10-0235-cv(L),
10-0251-cv(CON), 10-0767-cv(CON), 10-1190-cv(CON)

United States Court of Appeals
for the
Second Circuit

DISABILITY ADVOCATES, INC., UNITED STATES OF AMERICA,

Plaintiffs-Appellees,

– against –

NEW YORK COALITION FOR QUALITY ASSISTED LIVING, EMPIRE STATE ASSOCIATION OF ASSISTED LIVING,

Movants-Appellants,

– and –

DAVID A. PATERSON, in his official capacity as Governor of the State of New York, RICHARD F. DAINES, in his official capacity as Commissioner of the New York State Department of Health, MICHAEL F. HOGAN, in his official capacity as Commissioner of the New York State Department of Mental Health, NEW YORK STATE DEPARTMENT OF HEALTH, NEW YORK STATE OFFICE OF MENTAL HEALTH,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

BRIEF FOR *AMICI CURIAE* THE AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS (AACP) ET AL.* IN SUPPORT OF THE DISTRICT COURT'S DECISION AND REMEDIAL ORDER

(For List of Additional Amici Curiae See Inside Cover)

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1, counsel for the *Amici Curiae* hereby certifies that:

1. *Amici Curiae* The American Association of Community Psychiatrists (AACP), AARP, Mental Health America (MHA), The National Alliance on Mental Illness (NAMI), The National Association of Social Workers (NASW), The Depression and Bipolar Support Alliance (DBSA), The American Association of People with Disabilities (AAPD), The American Network of Community Options and Resources (ANCOR), The American Occupational Therapy Association (AOTA), ADAPT, The Disability Rights Education and Defense Fund, Inc. (DREDF), The Autistic Self-Advocacy Network (ASAN), The National Health Law Program, Inc. (NHeLP), The National Senior Citizens Law Center (NSCLC), The Public Interest Law Center of Philadelphia (PILCOP), The National Association of People with AIDS (NAPWA), The U.S. Psychiatric Rehabilitation Association (USPRA), National Council for Community Behavioral Health Care (National Council), and The National Council on Independent Living (NCIL) are not-for-profit associations that do not have parent corporations and are not owned, in whole or in part, by any publicly held corporation.

2. *Amicus Curiae* Daniel Fisher is an individual not subject to Federal Rules of Appellate Procedure 26.1.

Dated: October 13, 2010

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INTRODUCTION AND STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Both Title II of the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act require a state that provides services to individuals with disabilities do so in the most integrated setting appropriate to their needs. 42 U.S.C. § 12101 *et seq.*; 29 U.S.C. § 719 *et seq.*; 28 C.F.R. 35.130. For people with mental illnesses, this is more than a legislative mandate and a basic civil right; it is a necessity for taking control of their lives and pursuing recovery. While New York is a national leader in developing community-based services for people with mental illnesses, many of its citizens living in adult homes have been unjustly segregated and excluded from enjoying these benefits.

Common sense and years of studies have shown that people with serious mental illnesses, like people with other disabilities, want what most people want: the opportunity to interact with society, the right to make their own choices, and a home to call their own. Adult homes cannot serve these essential needs for most of their residents. Supported housing offers a fundamentally different approach

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[1] The parties to this action have consented to the filing of this brief. Pursuant to Local Rule 29.1(b), the *Amici Curiae* represents that (1) counsel for the *Amici Curiae* alone authored this brief and no counsel for the parties to this action authored any part of this brief; (2) no party or party's counsel contributed money that was intended to fund preparing or submitting this brief; and (3) no person or entity other than counsel for *Amici Curiae* contributed money that was intended to fund preparing or submitting this brief.

where people with mental illnesses actively work with the supported-housing providers to make choices and pursue their recovery in the community.

The 20 *Amici Curiae*[2] are organizations and an individual, who are committed to ensuring that people with mental illnesses and other disabilities can receive the care they need and desire, freely exercise their own life choices, and fully participate in community life. *Amici Curiae* are comprised of experts, professionals, and individuals involved in the fields of mental health, disability rights, law, community organizing and advocacy, social work, occupational therapy, independent living (including supported housing), and implementing the ADA. They have advocated before and worked with Congress, state legislatures, local communities, and the Supreme Court. Collectively, *Amici Curiae* represent millions of Americans with and/or concerned about people with mental illnesses and other disabilities. As a result of their years of professional and personal experience, *Amici Curiae* are in a unique position to detail the benefits and realities of supported housing to this Court.

[2] For a full listing of the *Amici Curiae*—including brief statements regarding their backgrounds and interests—please see the attached Addendum.

SUMMARY OF THE ARGUMENT

Plaintiff Disability Advocates, Inc. ("DAI" or "Appellees") brought this case on behalf of individuals with mental illnesses living in, or at risk of entering, "impacted" adult homes in New York City ("DAI constituents").[3] Following a five-week bench trial and several rounds of post-trial motions, the United States District Court for the Eastern District of New York (Garaufis, J.) (the "District Court") entered a permanent injunction requiring the Governor, the Department of Health, the Office of Mental Health ("OMH"), and the agencies' commissioners ("Defendants") to make supported housing and necessary services available to DAI constituents (the "Remedial Order").

The District Court's decision and order should be affirmed. Over twenty years of studies by professionals in the field, multiple federal government agencies, and even Defendants show that supported housing is an effective service and best practice for individuals with mental illnesses. The overwhelming evidence presented at trial—including studies commissioned by Defendants—proves that virtually all DAI constituents both qualify for and want supported housing. Lastly, the District Court's Remedial Order fully complies with the requirements announced by the United States Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581, 600 (1999) by providing for: (1) "in-reach" that enables DAI constituents to make

[3] Impacted adult homes are those in which 25 residents or 25% of the population (whichever is fewer) have a mental illness.

informed decisions about their housing options; and (2) a process for confirming each constituent's eligibility to be served in supported housing.

This Court's affirmance of the District Court's decision and Remedial Order, consistent with *Olmstead*, would uphold the rights of people with mental illnesses and end the unnecessary segregation of DAI constituents. Such a ruling will return to these citizens the control over their homes, treatments, and daily lives that the law demands. The ADA, Rehabilitation Act, and *Olmstead* require that DAI constituents have a real choice to live in and become a part of New York City's richly diverse community.

BACKGROUND ON SUPPORTED HOUSING

Supported housing starts with housing and then "add[s] and subtract[s] the supports as [a] person needs them."[4] Unlike adult homes, supported housing is designed for people with mental illnesses[5] and is based on three main principles. First, individuals served in supported housing live in their own apartments where they can be secure and in control. In these apartments, they are able to live without the limitations on freedom that are unnecessarily imposed on people with mental illnesses in adult homes.[6] They participate in the selection of their apartment.[7]

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[4] JA79:139; JA207:650-651; SX(4)-302.

[5] SX(3)-239.

[6] JA170:501-502; JA723:2751; PX(3)-542:204-05.

[7] SX(4)-14.

They sign a lease, abide by its terms, and contribute towards the rent.[8] They can live alone or with roommates of their own choosing.[9] Services and supports are provided in the home and community, allowing people to learn and practice skills in the actual environment where they will be used.[10] Among other things, they can decide what to eat, when to sleep, which television programs to watch, and who they spend their time with. While these choices may seem mundane and are often taken for granted by others, they are profoundly important to people who have been denied such freedoms for years, and they are essential "to build[ing] a sense of well being for the person."[11]

Second, people living in supported housing have access to a wide array of services and supports that are tailored to the needs and desires of each individual. People have a "say in what they want" and work with service providers on "developing services that are tailored to their individual needs."[12] Available services and support include mental-health and medical services, substance-abuse

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[8] JA104:238.

[9] JA297:1010-1011; JA117:290.

[10] JA166-167:488-489; JA87-88:170, 174-176. *See also* Substance Abuse and Mental Health Services Administration, *Transforming Housing for People with Psychiatric Disabilities*, (2005) available at https://store.samhsa.gov/shin/content/SMA06-4173/SMA06-4173.pdf.

[11] JA117:290-291; *see also* Nat'l Council on Disability, *Inclusive Livable Communities for People with Psychiatric Disabilities*, (2008) available at http://www.ncd.gov/newsroom/publications/2008/LivableCommunities.html.

[12] JA248:816.

treatment, medication management, case management, and help acquiring or reacquiring the skills needed to live independently and integrate back into the community (skills such as home management, budgeting, and organization). For people who require more intensive services and attention, there are Assertive Community Treatment ("ACT") teams comprised of specialists in psychiatry, psychology, nursing, occupational therapy, and social work.[13] Depending on a resident's requirements, delivery of services can range from monthly meetings with case managers to twice-daily visits from ACT team members.[14] At least one member of the ACT team is always available to respond to the residents' needs.[15] A creative "whatever-it-takes" approach is pursued, and typically, a less intense level of services is required over time as residents learn or regain independent living skills.[16]

Third, individuals served in supported housing are encouraged to be part of the community through employment, volunteer work, and social activities.

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[13] JA78:135; JA99-100:219-223.

[14] JA405:1443-1444; JA588:2172-2173.

[15] JA100-101:225-226. ACT teams maintain a low staff-to-client ratio to promote individualized service and are available 24 hours a day, seven days a week to respond to crises. JA100-101:225-227; *see also* D. Allness and W. Knoedler, *National Program Standards for ACT Teams*, 10-21 (2003) available at http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=50248.

[16] JA101:229; JA223:715; SX(2)-221.

"Scattered site" apartments are located throughout the community to promote integration into the neighborhood.[17] Training in vocations, managing symptoms in the workplace, and conflict resolution are often part of the programs offered. Supported housing providers often employ people with mental illnesses to assist their peers with adjustment to life outside of institutional settings like adult homes.[18]

ARGUMENT

I. CURRENT STUDIES, FEDERAL AGENCIES, AND EVEN DEFENDANTS RECOGNIZE THAT SUPPORTED HOUSING IS ESSENTIAL TO RECOVERY.

Supported housing is a well-established service in the field of mental healthcare. It helps people with mental illnesses regain their confidence and dignity. As one supported housing resident declared:

> This program has been excellent. ***It gave me my freedom and my life back. It helped me gain self-confidence again and feel like a human, not a disabled reject.*** I can never say enough about how good it is to get on my feet again![19]

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[17] JA103:236; JA916. For example, Pathways to Housing utilizes no more than 20% of any building to avoid creating a segregated environment. JA108:254.

[18] JA105-106:245-246; JA115:284-285. The Remedial Order promotes this by referencing "Peer Bridgers" who assist adult home residents make the transition to living in the community. SPA237-238.

[19] PX(3)-346 (emphasis added).

This person's experience is corroborated by over twenty years of literature in the field. Federal agencies and even Defendants recognize supported housing as a "best practice" that increases the chances of recovery.

A. Supported Housing Promotes Mental Health.

Supported housing provides a safe, stable, and permanent environment for residents where they can improve. Housing—or more aptly put, a home—is a key aspect of well being and recovery.[20] It enables people to meaningfully work on other aspects of their lives, including treatment engagement.[21] As Sam Tsemberis, the founder and executive director of Pathways to Housing ("Pathways"), explained to the trial court:

> ***I think, the key word in that sentence is "home." Home and not housing.*** There is something that a psychiatrist named [R. D. Laing] said, the sense of ontological security, and people like Maslow talk about it, ***home is…the foundation upon which a person can find their security, safety, sense of comfort and without that first in place, they won't be able to consider their treatment needs, or their higher order needs***, so it starts with, you know, it starts with home and starts with having a place to call home, absolutely.[22]

Dr. Tsemberis' testimony is supported by over forty years of expertise in the field and numerous studies. Studies conducted by Pathways and others have shown that

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[20] Nat'l Council on Disability, *supra* note 10, at 22–23.

[21] JA297:2010-2011.

[22] JA118:294 (emphasis added).

stable environment-supported housing improves the lives of people with mental disabilities and is a powerful motivator to seek and sustain treatment.[23] Studies also demonstrate that individuals with mental illnesses, who were labeled in other programs as "not housing ready," were capable of maintaining independent living in supported-housing programs.[24]

Overall, supported housing promotes long-term residential stability.[25] Supported-housing providers are invested in their client's success. For example, ACT teams help their clients through a crisis like a psychotic break or additional hospitalization and help return them to their apartment once the crisis has passed.[26]

Supported housing also increases people's ability to exercise meaningful choices in their lives. As defined by OMH's comprehensive plan, "recovery" is about the ability to take control of one's life.[27] To recover, individuals with mental

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[23] *See e.g.*, Sam Tsemberis et al., *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with Dual Diagnosis*, 94.4 Am. J. of Public Health, 665 (2004); Debra Srebnik et al., *Housing Choice and Community Success for Individuals with Serious and Persistent Mental Illness*, Community Mental Health Journal, Vol. 31, No. 2, 139 April (1995).

[24] *Id*.

[25] JA102:233. *See also* Debra Srebnik et al., *supra* note 22; Sam Tsemberis & Ronda F. Eisenberg, *Pathways to Housing: Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*, 51.4 Psychiatric Services, 487 (2000).

[26] JA104:239, 241.

[27] JA297:1009-1010.

illnesses must actively participate in making the choices that define their lives.[28] Mental-health professionals have recognized that individuals with the most severe mental illnesses can still make choices for themselves and live successfully within a community.[29] The research shows that supported housing enhances personal empowerment and function.[30] It also shows that when individuals with mental illnesses are given access to supported housing and control over their daily activities, the result is improvement in mental-health symptoms, decreases in hospitalization, and increases in psychological well-being, happiness, and satisfaction with housing and life in general.[31]

These benefits are a product of "living in a socially integrated environment," which exposes them to "the rhythm of daily life."[32] Indeed, the National Association of State Mental Health Program Directors issued a policy statement endorsing supported housing and stating: "All people with long-term mental

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[28] *See* U.S. Substance Abuse & Mental Health Services Admin., *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders* (2003) available at http://store.samhsa.gov/product/SMA04-3870; *see also* JA108-109; JA257; JA297.

[29] *See* Debra Srebnik et al., *supra* note 22.

[30] U.S. Surgeon General, Mental Health: A Report of the Surgeon General, Other Services and Supports, available at http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec6.html.

[31] *Id.*

[32] Priscilla Ridgway & Anthony M. Zipple, *The Paradigm Shift in Residential Services: From Linear Continuum to Supported Housing*, Psychological Rehabilitation Journal, Vol. 13, Issue 4 (1990).

illness should be given the option to live in decent, stable, affordable and safe housing, in settings that maximize their integration into community activities and their ability to function independently."[33]

B. Multiple Federal Agencies Endorse Supported Housing.

Along with mental-health professionals, the federal government strongly endorses supported housing and intervened as a plaintiff to support DAI constituents at the remedial phase of this litigation. The Surgeon General, the National Counsel on Disability ("NCD"), the Department of Housing and Urban Development ("HUD"), and the Substance Abuse and Mental Health Services Administration ("SAMHSA") all back supported housing.

The United States Surgeon General found that, among other positive benefits:

> ***[Supported housing] moves away from "placing clients***, grouping clients by disability, ***staff monopolizing decision making***, and use of transitional settings and standardized levels of service [and] [i]nstead, ***supported housing focuses on consumers having a permanent home that is integrated socially, is self chosen, and encourages empowerment and skills development***.[34]

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[33] *See* Paul J. Carling, *Major Mental Illness, Housing, and Supports: The Promise of Community Integration*, 45(8) American Psychologist 969–975, August (1990) (quoting text of policy statement).

[34] U.S. Surgeon General, *supra* note 29.

The Surgeon General also recognized that "resident control over decisions was directly related to satisfaction and empowerment."[35] The Surgeon General further lauded the fact that the services offered by supported-housing programs are "individualized, flexible, and responsive to changing consumer needs."[36]

The NCD (an independent federal agency established "to empower individuals with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society")[37] strongly endorsed supported housing as "one of the most exciting developments" for people with mental illnesses.[38] In a lengthy report, the NCD found that:

> While most people with psychiatric disabilities no longer live in large state institutions…***many are living in congregate housing that often does not meet their housing preferences, and they remain segregated from other people.***[39]

The NCD recommended that federal agencies "[i]mplement changes in federal and state funding and policy to encourage housing models that are integrated, [and] in accordance with individual choice…while providing ongoing flexible supports."[40]

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[35] *Id.*

[36] *Id.*

[37] Nat'l Council on Disability, *supra* note 10, at 74.

[38] *Id.* at 6.

[39] *Id.* (Emphasis added).

[40] *Id.*; *see also* Nat'l Council on Disability, *The State of Housing in America in the 21st Century: A Disability Perspective*, 310 (2010) available at

HUD has recognized that supported housing increases housing stability.[41] Accordingly, HUD has designed programs similar to the District Court's Remedial Order. For example, the Section 811 project extends federal rental subsidies to supported-housing programs that are designed to address mental health, as well as other, needs. *See* 42 U.S.C. § 8013(a).

SAMHSA, a branch of the U.S. Department of Health and Human Services whose purpose is to reduce the impact of substance abuse and mental illnesses, also endorses supported housing.[42] In a recent report, SAMHSA recognized Pathways, a New York supported housing provider, as an exemplary program.[43] The report recognizes "that even people with the most severe mental disabilities can live in supported housing, even people coming in directly off the street, and even in an expensive market like New York's."[44] Moreover, SAMHSA

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http://www.ncd.gov/newsroom/publications/2010/NCD_Housing_Report508.pdf ("The best types of supportive housing maximize tenant empowerment by unlinking housing from support services and allowing tenant to choose from a broad array of voluntary support services that can be provided onsite or offsite at the tenants option.").

[41] *See* U.S. Dep't of Housing & Urban Dev. Office of Policy Dev. & Research, *The Applicability of Housing First Model to Homeless Persons with Serious Mental Illness*, 1 (2007) available at http://www.huduser.org/Publications/pdf/hsgfirst.pdf.

[42] Substance Abuse and Mental Health Services Administration, *Transforming Housing for People with Psychiatric Disabilities*, (2005) available at https://store.samhsa.gov/shin/content/SMA06-4173/SMA06-4173.pdf.

[43] *Id*. at p. 24.

[44] *Id*.

recommended to "***end reliance on board and care homes for people with psychiatric disabilities by 2010***."[45]

C. Defendants and Their Related Agencies Recognize Supported Housing as a Best Practice.

Notwithstanding their vehement opposition to the District Court's decision and Remedial Order, Defendants also recognize the benefits of supported housing. New York was one of the first states to implement supported-housing programs for people with mental illnesses.[46] The Guiding Principles for the Redesign of the Office of Mental Health Housing and Community Support Policies recognize that "[h]ousing is a basic need and necessary for recovery."[47] New York currently funds over 15,000 supported-housing apartments and is currently focusing on supported housing because, as Michael Newman—Director of OMH's Bureau of Housing Development and Support—and Robert Myers—OMH's Senior Deputy Commissioner for Adult Services—testified, supported housing is successful, cost-effective, recognized as a best practice, and what people with mental illnesses want.[48]

OMH's own studies show that individuals receiving supported housing are "very happy" with the services they receive, have few unmet needs, and report a

[45] *Id*. at 27 (emphasis added).

[46] JA232-233:752-753; JA330:1142; SX(1)593-608; SPA163.

[47] PX(2)-67.

[48] JA585:2159-2160; JA829:3172-73.

"significantly higher overall quality of life."[49] OMH's research also shows that informed choice and the ability to make one's own decisions leads to "healthier and more positive choices."[50] Accordingly, individuals served in supported housing are "likely to recover more quickly."[51]

Additionally, New York's Most Integrated Setting Coordinating Counsel ("MISCC"), which was created in 2002 in response to the *Olmstead* decision,[52] found that:

> For many consumers being served in the community, ***supported housing is needed as a means to move to a least restrictive setting. This is especially true for recipients currently living in adult homes***. ***These homes differ from supported housing in that they are more institutional in nature and provide a structured environment focused on caring for the individual in large, congregate settings.*** Many of the newer models of supported housing focus on providing affordable housing and assuring that treatment, rehabilitation and natural supports are available in the community not in the individual's home. ***The result is that persons in these settings [supported housing] are able to become a part of their community, rather than apart from their community.***[53]

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[49] PX(3)-346.

[50] SX(4)-3.

[51] *Id.*

[52] JA301:1082.

[53] PX(4)185 (emphasis added).

Sadly, despite MISCC's findings and New York's use of supported housing for other people with mental illnesses, Defendants have done very little to expand the benefits of supported housing to adult-home residents with mental illnesses.[54] Without affirmance of the District Court's Remedial Order, DAI constituents will likely never gain access to supported housing.[55]

II. THE DISTRICT COURT PROPERLY FOUND THAT VIRTUALLY ALL DAI CONSTITUENTS QUALIFIED FOR SUPPORTED HOUSING.

After considering the testimony of 52 witnesses and more than 300 exhibits, the District Court determined that virtually all DAI constituents were capable of living in supported housing and most wanted to do so. *Disability Advocates, Inc. v. Paterson et al.*, 653 F. Supp. 2d 184, 256–258, 267 (2009). These findings of fact are entitled to deference and cannot be set aside unless clearly erroneous. Fed. R. Civ. P. 52(a)(6). In fact, Defendants' Opening Brief admits that "supported housing is considered the preferred community housing model for many persons with mental illness." (Op. Br. 12–13.)

A. Virtually All DAI Constituents Are Capable of Living in Supported Housing.

Defendants do not dispute that today supported housing is the preferred service setting for most people with mental illnesses. (Op. Br. 12.) Defendants'

[54] JA315-316:1083, 1087.

[55] JA317:1090-1091.

own studies and testimony from a former OMH executive deputy commissioner, coupled with DAI's evidence and expert testimony, demonstrate that DAI constituents share the same traits and characteristics as current residents of supported housing.

In 2002, then-Governor George Pataki convened the Adult Care Facilities Workgroup (the "Workgroup") to perform a comprehensive review of adult-home policies and procedures in response to a series of scathing articles published by The New York Times. The Workgroup was a "blue-ribbon panel" of clinicians, adult-home operators, and mental-health providers, including 38 OMH and/or DOH employees.[56] After substantial study, research, and discussion, the Workgroup found that adult-home residents had characteristics similar to individuals living more independently.[57] The Workgroup recommended that 6,000 adult-home residents be served in supported housing by 2009.[58] While then-commissioner of DOH Antonia Novello "applauded" the Workgroup's report, Defendants did not follow this recommendation.[59]

That same year, Defendants commissioned New York Presbyterian Hospital to conduct the Adult Home Assessment Project (the "Assessment Project") to

[56] JA:449-450:1616-1619, JA463-464:1673-1675.

[57] SPA132; SX(4)-33.

[58] SPA240.

[59] DX(3)-131.

collect data on, among other things, the demographics of adult-home residents.[60] The Assessment Project included 2,611 residents living in 19 adult homes, 15 of which are at issue in this case.[61] Notwithstanding the fact that New York spent over a million dollars on the Assessment Project, the state inexplicably terminated the project before its analysis was completed.[62] However, the Assessment Project's data shows that the vast majority of adult-home residents are not severely impaired, and could be served in supported housing:

- 93% had no-to-mild impairment of their overall cognitive skills (MMSE)
- 68% of the currently unemployed responders reported that they had held some type of job in the past two years
- 67% had no psychiatric hospitalizations or were only hospitalized once in the last three years[63]

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[60] SPA238.

[61] *Id.*

[62] JA916.

[63] *See* PX(1)-80-103; PX(4)83,87-88, 90. The relatively high levels of functionality of adult-home residents correspond with the statutory limitations on admissions into adult homes. State regulations prohibit adult homes from taking individuals who pose a danger to themselves or others, require "continual medical or nursing care," have "unstable medical conditions," or chronically require the physical assistance of another person. *See, e.g.*, N.Y. Comp. Codes R. & Regs. tit. 18 § 487.4. Indeed, whether a particular individual ends up in an adult home or supported housing is based purely on availability. JA206:646.

DAI's expert on the administration of mental-health programs, Dennis Jones,[64] determined that the characteristics displayed by residents of adult homes presented "a very similar picture" to—if not one "almost better" than—what one would expect to see in residents of supported housing.[65] He testified that there was a "huge mismatch" between the people who ended up in adult homes and the homes themselves.[66] Based on this and other data, Mr. Jones concluded that virtually all of DAI's constituents could be served in supported housing given the proper supports.[67]

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[64] Mr. Jones served as the top mental-health official for Indiana from 1981 through 1988 and held a similar position in Texas from 1988 through 1994. From 1994 through 2003 he was the chief executive officer of the largest community-based mental-health center in Indiana. Additionally, he was appointed by a federal district court to act as the receiver for the District of Columbia's mental-health system from 2000 through 2002. In this capacity, he created a plan to completely restructure the public mental-health system in DC. JA290:984; *see also* SX(4)-278-279, 311-314.

[65] JA302-303:1032, 1034.

[66] JA303-304: 1036-1038; JA304-305:1040-1041.

[67] JA293:995; SX(4)-287. Additionally, Dr. Ivor Groves, another expert, also reviewed and analyzed the Assessment Project data, and determined that adult-home residents "are not a seriously impaired population in the vast majority; meaning they don't have severe cognitive deficits and they don't have real significant problems with daily living skills." JA804:3072. He also found that "the vast majority" of adult-home residents "could live in supported housing with appropriate supports." JA804:3074; SX(4)-435-436.

Elizabeth Jones, DAI's expert on institutions and alternative community-based mental-health services,[68] came to the same conclusion by visiting 23 of the 28 impacted adult homes from 2003-2004.[69] In the course of her investigation, she spoke to approximately 179 residents and reviewed over a hundred records of DAI constituents, many of whom she had previously interviewed.[70] Based on her years of working with people who had been moved from institutional settings to community-based alternatives, Ms. Jones determined that virtually all were capable of living in supported housing.[71] Ms. Jones saw "nothing in [her] visits to the adult homes that would lead [her] to believe that people [being moved from adult homes to supported housing] required more than is available already in the community in

[68] Ms. Jones has over 30 years of experience in the field of mental health, including serving as the superintendent/director of three institutions and a court-appointed receiver of a psychiatric institution. Ms. Jones specializes in the planning, development, and management of community services for people with mental illnesses and has overseen the transitioning of such individuals from institutions and quasi-institutions to community-based care services, including supported housing. She has served as an expert in institutional conditions and the development of alternative community-based programs in Massachusetts, Texas, North Dakota, Iowa, Michigan, Romania, Bulgaria, and Paraguay. JA53-55:35-42; SX(4)-325, 338-345.

[69] SX(4)-325-326.

[70] JA56:45-46; JA57:49-51; JA66-67:87-89.

[71] JA57-57:52-53.

New York, or that they presented any particular challenge other than what we work with everyday in the field of mental health."[72]

Dr. Kenneth Duckworth, DAI's expert psychiatrist,[73] also concurred that the vast majority of adult-home residents could be served in supported housing. In reaching this conclusion, he reviewed over 260 mental-health records of DAI constituents selected by Defendants' expert.[74] He also visited five of the impacted adult homes, interviewed 38 of their residents, and reviewed the deposition testimony of several current residents.[75] Based on his analysis of these and other materials, as well as his years of experience working with supported-housing programs, Dr. Duckworth found that "there are no material clinical differences between adult home residents and supported housing clients."[76] Duckworth specifically reviewed the records for factors that would contraindicate placement in

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[72] JA64-65:79-81.

[73] Dr. Duckworth is a licensed psychiatrist with 20 years of experience working with people with serious mental illnesses including schizophrenia, bipolar illness, schizoaffective disorder, and severe depression, among other disorders. Dr. Duckworth has served as the Medical Director and Acting Commissioner of the Massachusetts Department of Mental Health, where he was involved with the Massachusetts equivalent of ACT. He has worked in various treatment settings including hospital inpatient and outpatient programs, emergency triage, homeless outreach, and supported housing. JA244-246:800-807; SX(4)-388-391; SX(4)-426-431.

[74] JA248:813-814; JA249:820

[75] JA248:813-814; JA264-265:880-83.

[76] JA258:854; SX(4)-392.

supported housing like dementia, pyromania, severe cognitive or physical impairment, and found very few in the records.[77] He concluded that "virtually all" DAI constituents could live in supported housing with appropriate supports.[78]

Additionally, Linda Rosenberg—the former Senior Deputy Commissioner for OMH—also testified that, based on her direct experience and knowledge of New York's service system, virtually all DAI constituents are qualified for supported housing.[79] Ms. Rosenberg is aptly placed to make such an assessment. During her tenure at OMH (1997-2004), she oversaw the "community system of care for people with serious mental illnesses," including OMH's housing programs.[80] In this capacity, Ms. Rosenberg met and observed literally thousands of adult-home residents.[81] She also worked with New York's supported-housing programs. Ms. Rosenberg testified that DAI constituents "by and large have similar characteristics" to current residents of supported housing.[82] Indeed, even

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[77] JA197-198:812-813; JA269-270:900-901; JA271-272:907-910. In his testimony Dr. Duckworth agreed that residents exhibiting these factors may not be appropriate for supported housing and would require more intense evaluation; he further noted that such individuals do not belong in adult homes either. *Id.*

[78] JA247: 809; SX(4)-405-406.

[79] JA203:636; JA:222:710.

[80] JA203:636.

[81] JA204-205:640-42.

[82] JA222:709.

Defendants' expert Dr. Jeffrey Geller conceded that adult-home residents could live in apartments with varying degrees of support.[83]

B. DAI Constituents Want Supported Housing.

In spite of these facts, Defendants have done little to extend the benefits of supported housing to adult-home residents. Sadly, Defendants' efforts have been limited to issuing only one Request for Proposal ("RFP") to create 60 supported housing beds for adult-home residents in 2007.[84] To fill these newly created beds, OMH conducted housing forums at eleven adult homes. The response was enthusiastic. For example, an adult-home administrator, who appeared on behalf of Defendants, testified:

> ***I think they were very excited that there's something out there for them.*** This is the first time ever that agencies have approached them. Usually it's—***there have historically been very long waiting lists for independent housing and*** there have been—***the path wasn't clear***. So having an agency, OMH also explained the process. ***So having an informational setting where the residents can get all the information they would need to move on was just very, very informative, and it was very encouraging, and it gave residents a lot of hope.***[85]

At the Anna Erika home, "all the residents raised their hands," when asked who wanted to move out of the home and "[s]ome of the residents commented…that

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[83] SPA119; JA637:2370.

[84] SPA190; SX(2)-216-49.

[85] JA566:2083-2084 (emphasis added).

they felt 'trapped' living in the adult home…."[86] At other adult homes residents asked detailed questions and expressed a lot of interest in the opportunity to move into supported housing.[87]

This is not surprising. As Dr. Duckworth testified: "Most people have the dream of having their own place whether they've been saddled with schizophrenia or not." This common-sense insight is backed by the literature. Studies show that "a majority of consumers of mental health services prefer to live in their own apartments or houses and not in residential mental health programs or facilities."[88] They also show that individuals with mental illness desire "social integration and participation in typical social roles."[89] Similarly, a study by the Surgeon General found that "these individuals strongly desire their own decent living quarters where they have control over who lives with them and how decisions are made."[90]

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[86] PX(2)-132.

[87] PX(2)-129-133.

[88] Beth Tanzman, *An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services*, 44 Hosp. & Cmty. Psychiatry, 450-55 (1993); Priscilla Ridgway & Anthony M. Zipple, *supra* note 31, at p. 11 ("[C]lients have definite housing preferences, and that the vast majority prefer typical housing to residential treatment settings."); Ann O'Hara, *Housing for People With Mental Illness: Update of a Report to the President's New Freedom Commission*, Psychiatric Services, Vol. 58, No. 58, p. 909 (2007) ("Consistently, research demonstrates that this preference is for an innovative and independent form of housing known as supported housing. . . .").

[89] *Id*.

[90] U.S. Surgeon General, *supra* note 29.

At deposition and trial, many current and former residents testified about their desire to leave the adult homes and live in a more integrated community.[91] G.L. testified that he prefers supported housing because, "I have much more freedom." When asked if he would ever voluntarily return to an adult home, he flatly answered "No."[92] I.K. eloquently described her experience in supported housing:

> ***It's free. It's freedom for me. It's freedom. It's being able to actually live like a human being again.***[93]

These responses comport with the findings of Ms. Jones, who observed in her expert report that 91% of the adult-home residents she interviewed wanted to live elsewhere.[94]

This evidence is further supported by the Assessment Project's finding that a majority of adult-home residents interviewed wanted to leave the homes either to move to their own apartments, in with their families, or elsewhere.[95] Dr. Ivor Groves, DAI's expert who interpreted the Assessment Project's data, found 75% of

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[91] SLX-278-279:168-170; SLX-310-311:89-90; SLX-360:102-103; SLX-580: 203-204.

[92] JA:501-502.

[93] JA723:2751 (emphasis added).

[94] SX(4)-333; JA55:44; JA67:89-90.

[95] PX(4)-84; *see also* PX(1)-100.

the residents assessed (i) expressed an interest in living elsewhere or (ii) did not express a preference for the adult home they were living in.[96]

The foregoing statistics do not fully account for all the adult-home residents who would take advantage of supported housing given the opportunity. The residents interviewed for the Assessment Project were not informed about other service options, artificially minimizing the number expressing an interest in moving.[97] Moreover, as several expert witnesses testified, persons with mental illnesses are skeptical about making major changes in their lives because of their past experiences with the system.[98]

Taking this into consideration, Dr. Duckworth opined that the Assessment Project's findings represented "a floor" and that probably "four out of five" adult-home residents would likely take advantage of more independent living if presented with the opportunity to do so.[99] Mr. Jones also determined that not only were the majority of DAI constituents likely to want supported housing but that the amount of support needed to accommodate this desire could readily be supplied by New York's systems.[100]

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[96] SX(4)-435; JA300:1023-24; JA306-307:1048-1050.

[97] JA300:1021-1022.

[98] JA67:91-92; JA312:1070-1071.

[99] JA247:810; JA:262-264:872-877.

[100] JA307:1050-1052.

III. THE TRIAL COURT'S REMEDIAL ORDER IS NECESSARY AND PROPER.

The District Court's Remedial Order offers DAI constituents the opportunity to exercise meaningful choices and take more control of their lives by creating access to supported housing. The Remedial Order creates 1,500 supported housing beds per year for the next three years and requires Defendants to continue at this rate until there are sufficient beds for all current DAI constituents and all "Future Adult Home Residents" who desire them.[101] Consistent with the ADA, Rehabilitation Act, and *Olmstead*, the Remedial Order gives individuals qualified for supported housing the choice to be served in a more integrated setting, *Olmstead*, 527 U.S. at 602–603.

A. The Remedial Order Enables DAI Constituents to Make a Fully Informed Choice About Their Housing Options.

Because of the lack of education and information about available options, particularly supported housing, DAI constituents do not currently have adequate information to make an informed choice.[102] To rectify this, the Remedial Order requires "in-reach" to:

- Discuss supported housing and its financial aspects;
- Facilitate visits to prospective apartments;

[101] SPA234-236. The Remedial Order defines "Future Adult Home Residents" as DAI Constituents who are admitted to adult homes during and after the transition period.

[102] JA566:2083; JA649:2416.

- Assess DAI constituents' interest in and eligibility for supported housing;
- Explore and address potential concerns; and
- Review preferences and identify services that are needed and arrange for their timely provision.[103]

In-reach will be conducted by those who are in the best position to do so, supported-housing providers.[104] Having received the necessary information, DAI constituents can choose the type of service setting that best meets their needs.

B. The Remedial Order Properly Requires that Supported-Housing Providers Determine Service Needs.

DAI constituents who choose supported housing are deemed qualified unless they (i) have severe dementia, (ii) require a high level of skilled nursing that cannot be met in supported housing with Medicaid home-care or other waiver services, or (iii) are likely to cause imminent danger to themselves or others.[105] This standard properly considers the factors Dr. Duckworth testified would contraindicate placement in supported housing.[106] It also comports with New York's own statute regulating who can be admitted into adult homes. *See*, N.Y. Comp. Codes R. &

[103] SPA237.

[104] *Id.*

[105] If one of these conditions exists, further assessment is performed, and the person can move into supported housing if she or he is determined to be appropriate for it with the concurrence of OMH. SPA-239.

[106] JA247-248:812-813.

Regs. tit. 18 § 487.4.[107]

In accordance with current New York and national practice, providers determine whether or not DAI constituents qualify for supported housing and what services they will need to succeed. These mental health providers are selected by OMH.[108] Supported-housing providers employ clinical professionals—including psychologists, psychiatrists, nurses, and clinicians—and specialize in determining the treatment and supports required. They routinely perform similar assessments and are in the best position to determine whether or not they can appropriately serve DAI constituents' needs.[109]

Since many adult-home residents have been deprived of the opportunity to live in the community, it is important to plan for their transition to supported housing before the moves actually take place. Individuals should be linked with needed services and supports in accordance with their needs and preferences. For some, it will be important to sustain these supports over time, including services such as ACT for those who need it. The Remedial Orders use of "in-reach" to identify DAI constituents' needs and supported-housing providers to determine that those needs can be met, promotes a smoother transition into non-institutionalized life.

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[107] Discussed *supra* note 62.

[108] SPA236.

[109] JA416:1486-1487; PX(4)-522.

CONCLUSION

Affirming the District Court's decision and Remedial Order will give DAI constituents access to the benefits of supported housing: (1) the opportunity to live in and integrate into their community and (2) the necessary services to support their success as tenants and members of that community. For the foregoing reasons, the *Amici Curiae* respectfully request that the Court affirm the decision below.

Dated: October 13, 2010

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ADDENDUM
AMICI CURIAE BACKGROUND INFORMATION

1. **The American Association of Community Psychiatrists (AACP)** is a national membership organization consisting of psychiatrists, psychiatric residents, medical students, and associate members from the range of allied behavioral health professions. Since 1985, the AACP has been a professional voice for psychiatric clinicians, academicians, and public policy experts who work in community-based and other public sector settings. The organization's mission is to "encourage, equip, and empower community and public psychiatrists to develop and implement policies and high-quality practices that promote individual, family, and community resilience and recovery." Within AACP there exists a concentration of experience, talent, and expertise that has positioned it as a national leader in advancing quality care, advocating public health, and educating psychiatrists. As such, AACP endorses the need to create sufficient supported housing in New York State for people with mental illnesses who currently live in adult homes in New York, enabling them to freely elect to move to non-institutional, community-based housing so that they might ably pursue integration into communities, effect personal healing, and optimize their quality of life.

2. **AARP** is a nonpartisan, nonprofit social welfare organization with a membership that helps people aged 50+ have independence, choice, and control

in ways that are beneficial and affordable to them and society as a whole. AARP supports providing people access to quality long-term health care services in the setting that they choose and a range of financing sources for long-term care. To that end, AARP supports efforts to ensure that individuals in New York and elsewhere have access to long-term care in the most integrated settings. In several cases around the country, AARP attorneys represent classes of plaintiffs seeking enforcement of the Americans with Disabilities Act, one goal of which is the expansion of supported-housing options in order to enable older people and those with disabilities to avoid unnecessary institutionalization in nursing facilities and other segregated settings.

3. **Mental Health America (MHA)**, formerly the National Mental Health Association, is a national membership organization consisting of individuals with mental illnesses and their family members. The nation's oldest and largest nonprofit mental health organization, MHA has over 320 affiliates that are dedicated to improving the mental health of all Americans, especially the 54 million people who have mental disorders. Through advocacy, education, research, and service, MHA helps to ensure that people with mental illnesses are accorded respect, dignity, and the opportunity to achieve their full potential. Mental Health America's Position Statement No. 21 specifically endorses the

principles of the *Olmstead* decision, which is at the core of this case, and the need for supported housing as elaborated in this brief.

4. **The National Alliance on Mental Illness (NAMI)** is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. Founded in 1979, NAMI has over 1100 state and local affiliates that engage in research, education, support, and advocacy. A vital part of NAMI's mission is to promote and advocate for access to treatment and services, including supported housing, that fosters recovery and enables individuals living with mental illnesses to achieve the highest possible level of functional independence and productivity in the community.

5. **The National Association of Social Workers (NASW)**, established in 1955, is the largest association of professional social workers in the world with 145,000 members and chapters throughout the United States, in Puerto Rico, Guam, the Virgin Islands, and an International Chapter in Europe. The NASW, New York State and New York City Chapters, have a combined membership of nearly 20,000 social workers. With the purpose of developing and disseminating standards of social work practice while strengthening and unifying the social work profession as a whole, NASW provides continuing education, enforces the *NASW Code of Ethics*, conducts research, publishes books and studies,

promulgates professional criteria, and develops policy statements on issues of importance to the social work profession.

The *NASW Code of Ethics* states that social workers are to "respect and promote the right of clients to self-determination" unless it would pose a "serious, foreseeable, and imminent risk" to the client or others. NASW's policy on mental health specifically supports "the elimination of stigma associated with mental illness," "a broader range of housing and vocational services to improve the quality of life, enhance independent community living, and build effective and stable interpersonal relationships," and "culturally responsive treatment in the most therapeutic and least restrictive environment." NASW, SOCIAL WORK SPEAKS 229, 234-5 (8th ed., 2009). Accordingly, given NASW's policies and the work of its members, NASW has expertise that will assist the Court in reaching a proper resolution of the questions presented in this case.

6. **The Depression and Bipolar Support Alliance (DBSA)** is the nation's leading consumer-focused mental health organization, with the mission "to improve the lives of people living with mood disorders." Through over 1,000 support groups and 450 national chapters, DBSA reaches nearly 5,000,000 people each year with current, consumer-friendly information about depression and bipolar disorder, as well as empowering tools focused on an integrated approach to wellness and recovery. DBSA joins this amicus brief on behalf of its members and

constituents who will benefit from the proper application of *Olmstead* and the affirmance of the District Court's decision and Remedial Order.

7. **The American Association of People with Disabilities (AAPD)** is the country's largest cross-disability membership organization. AAPD organizes the disability community to be a powerful voice for change—politically, economically, and socially. AAPD was founded in 1995 to help unite the diverse community of people with disabilities, including their family, friends, and supporters, and to be a national voice for change in implementing the goals of the Americans with Disabilities Act (ADA).

8. **The American Network of Community Options and Resources (ANCOR)** is a nationwide association of over 800 private agencies that provide support and services to more than 500,000 people with disabilities, including individuals with mental illness and dual diagnosis. ANCOR has been involved for almost 40 years in increasing housing options for people with a variety of disabilities, and ensuring the availability of needed supports.

9. **The American Occupational Therapy Association (AOTA)** is the national professional association representing the interests of more than 140,000 occupational therapists, occupational therapy assistants, and students. Occupational therapy is science-driven, and evidence-based practice, which enables people of all ages to live life to its fullest by promoting health and

minimizing the functional effects of illness, injury, and disability. Occupational therapy has its roots in the mental-health arena, and now works to support individuals with mental illness to live in the community, to recover and maintain functional abilities, and to live life to its fullest.

10. **ADAPT** is a national grass-roots community that organizes disability rights activists to advocate for the civil and human rights of people with disabilities. For over 20 years, ADAPT has been striving to end the institutional biases that promote the segregation of people with disabilities into institutional settings like adult homes. ADAPT works so that people with disabilities can live in the community with real supports and the freedoms that are due to all citizens.

11. **The Disability Rights Education and Defense Fund, Inc. (DREDF)** is a national nonprofit law and policy center dedicated to advancing and protecting the civil rights of people with disabilities. Founded in 1979 by people with disabilities and parents of children with disabilities, DREDF remains board- and staff-led by members of the community it represents. DREDF pursues its mission through education, advocacy, and law reform efforts, and is nationally recognized for its expertise in the interpretation of federal disability civil rights laws. DREDF participated in an amicus brief submitted to the U.S. Supreme Court in the *Olmstead* case, which highlighted the critical importance of the ADA's community integration mandate. *DAI v. Paterson et al.*, represents an important

application of *Olmstead*, the affirmance of which will help to fulfill the promise of the ADA.

12. **The Autistic Self-Advocacy Network (ASAN)** is a nonprofit organization run by and for autistic people. ASAN was created to provide support and services to individuals on the autism spectrum while working to change public perception and combat misinformation by educating communities about persons on the autism spectrum. ASAN seeks to advance the principles of the disability rights movement in the world of autism. Drawing from the principles of the cross-disability community on issues such as inclusive education, community living supports, and others, ASAN seeks to organize the community of autistic adults and youth to have their voices heard in the national conversation about autism. ASAN initiatives include the Academic Autistic Spectrum Partnership in Research and Education (AASPIRE), an active Speaker's Bureau, and advocacy in support of autism and disability-related issues such as de-institutionalization and community-living supports, educational opportunity and inclusion, employment supports, and other initiatives at both state and federal levels.

13. **The National Health Law Program, Inc. (NHeLP)** is a national public interest law firm working to improve access to quality health care on behalf of limited income people by providing litigation assistance, legal and policy analysis, information, and education. Since its inception 40 years ago, NHeLP has

represented thousands of families and children, elderly people, and people with disabilities in federal court cases seeking to enforce provisions of the federal Medicaid Act, the Americans with Disabilities Act, and other federal civil rights laws. NHeLP has developed recognized expertise in the areas of public insurance and disability law, and serves as a national clearinghouse for legal information. As an advocate for quality health care, NHeLP works to promote greater understanding of the barriers to health care faced by low-income individuals and people with disabilities. NHeLP has worked to analyze and enforce Medicaid and ADA requirements. It has also worked to ensure that individuals have avenues for redress when their requests for publicly funded services are denied or not acted on. NHeLP is vitally interested in, and joins, the subject matter of this case and this amicus brief.

14. **The National Senior Citizens Law Center (NSCLC)** is a nonprofit organization that advocates nationwide to promote the independence and well-being of low-income older persons and people with disabilities. For more than 35 years, NSCLC has served these populations through litigation, administrative advocacy, legislative advocacy, and access to attorneys. NSCLC recently released the report, *10-Plus Years After the Olmstead Ruling: Progress, Problems, and Opportunities*. NSCLC is deeply committed to the implementation

of the *Olmstead* decision and its progeny, including this case, which will benefit its constituents in adult homes in New York City.

15. **The Public Interest Law Center of Philadelphia (PILCOP)** is one of the original affiliates of the Lawyers' Committee for Civil Rights Under Law, and has a long history of representing persons with disabilities seeking quality, community-based services so that they can avoid being confined to segregated institutions. The Law Center was lead counsel in *Halderman v. Pennhurst*, 451 U.S. 1 (1981); 465 U.S. 89 (1984). This case, argued three times before the United States Supreme Court, resulted in the closing of the Pennhurst institution for individuals with intellectual disabilities and the placement of its residents in quality, community-based settings.

As a result of *Pennhurst*, similar suits were brought by the Law Center, along with others, in Connecticut, Oklahoma, New Mexico, Illinois, Montana, Delaware, and Tennessee to end or prevent the segregation of persons with disabilities both before and after the *Olmstead* decision. This year, the Law Center, enforcing the principles of the *Olmstead* decision, settled *Messier v. Connecticut*, 3:94-cv-01706-EBB, Doc. 1036-1 (D. Conn., July 12, 2010), *and see decision at* 562 F. Supp. 2d 294 (2008), enabling hundreds of individuals segregated in the Southbury Training School to move into their communities. Because this right to live in the community is a mirage if housing and services

adapted to their needs are not available, the Law Center has devoted substantial resources to removing barriers to those services, including an amicus brief in *City of Cleburne v. Clebourne Living Center*, 473 U.S. 432 (1985), filing numerous suits contesting zoning restrictions on group homes, and enforcing decrees around the country concerning adequate support services for persons moving from institutions.

Both through advocacy and litigation, the Law Center helps to ensure that people with intellectual disabilities and mental illness may live in the community; it knows how important supported housing is for its clients, as explained in this brief.

16. **The National Association of People with AIDS (NAPWA)**, founded in 1983, is the first coalition in the world of people living with HIV/AIDS, as well as the oldest AIDS organization in the United States. NAPWA is the trusted, independent voice of the more than one million people living with HIV/AIDS in America. NAPWA is a strong voice in policy, capacity building, leadership development, and social networking. NAPWA works to improve access to early and comprehensive treatment for persons living with HIV/AIDS. Advocacy initiatives support administrative, appropriations, and legislative opportunities that expand the quality of life for persons living with HIV/AIDS, including the opportunity to live in the community with necessary supports.

NAPWA programs focus on capacity-building and consumer advocacy, providing advocacy and assistance in obtaining medical, legal, financial, housing, and other needed supportive services for people living with HIV/AIDS.

17. **The U.S. Psychiatric Rehabilitation Association (USPRA)** is a 501(c) (3) organization whose mission is to advance the practice of psychiatric rehabilitation so that individuals with mental illness can recover in order to be able to achieve successful and satisfying lives in the working, learning, and social environments of their choice. USPRA provides access, advocacy, and strategies to implement state-of-the-art psychiatric rehabilitation and recovery-oriented practices through education, professional credentials, research, service outcomes, and networking. As a result of its years of experience in the field, USPRA recognizes that active participation in decision making, as well as interaction with the community at large, are essential to the recovery of people with mental illnesses.

18. **National Council for Community Behavioral Health Care (National Council)** is the unifying voice of America's behavioral health organizations. Together with 1,700 member organizations, the National Council serves our nation's most vulnerable citizens—more than 6 million adults and children with mental illnesses and addiction disorders. The National Council is

committed to providing comprehensive, quality care that affords every opportunity for recovery and inclusion in all aspects of community life.

19. **Daniel Fisher** earned a PhD in biochemistry, and conducted research at the National Institutes of Mental Health into the possible biochemical basis of schizophrenia. During the course of that work, at age 25, he was diagnosed with schizophrenia, and was hospitalized on several occasions. His full recovery inspired him to help others find the keys to their recovery from mental illness. Earning an MD from George Washington University and training as a psychiatrist at Harvard Medical School, he has practiced as a psychiatrist and Medical Director at Riverside Community Care in Wakefield, Massachusetts, for 25 years. Dr. Fisher's work has been recognized by several awards, including the Clifford Beers Award for Mental Health Advocacy and the Frances Olivero Advocacy Award. He was appointed as a Commissioner to the White House New Freedom Commission on Mental Health. Dr. Fisher co-founded the National Empowerment Center and is a voice for consumers in the development of national mental health policy. Dr. Fisher endorses supported housing based on his years of experience in the field and his own experience with mental illness.

20. **The National Council on Independent Living (NCIL)** is the longest-running national cross-disability, grassroots organization run by and for people with disabilities. Founded in 1982, NCIL represents thousands of

organizations and individuals including: Centers for Independent Living (CILs), Statewide Independent Living Councils (SILCs), individuals with disabilities, and other organizations that advocate for the human and civil rights of people with disabilities throughout the United States. Through consumer-driven advocacy, NCIL advances independent living and the rights of people with disabilities. NCIL was founded to embody the values of the disability culture and Independent Living philosophy, which creates a new social paradigm that emphasizes that people with disabilities are the best experts on their own needs, that they have crucial and valuable perspectives to contribute to society, and that they are deserving of an equal opportunity to decide how to live, work, and take part in their communities. NCIL envisions a world in which people with disabilities are valued equally and participate fully.

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Dated: October 13, 2010

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) ss.:
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AFFIDAVIT OF CM/ECF SERVICE

I, Mariana Braylovskiy, being duly sworn, depose and say that deponent is not a party to the action, is over 18 years of age.

On October 13, 2010

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