that process. "Although trial courts rarely establish new legal rules, they do constitute the actual meaning of legal rules and, in addition, they play an important role in the definition of policy problems, in the formulation of alternatives, and certainly in the implementation and evaluation stages of the policy process." Lynn Mather, *The Fired Football Coach (Or, How Trial Courts Make Policy)* in CONTEMPLATING COURTS 170, 174 (Lee Epstein, ed. 1995). Mather shares the view of others that "no single political actor or institution could command the entire policy process. . . . [P]ublic policy is made through the actions and interaction of different political players at different points in the process." *Id.* See also, Nico Calavita, Kenneth Grimes and Alan Mallach, *Inclusionary Housing in California and New Jersey: A Comparative Analysis*, 8 HOUSING POLICY DEBATE 109, 137 (1997) (describing the judiciary's role in promoting the development of inclusive housing for low and moderate income individuals in New Jersey through the *Southern Burlington NAACP v. Township of Mount Laurel* litigation; court initiated change in a highly resistant political and social climate, forced other government agencies to act and "set in motion a process, mechanisms and an awareness that would not otherwise exist.").

rights that Congress has clearly established under the ADA, and the equitable remedy it ordered merely required the county to implement the zoning standard its own attorneys and planning officials had advised applied to methadone programs.²⁹⁰ The Court's was powerless, however, to implement its decree and prevent the county from reinstating the discriminatory practices via legislation when political and public support for the equitable siting of treatment programs did not exist.²⁹¹

Those same factors are operating in Baltimore City.²⁹² Notwithstanding the existence of legal

290 As noted above, the county had interpreted its own zoning code as requiring methadone programs to be treated like other medical offices that provided care on an out-patient basis. Thus, issuing an injunction that required the county to implement that standard was not a far reach. *See supra* text accompanying notes 170 and 175.

291 The county's enactment of the zoning ordinance demonstrates that unwilling government players "have a practically limitless capacity to sabotage reform." ROSENBERG, *supra* n. 285, at 19. The county defended its ordinance as not violating the original injunction on the implausible ground that the court had invalidated an unwritten *administrative practice*, not a legislatively enacted ordinance. Thus, asserted the county, a new action was required to challenge the ordinance, even though it reinstated standards that had been invalidated by the court. The District Court, while unwilling to hold the county in contempt, did enjoin the implementation of the new ordinance, finding it in violation of its injunction. The county's ability to thwart enforcement of the injunction through an appeal to the Fourth Circuit Court of Appeals amply demonstrates Rosenberg's observation that parties can use the judicial process to delay and prevent change. *Id.* at 18.

The county's ability to enact a restrictive zoning ordinance after the *Smith-Berch* litigation, when it had been unsuccessful in doing so prior to that, also confirms Rosenberg's observation that litigation success often mobilizes the opposition. Gerald N. Rosenberg, *The Real World of Constitutional Rights: The Supreme Court and the Implementation of the Abortion Decisions*, in CONTEMPLATING COURTS 390, 415-17 (Lee Epstein, ed. 1995). *See also*, Malkin, *supra* n. 39, at 823-826 (describing local legislative efforts to prevent the establishment of group recovery homes following the Supreme Court's decision in *City of Edmonds v. Oxford House, Inc.*).

292 Two case studies may provide a better basis for raising relevant issues than establishing broad generalizations. One should certainly examine the outcome of other zoning litigation to see whether it has facilitated the siting of not only the litigant but other treatment programs as well. For example, the treatment provider who prevailed in *Innovative Health Services, Inc. v. City of White Plains*, never moved into the property. In Maryland, several methadone treatment programs were blocked from locating in Howard County in the summer of 2003 because of community and official opposition, even

rights that render notice and approval requirements unlawful, some public officials believe residents should have a voice in whether a treatment program is permitted to locate in a particular community. This derives from deeply held fears by some that treatment services expose neighborhoods to more harm than they prevent. Even those public officials who know those sentiments to be generally unfounded have demonstrated little interest in opposing vocal opponents. Legal precedent has little sway even with those in communities who recognize the benefit of treatment services; they care more about whether providers demonstrate respect, are willing to work with the community and respond to its needs. They generally have little regard for the program's *legal* right to locate in the community and are ambivalent at best about affording civil rights protections to persons with histories of alcoholism and drug dependence.

Moreover, even if litigation were successful in invalidating the city's zoning scheme, the hard work of crafting a workable zoning standard, persuading local officials and residents to support it, and equipping providers to work with communities would still remain to be done. In the meantime, valuable time and resources that could have been used to mobilize those who support treatment, work with communities to identify their treatment needs and address legitimate concerns, and organize political support for equitable zoning standards would have been lost.²⁹³ The lessons from extensive litigation in

though *Smith-Berch, Inc.* sets the legal standard in the state. *Lawmakers plan legislation to limit drug clinic sites*, HOWARD COUNTY TIMES.COM, October 2, 2003

293 See discussion in ROSENBERG, *supra* n. 285, at 12 and 341-43 (“Social reformers, with limited resources, forgo other options when they elect to litigate. Those options are mainly political and involve mobilizing citizens to participate more effectively.”); and Jacobson, *supra* n. 285, *Litigation and Public Health Policy Making*, at 797 (“litigation might detract from other policy efforts if the public perceives that the problem has been ‘solved’ through litigation”) The *Smith-Berch* litigation again provides a useful lesson. While the litigation was pending, those who wanted to establish treatment programs

another public health context – tobacco control – are instructive: “policy-making responsibility and power will continue to rest with legislators and regulators.”²⁹⁴

Ultimately, community resistance to alcohol and drug treatment services will not be overcome until those services are fully integrated into medical education and practice and adequately funded through both federal funding and private insurance. The mainstreaming of comprehensive addiction care for individuals of all socio-economic classes, while no easy task,²⁹⁵ will gradually reduce the need for specialty treatment services that are not only more readily targeted and but also tacitly reinforce the notion that “special” treatment is perhaps warranted.

Communities across the country, however, cannot wait for this transformation of our health care system; the magnitude of the problem, unmet demand for treatment, and societal costs are too great.

Instead, we must take what we know about community concerns, treatment efficacy, and legal

waited to see how the court would rule and did not press county officials to establish much needed treatment services. After the litigation, providers operated under the false sense of security that the problem had been resolved. No one initiated an education, planning or political process that could have perhaps prevented the enactment of the discriminatory zoning ordinance.

294 Jacobson, *supra* n. 285, *Litigation and Public Health Policy Making*, at 802. Jacobson notes that litigation has been most effective in achieving public health goals where “advocates built the moral and political case against the tobacco industry through years of legislative lobbying, grassroots organizing and savvy use of media.” *Id.* at 797. He concludes that while “[l]itigation has stimulated a national debate over the role of smoking in society and eventually may well move the policy agenda, . . . a sustained legislative and regulatory presence is required to ensure meaningful policy changes.” *Id.* at 802.

295 See Cindy Parks Thomas and Dennis McCarty, *Adoption of Drug Abuse Treatment Technology in Specialty and Primary Care Settings*, in *NEW TREATMENTS FOR ADDICTION: BEHAVIORAL, ETHICAL, LEGAL AND SOCIAL QUESTIONS* App. D, D-11 – D-15 (Henrick R. Harwood and Tracy G. Myers ed. (2004) (identifying barriers to a fuller integration of primary care and addiction treatment, including provider education, financing mechanisms and disincentives, confidentiality requirements and concerns, and the persistent presence of stigma).

protections for persons who seek and participate in treatment and develop legislative and community-based strategies to facilitate the establishment of treatment services.²⁹⁶ These strategies will require treatment programs, government officials and communities to operate under a new set of rules that are equally responsive to well-established legal rights on the one hand and legitimate community concerns about public safety and quality of care on the other. They also require significant investment in education about addiction, analysis of treatment needs across regions, and comprehensive planning. A strategy that is based on securing the establishment of “one treatment program at a time” will fail because resources become consumed with responding to the vocal minority who want to prevent programs from siting “next door,” instead of tapping into the public’s general support for treatment, which must be mobilized to create substantially more capacity.²⁹⁷ Finally, the strategies require action both within communities, so that treatment programs are known by and interact with their neighbors, and by local and state governments, so that the necessary environment for the expansion of treatment exists. State and local governments have a critical role in ensuring that non-discriminatory zoning

296 Other commentators have suggested litigation as well as legislative strategies to facilitate the expansion of group recovery homes. *See Eastman, supra* n. 39, at 34-35 (calling for Congress to amend the FHA to clarify reasonable accommodations standard and for state legislatures to preempt local zoning standards that treat residential structures for persons with disabilities differently from residences of families or other unrelated individuals); and Malkin, *supra* n. 39, at 817-26 (arguing that courts must do a better job enforcing the FHA by giving broad effect to the reasonable accommodations requirement and scrutinizing facially neutral zoning standards, such as the definition of “family,” conditional use and distance requirements, that exclude group recovery homes).

297 One commentator has noted that, in most cases, the number of people expressing opposition to social service programs is generally quite small and that the number of people actually taking action against a facility – the “vocal minority” – is likely to be even smaller. “Little more than 2-4 blocks away from the center of any dispute lies the silent majority – people who are often unaware of the conflict, and generally in favor of community care for the needy.” Dear, *supra* n. 261, at 15-16 and 25.

standards are in place across a state; sufficient regulatory oversight exists; the scope of treatment need and existing services is documented; and program-specific problems, when they arise, are addressed promptly through existing police powers.

The following recommendations provide a framework for such comprehensive and collaborative strategies.

1. Implement fair, non-discriminatory zoning standards for out-patient and residential alcohol and drug treatment services and a reasonable accommodations policy.

Civil rights standards that have evolved under the ADA and FHA provide a strong mandate for the implementation of fair, non-discriminatory zoning standards for both out-patient and residential treatment services. The failure to implement such standards not only inhibits the establishment of treatment services but also creates an environment in which treatment programs are more inclined to avoid community interaction and locate in communities that are perceived as either less hostile or unable to block the program. This may lead to the establishment of services that are less accessible to those who need them and less effective in addressing a region's drug problem.²⁹⁸ It also results in mutual distrust, a sentiment (whether perceived or real) of clustering or "over-concentration" of programs in certain communities, and a missed opportunity to tailor services to address the community's needs.

Thus, the starting point for creating more open communities is to implement a zoning standard that permits drug treatment programs to locate under the same standard as similarly situated medical

298 For example, one study in Maryland concluded that persons who traveled less than a mile to outpatient treatment in Baltimore had a 50% greater likelihood of completing treatment. MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, *supra* n. 33, at 37. Studies have uniformly concluded that length of stay in treatment is one of the most critical factors in treatment success. NATIONAL INSTITUTE ON DRUG ABUSE, *supra* n. 21, at 16.

services. Out-patient drug treatment programs, which must satisfy state licensure requirements and, in some cases, federal regulations and national health accreditation standards, should be permitted to locate like other general medical practices that provide medical care on an out-patient basis. Residential services, including programs that are licensed to provide treatment services and group recovery homes that provide no services, should be permitted in residential communities on the same basis as single and multi-family dwellings of comparable size, density and function. To the extent general medical practices and dwellings are permitted to locate in certain zoning districts without obtaining special approval, participating in hearings, or adhering to conditional use requirements, treatment services should be afforded the same rights. This means that treatment services should not be required to notify communities of their intention to locate at a particular site if other similar services are not required to do so.²⁹⁹

Reasonable accommodations policies must also be implemented as part of fair zoning practices to give treatment services the opportunity to obtain a waiver of rules that would otherwise prevent them from locating in particular areas. Local jurisdictions may, consistent with ADA and FHA standards, require providers to seek an accommodation through a public hearing process as long as that same process is required of all entities that seek a waiver of zoning standards. At the same time, localities may wish to use an administrative, non-hearing process for deciding such requests. A public hearing process always carries the risk that the decision-making process will be infused with bias and stereotypical considerations that taint the final decision and expose the jurisdiction to claims of discrimination. An administrative fact-gathering process that evaluates the necessity of a requested

²⁹⁹ Community notification and involvement is better achieved through other means outlined below.

modification and the impact on the surrounding community will protect both the jurisdiction and the treatment program, while permitting an inquiry into legitimate zoning considerations.

The establishment of fair zoning standards need not be left to local officials. While zoning is quintessentially a local activity, states retain sufficient police power in this area to step in where local authorities fail to ensure non-discriminatory zoning standards.³⁰⁰ Indeed, since it is the state that must ultimately deal with the costs of untreated alcohol and drug dependence by expending funds on law enforcement, health care and social welfare programs, state officials have a significant interest in ensuring that treatment services are available. Thus, states should enact statewide legislation or promulgate regulatory standards that establish a single, uniform zoning standard based on the above general principles.³⁰¹

300 States have enacted statewide standards that govern the siting of residential services for persons with disabilities. See 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, 974-78 (1994) (outlining state zoning statutes that preempt local ordinances that impose restrictive zoning laws to group homes for persons with mental disabilities). In Maryland, for example, a state-wide statutory standard authorizes licensed homes for persons with mental illness to locate in residential neighborhoods on the same basis as single-family dwellings and multi-family dwellings based on the number of residents, which are set forth in the statute. MD. CODE. ANN., HEALTH-GEN. I § 10-518(b)(1) and (2) and MD. REGS. CODE tit. 10 §§ 10.21.04.02(B)(2)(a) and (b) (2003). The law also preempts the application of any special exception, conditional use permit or procedure that differs from that required of single-family or multi-family dwellings of similar density. MD. CODE. ANN., HEALTH-GEN. I § 10-518(b)(3).

301 The experiences of state and local governments in creating inclusive housing for low and moderate income individuals provide valuable lessons for crafting such standards. For example, in New Jersey, a state administrative agency was created in 1985 to assume responsibility for implementing the *Mount Laurel* remedy, which required developing municipalities to provide their fair share of low and moderate income housing. The state agency determines the “fair-share” obligation of each municipality and is required to certify that the municipal plan provides a realistic opportunity to achieve its fair share goal. The municipality’s plan is required to identify present and future fair-share obligations and specify land that would be most appropriate for development. In California, the California General Plan Law requires localities to adopt a general plan that includes, among other items, a housing element that

The executive branch should also consider using its fiscal power to create economic incentives for local authorities to *implement* fair zoning standards.³⁰² Local jurisdictions are dependent upon state funding for both treatment services and law enforcement. The executive branch should condition the receipt of these appropriations on proof that the locality has established and adheres to non-discriminatory zoning standards. In distributing discretionary state and block grant funds, states should provide funding incentives to jurisdictions that demonstrate success in establishing services. State monitoring and oversight beyond the standard check-off on a funding application will be required to ensure compliance, and administrative agencies may need to provide technical assistance to localities to help them develop and win support for such standards.³⁰³

addresses the locality's need for lower-income housing and its program for meeting its "fair share" of that need. A state agency must certify compliance with the housing element, but has no authority to mandate changes. Calavita, *supra* n. 289, at 117-19. According to Calavita, the inclusive housing programs in both states have produced significant and measurable results because of intervention by either a higher level of government or the courts. Inclusive housing was achieved in New Jersey through the judicial imposition of fair-share obligations on local jurisdictions and in California through a legislatively mandated housing element and fair-share doctrine. Calavita concludes that the enactment of an effective inclusive housing program cannot be expected without such intervention. *Id.* at 135.

302 Both New Jersey and California offered economic and other incentives to localities and developers to create inclusive housing. In California, eligibility for state-administered federal housing programs is linked to housing element compliance. The threat of litigation also provides an incentive, as the California General Plan Law authorizes litigation to stop the issuance of building permits until an approved housing element is produced. On the local level, developers have received cost-offsets (including the use of federal low-income housing tax credits) and regulatory relief (density increases, impact fee waivers, fast-track permit approval, reduced parking requirements, and relaxed design restrictions) to counter the costs incurred in providing inclusionary units. Calavita, *supra* n. 289, at 117 and 121-22. In Jersey, incentives have included cost offsets, bonus credits to municipalities that produced affordable rental units, and a "builder's remedy" that authorizes courts to grant zoning relief and building permits to projects that include an appropriate portion of low and moderate income housing. Calavita, *supra* n. 289, at 115-16 and 128.

303 This, of course, requires policy-makers on the state level to be committed to enforcing non-

2. Conduct a comprehensive planning process that assesses the need for treatment services in a particular region, the existing out-patient and residential services and appropriate locations for new services.

The staggering numbers of individuals who are not receiving treatment for alcohol and drug dependence leaves little doubt that treatment services are not available to meet the need. Yet, a frequent refrain from those who face the prospect of a treatment program or group home entering their community is “we have enough treatment programs already.” While this response is generally based more on perception than reality, data is needed to document the extent of need, the type of treatment services available, and the location of existing out-patient and residential services. These data are essential to determine whether communities lack services that their residents need or have the correct mix of out-patient, residential and group living services; whether services are, in fact, clustered in some communities; and whether there is an “over” or “under” concentration of services based on the needs of the locality.

State agencies, which administer the publicly-funded treatment system and license public as well as private treatment services, must collaborate with the appropriate local jurisdictions and local health

discrimination standards and willing to withstand pressure from local officials and the public to intercede and implement practices that delay or prevent programs from siting. *See supra* text accompanying notes 169 and 177. State officials will undoubtedly engage in political compromises between different parties, requiring treatment providers and advocates to monitor state decisions to prevent the implementation of discriminatory practices. *See, e.g., Lawmakers plan legislation to limit drug clinic sites*, HOWARD COUNTY TIMES.COM, October 2, 2003 (In response to opposition by some Howard County residents and officials to the proposed siting of two methadone treatment programs, Maryland’s chief health official agreed to implement a newspaper notification requirement for methadone treatment programs as part of the state licensure process.)

departments, to gather this data and then use it to plan for the siting of new programs.³⁰⁴ Armed with data on geographical areas in which treatment services are lacking and bound by a non-discriminatory zoning standard, local health and planning officials should evaluate where treatment services are needed and identify buildings and dwellings that would be available and appropriate for such services. While providers can not be limited to those sites, this process would assist them in the difficult and time-consuming job of identifying appropriate properties and would establish a more collaborative relationship.

A comprehensive planning process is also an important vehicle for building community support for treatment and ensuring that services meet the needs of the particular community and are available in the best locations. Residents of communities are more invested in drug treatment services if they understand that they serve the needs of those living in the community. By helping to shape the services that will be provided, residents will begin to view a treatment program as a resource that meets their health care needs and a potential source of employment, educational services and child-centered services.

304 Others have emphasized the importance of comprehensive planning in addressing local zoning conflicts. *See, e.g.*, California Task Force Recommendations, *supra* n. 165, at 9-11 (outlining types of information to be gathered, development of a pilot program to conduct needs assessment and devise a plan, and funding and other incentives for encouraging compliance with the plans); and CAMERON WHITMAN AND SUSAN PARNAS, FAIR HOUSING 23 and 29-30 (Washington, D.C. 1999). A comprehensive planning process is already required of States and localities that receive certain federal block grant funds for housing assistance from the Department of Housing and Urban Development. Recipients are required to assess and respond to community-wide needs as part of the Consolidated Plan and Analysis of Impediments. *See* 42 U.S.C. §§ 12701 and 5301 *et seq.* and 24 C.F.R. parts 91 and 570. Advocates for persons with disabilities have observed that this process must be used more effectively to address the housing needs of persons with disabilities. Whitman at 30.

3. Ensure that all entities that provide treatment services are certified or licensed and that licensure requirements are enforced.

All programs that provide therapeutic services, as defined by a state's licensure and regulatory scheme, must be subject to licensure and oversight. This ensures that individuals will receive high quality care and that providers who do not conform to regulatory standards will either improve their practices or face sanction. Licensure and oversight functions must be adequately funded so that regulations are enforced and technical assistance is provided to programs that require help to improve quality and compliance with standards of care. At the same time, localities must recognize and respect the different roles that zoning and licensure play in the establishment of treatment services so as not to impose zoning standards as an additional, yet unnecessary, means of quality control.

Oversight of group recovery homes is a particularly important concern in many communities across the country. Group recovery homes are an essential source of housing to many individuals who are without family supports or require a living environment that is removed from the influences of alcohol and drug use. They also provide a continuum of services and support that many find necessary to maintain sobriety. Group homes provide varying levels of services, ranging from the Oxford House and faith-based sober living models that provide no therapeutic services to those that have therapeutic services provided on-site by outside providers to those that provide therapeutic services that fall under the state's regulatory scheme. Ensuring that group homes operate effectively in neighborhoods is critical for both therapeutic and community support purposes because they are imbedded in neighborhoods and become the "face" of treatment.

Group homes should be subject to state oversight based upon whether they provide services that

are otherwise subject to state regulation. While group homes that provide housing exclusively should not be subject to any different oversight than the personal residence of persons with or without disabilities, those houses must certainly comply with uniformly enforced occupancy and health and safety codes that are applied to similarly situated housing. To the extent, treatment or other health services are provided by outside professionals, it is those care givers who must be licensed to provide the specific health service. The fact that those services are obtained in a residential setting should not require the group home to be licensed, given that a private residence need not be licensed when health services are delivered in the home.³⁰⁵

State and local governments can provide an incentive to residential services to comply with licensure requirements and health and safety codes by ensuring that client referrals are made only to those facilities that demonstrate compliance. As courts, probation and parole systems, and government funded social service agencies increase their reliance on residential services and group homes, this becomes an important mechanism to raise the level of group home services.³⁰⁶

4. Implement practices that facilitate the inclusion of programs in communities and resolve disputes.

A wide range of education practices must be implemented at the community level to ensure that

³⁰⁵ See Whitman, *supra* n. 304, at 28. Some have suggested that membership organizations representing unlicensed group homes (those that provide housing exclusively) should develop standards to ensure safe living environments. California Task Force Report, *supra* n. 165, at 12. In an effort to identify which residential services should be subject to state licensure or certification, the California Task Force identified four factors that would bring a group home under state regulation: the entity provides services to residents; receives funding to provide housing or services to residents from sources other than the resident's personal income; requires residents to attend or participate in outside programs or activities; and maintains records beyond personal biographical emergency data on residents. *Id.*

³⁰⁶ California Task Force Report, *supra* n. 165, at 12.

treatment services are recognized as an asset and that community concerns are addressed. Local officials must begin by implementing outreach programs to educate communities about treatment services and non-discrimination requirements. Teams consisting of health officials, drug and alcohol treatment experts, individuals in recovery, community organizers and law enforcement officials should offer education programs to dispel myths and stereotypes about individuals who participate in treatment and provide research-based information about the effect of treatment services on crime, drug and alcohol use and other health problems, employment, and quality of life in communities. The teams should also discuss state and local standards for certification and oversight and identify actions that residents can take to report programs that do not comply with those standards. Local officials must also send a strong message that non-discriminatory zoning standards will be enforced in all communities.

Treatment providers must also recognize the importance of establishing and maintaining good community relations to both build support for their services and contribute to the neighborhood. To the extent a locality adopts and stands behind a fair zoning standard, providers should be less concerned that revealing their presence and engaging the community at an early stage of program development will have a detrimental effect. The adoption of “good neighbor practices,” like those prepared by providers and neighborhood associations in Baltimore and other jurisdictions, will also help providers demonstrate their interest in working collaboratively with neighbors and helping them resolve community problems. By including residents on the program’s advisory board and participating in neighborhood association activities, providers will help educate community members about treatment services and create opportunities to introduce the community to other providers who wish to establish services. Neighborhood associations must also adopt “good neighbor practices,” which include a commitment to

welcome qualified programs into neighborhoods and not oppose the siting of programs that agree to implement good neighbor policies.³⁰⁷ This assurance will also make providers more comfortable approaching community associations about plans for future programs and obviate the need for formal notification requirements which violate non-discrimination standards.

Localities, working with community organizers and established treatment programs, must also offer technical assistance to those providers that are hesitant or ill-equipped to work with neighborhood associations. An effective way to address this need is to create or support an existing community-based organization that can identify barriers to effective collaboration, help programs address deficiencies, and mediate differences that arise between community associations and treatment programs.³⁰⁸

Conclusion

There is no “quick fix” that will eliminate opposition to community-based alcohol and drug treatment services and ensure that these services can locate in communities. This article suggests that, like other complex public health problems, the adoption of legislative and regulatory standards based

307 The Citizen’s Planning and Housing Association, working in collaboration with a group of treatment programs, has developed a single “good neighbor” policy that contains commitments on the part of both providers and communities. Community associations that adopt the policy agree that they will not oppose the siting of a treatment program solely on the basis of the clients who will be served. The policy is on file with the author. Many other organizations have developed and recommend the adoption of “good neighbor” practices. See California Task Force Report, *supra* n. 165, at 12; and Whitman, *supra* n. 304, at 12-13 and 30 (disability advocates emphasize that responsibilities under good neighbor practices must be multilateral, with elected officials and neighbors having a duty to welcome group homes and community residences and to educate themselves about non-discrimination standards, just as providers and residents have a duty to be a good neighbor and correct breaches of that duty.)

308 As noted above, the Citizen’s Planning and Housing Association has performed this role in Baltimore. See *supra* text following note 260. Portland, Oregon has a Community Residential Siting Program in its Office of Neighborhood Involvement that provides information about siting, community involvement guidelines and mediation/facilitation services. See <http://www.bettercommunities.org>.

on federal non-discrimination standards, comprehensive planning, and community education will, in the long run, be more effective in establishing treatment services than a sole reliance on litigation. Successful expansion will also depend upon the investment of adequate resources to increase treatment capacity to meet the demand for services and ensure the availability of high quality, comprehensive services, including links to education, job training and placement, housing and family services where appropriate. Modifications in health care financing in both the private and public sectors will also be necessary to expand capacity, and those financing models must take into account that alcohol and drug dependence are chronic, not acute, medical conditions.

There is no better time to begin to adopt these public health strategies. Politically, both the public and policy-makers have grown weary of our Nation's over-reliance on criminal justice policies that impose huge financial and human costs, perpetuate racial discrimination, and do little to address the underlying health and crime problems. Rapid advancements in scientific and medical research now provide a solid foundation for relying on treatment and prevention strategies. And civil rights standards that protect individuals with alcohol and drug problems have withstood many challenges in this arena. It is time to pay serious attention to treating the "American Disease."