UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

DISABILITY ADVOCATES, INC.,

Plaintiff,

v.

ELIOT SPITZER, in his official capacity as Governor of the State of New York, RICHARD DAINES, in his capacity as Commissioner of the New York State Department of Health, THE NEW YORK STATE DEPARTMENT OF HEALTH, MICHAEL HOGAN, in his capacity as Commissioner of the New York State Office of Mental Health, and THE NEW YORK STATE OFFICE OF MENTAL HEALTH

Defendants.

03 Civ. 3209 (NGG) (MDG)

DISABILITY ADVOCATES, INC.'S MEMORANDUM OF LAW
IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

December 3, 2007

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Plaintiff Disability Advocates, Inc. ("DAI") respectfully submits this Memorandum of Law in Opposition to the Motion for Summary Judgment of defendants the Governor of the State of New York, the Commissioners of Health and Mental Health, the Department of Health and the Office of Mental Health (collectively, "defendants" or "the State").

Preliminary Statement

The State's motion for summary judgment is replete with disputed issues of fact and errors of law. But it establishes one thing—that the State is committed to relying on segregated adult homes in its mental health system as a last stop for people with mental illness. Far from setting forth an effective plan to enable residents of adult homes to have a meaningful opportunity to access more integrated housing, the defendants argue instead that adult home residents already live in fully integrated settings, that they receive mental health services that will help them live more independently and that the State has developed community-based housing that they can access if they so desire. But the record evidence establishes otherwise.

The testimony of adult home residents, adult home operators, State employees and DAI's and defendants' experts alike demonstrate that adult homes are segregated settings akin to psychiatric institutions. People with mental illness who reside in adult homes live in close quarters entirely with other persons with disabilities and almost exclusively with other persons with mental illness. Almost every aspect of their daily lives is highly regimented and limited by rigid rules and practices.

While defendants extol activities and programs that are available to adult home residents, any benefit these programs may offer is purely artificial for someone who has been relegated indefinitely to an institution, with scores of other persons with

mental illness and with no hope of moving on to a setting in which he or she would use those daily living skills. Moreover, the evidence shows that such programs do nothing to enable adult home residents to move to more integrated settings because, with very few exceptions, *no one moves*. Indeed, the State acknowledges that only a handful of adult home residents have moved to supported housing. Additionally, the State concedes that there is a 2% vacancy rate in supported housing and that demand for that housing far exceeds availability. Thus, despite the State's recent designation of adult home residents as one of many "priority" populations for a very small percentage of OMH housing, such individuals are a priority in name only, as there is no realistic probability that they will be able to access supported housing.

To counter the fact that very few adult home residents move to supported housing, defendants argue that adult home residents are not capable of living in such housing and that only individuals who are capable of living independently with few support services are eligible for such housing. But the record evidence shows that numerous individuals with mental illness who reside in adult homes *are capable* of living in supported housing. A governor-appointed workgroup reached that conclusion; medical professionals hired by the State reached that conclusion; DAI's mental health experts reached that conclusion; and even defendants' expert reached that conclusion.

Defendants claim that the relief DAI seeks in this action would prejudice other persons with mental illness who seek community housing. But DAI does not ask that defendants use money now designated for other needy populations to fund a remedy in this case; DAI seeks to redirect funds the State currently spends on persons with mental illness in adult homes to support those same individuals in supported housing.

For this reason, the relief in this action will not require the State to cut services currently provided to other needy populations.

While defendants criticize DAI for seeking a "set aside" of beds for a particular group, defendants have, on several occasions, reserved beds solely for certain populations. Such a remedy is thus consistent with the State's own practices. People with mental illness who reside in adult homes have been almost entirely excluded from the State's community-based housing for decades. DAI simply seeks through this action to enforce the State's obligation to ensure that these individuals have access to this housing.

Perhaps it is because the State has no viable plan to bring its mental health system into compliance with *Olmstead* v. *L.C.*, 527 U.S. 581 (1999), and the Americans with Disabilities Act ("ADA") that defendants argue at this late date that DAI lacks standing to bring this suit and that the State cannot be held liable under the ADA because it does not own or operate the homes. This case is not premised on the poor conditions and abuses in adult homes; it is about the choice the State has made to plan, structure and administer its mental health system to deliver services to thousands of individuals with mental illness in large, segregated adult homes, and to allocate funding to serve these individuals in adult homes rather than in more integrated settings. It is the State itself that is causing injury to adult home residents, and DAI has standing, by statute, to bring claims on behalf of people with mental illness in adult homes to remedy that injury.

Defendants' motion for summary judgment should be denied for the following reasons:

First, as a protection and advocacy agency, DAI has standing, under the Protection and Advocacy for Individuals with Mental Illness Act ("PAIMI"), 42 U.S.C. § 10801, *et seq*., to bring this action on behalf of individuals with mental illness who reside in adult homes in New York State. DAI's constituents are suffering injury in fact; that injury is caused by the actions of the State; and an order directed to the State will remedy that injury. Thus, DAI has standing to bring this action on behalf of its constituents.

Second, DAI's claims seek to end discrimination by defendants in their own services, programs and activities. DAI does not, as defendants suggest, challenge the conduct of licensees of the State, but rather the State's own failure to ensure that its service system affords individuals with mental illness the opportunity to receive services in the most integrated setting appropriate to their needs. In discharging their responsibility to coordinate a system of mental health services with appropriate residential arrangements, defendants have chosen to administer the State's mental health system in a way that segregates persons with mental illness in large institutional adult homes rather than provides services in more integrated settings. Defendants cannot evade their responsibilities under the ADA and *Olmstead* by arranging to use privately-owned facilities as part of their mental health system.

Third, DAI's constituents are not in the most integrated setting appropriate to their needs. Defendants argue that the integration mandate of the ADA and *Olmstead* requires only "opportunity for contact with nondisabled persons," but the law unequivocally requires the State to administer its services in the "most integrated setting appropriate to the needs of qualified individuals with a disability." The record is replete

with evidence, including the opinions of defendants' own experts, that adult homes segregate and isolate persons with mental illness and impose significant barriers to integration and interactions with nondisabled persons. While the State makes available scattered-site supported apartments that are far more integrated than adult homes and serve persons with the same diagnoses and symptoms as those in adult homes, individuals with mental illness in adult homes are not afforded the opportunity to access such housing.

Fourth, the record evidence shows that numerous persons with mental illness in adult homes both desire to live in supported housing and are capable of doing so with appropriate supports. Estimates reached by State workgroups and conclusions reached by professionals conducting assessments for the State indicate that thousands of adult home residents could live in more integrated settings. Additionally, DAI's experts—(1) a psychiatrist and former Director of the Massachusetts Department of Mental Health, (2) a former public mental health official who has overseen the development of housing and services in integrated settings for people with mental illness, and (3) a former Assistant Secretary for Alcohol, Drug Abuse and Mental Health of the State of Florida, and (4) a former Commissioner of the Texas Department of Mental Health and former Commissioner for Mental Health in the State of Indiana—have concluded that virtually all of the residents of the adult homes at issue are qualified to move to more integrated supported housing.

Fifth, defendants have failed to demonstrate that granting relief in this action would fundamentally alter the nature of their services, programs or activities. As DAI demonstrated in its motion for partial summary judgment, defendants' failure to

develop a comprehensive, effectively working plan to enable persons with mental illness in adult homes to receive services in more integrated settings places the fundamental alteration defense beyond their reach. Even if defendants could avail themselves of such a defense, they have failed to perform a fiscal analysis sufficient to sustain their burden of proof. Moreover, to the extent they performed a post-litigation fiscal analysis, their analysis was seriously flawed in that it relied on baseless assumptions and failed to consider cost savings the State would realize from the relief sought. They have similarly failed to demonstrate that the relief sought would alter the nature of the State's existing programs, as DAI simply seeks meaningful access to a service that already exists.

Finally, contrary to the defendants' assertions, the presence of the Governor is necessary for the full relief requested by DAI. Consistent with the obligations conferred on him by the State's mental health laws, the Governor has extensive involvement in overseeing and administering the State's mental health system. Because the relief sought in this action requires the coordinated effort of all the defendants, including the Governor, he should not be dismissed from this action.

For all of these reasons, defendants' motion for summary judgment should be denied.

Statement of Facts

A. Disability Advocates, Inc.

DAI is a New York not-for-profit corporation which since 1989 has been an authorized protection and advocacy agency pursuant to the Protection and Advocacy

for Individuals with Mental Illness Act, 42 U.S.C. § 10801, *et seq*. ("PAIMI").[1] (Zucker Decl. ¶ 4.)[2] DAI's mission is "to protect and advance the rights of adults and children who have disabilities so that they can freely exercise their own life choices, enforce their rights, and fully participate in their community life." (Murray Decl. Ex. 52 (Disability Advocates, Inc., http://www.disabilityadvocates.info/.) Its constituents consist of "individual[s] with mental illness," as defined under PAIMI. 42 U.S.C. § 10802(4).

B. Defendants

Defendant New York State Department of Health ("DOH") is an agency of New York State. (Answer ¶ 14.) Defendant Richard Daines is the Commissioner of DOH. DOH administers and enforces New York's public health laws. DOH licenses and monitors facilities in which health care and other services are provided, and enforces the laws and regulations applicable to these facilities. (Wickens Dep. 12:9-19; Reilly Dep. 39:18-20; Kerr Dep. 38:5-10.)

Defendant New York State Office of Mental Health ("OMH"), a component of the Department of Mental Hygiene, is also an agency of New York State. (Answer ¶ 16.) Defendant Michael Hogan is the Commissioner of OMH. OMH funds, oversees, licenses, and credentials mental health programs serving persons with mental illness in New York State. (Answer ¶ 40; Tacaronti Dep. 18:2-19:3, 167:8-11; Baer Dep.

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[1] Pursuant to PAIMI, every state, the District of Columbia, Puerto Rico, and the federal territories have established protection and advocacy organizations ("P&As") for individuals with mental illness. (Zucker Decl. ¶ 5.)

[2] Throughout this Memorandum of Law, Declarations will be cited by the witness's name and "Decl. ¶ __," Affidavits will be cited by the witness's name and "Aff. ¶ __," and Depositions, which are attached to the declarations of Francine N. Murray, Esq. will be cited by the witness's name and "Dep. __." Defendants' Memorandum of Law in Support its Motion for Summary Judgment is referred to throughout as "Defs.' Br."

237:17-242:15.)[3] Among these programs, OMH operates 25 state psychiatric hospitals located across the state.[4] OMH funds other mental health programs by issuing requests for proposals (RFPs) that seek proposals from localities and nonprofit service providers. (*See, e.g.*, Newman Aff. ¶¶ 60-63; Murray Decl. Ex. 128 (2000 Supported Housing RFP); Murray Decl. Ex. 55 (2003 CR/SRO RFP); Murray Decl. Ex. 56 (2005 Supported Housing RFP).) These programs include "supported housing" programs: scattered site apartments with supportive mental health services and other services. *See infra* Part E.

Defendant Eliot Spitzer, sued in his official capacity, is the Governor of the State of New York. He is ultimately responsible for ensuring that New York operates its service systems in conformity with the Americans with Disabilities Act and the Rehabilitation Act.

Defendants are jointly responsible for New York State's mental health care delivery programs and services: "It shall be the policy of the state . . . to develop a comprehensive, integrated system of treatment and rehabilitative services for the mentally ill. Such a system . . . should assure the adequacy and appropriateness of residential arrangements . . . and it should rely upon . . . institutional care only when necessary and appropriate." (Declaration of Anne S. Raish in Support of DAI's Motion for Partial Summary Judgment, dated Aug. 10, 2007 ("Raish Decl.") Ex. 36 (N.Y. MENTAL HYG. LAW § 7.01).) Specifically, DOH is responsible for promoting the "development of sufficient and appropriate residential care programs for dependent

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[3] *See also* Murray Decl. Ex. 53 (New York State Office of Mental Health, *About OMH* (last visited Dec. 3, 2007), *at* http://www.omh.state.ny.us/omhweb/about/).

[4] Murray Decl. Ex. 54 (Comprehensive Statewide Plan for Mental Health Services, October 2007 Update, *at* http://www.omh.state.ny.us/omhweb/Statewideplan/childrens_mental_health_act/oct2007_update.html.).

adults." (Raish Decl. Ex. 34 (18 N.Y.C.R.R. §§ 485.3(a)(1), 487.1(b).) OMH is responsible for "assuring the development of comprehensive plans, programs, and services in the areas of research, prevention, and care, treatment, rehabilitation, education, and training of the mentally ill." (Raish Decl. Ex. 36 (N.Y. MENTAL HYG. LAW § 7.07(a).) Among its programs are community support, residential, and family care programs.[5] Further, OMH "advise[s] and assist[s] the governor in developing policies designed to meet the needs of the mentally ill and to encourage their full participation in society." (*Id.* § 7.07(b).)

C. Adult Homes Are Part of the State's Mental Health System

As New York State downsized its state hospital system, it increasingly relied on adult homes to provide housing for people with mental illness. (Murray Decl. Ex. 57, at 1 (ADULT HOME WORKGROUP, THERE'S NO PLACE LIKE HOME: RECOMMENDATIONS FOR IMPROVING THE QUALITY OF LIFE IN ADULT HOMES SERVING PEOPLE WITH MENTAL ILLNESS (June 2000).) The placement of large numbers of people with mental illness into adult homes is the result of a conscious State policy to discharge patients from psychiatric hospitals into these facilities due to the absence of other housing alternatives at a time when psychiatric centers were under pressure to downsize. (Sundram Aff. ¶ 8; Rosenberg Aff. ¶ 5; Raish Decl. Ex. 38 (Memorandum to Members of Mnetal Health Services Council from Commissioner James Stone (Nov. 22, 2002); Schimke Dep. 10:15-11:10.) To meet the growing need for housing created by the large numbers of discharges from State psychiatric hospitals, the State licensed private

[5] Murray Decl. Ex. 53.

providers to create adult homes using under-utilized facilities, such as hotels, motels, YMCAs and other similar buildings. (Sundram Aff. ¶ 9; *see also* Raish Decl. Ex. 38.)

The number of people with mental illness living in adult homes has increased by 27% since 1979. (Murray Decl. Ex. 57, at 2.) In 2002, there were 12,586 recipients of mental health services residing in adult homes—more than twice the number served in state hospitals. OMH, 2004-2008 Statewide Comprehensive Plan for Mental Health Services (Raish Decl. Ex. 56 at 69.)[6]

Together, DOH and OMH monitor and inspect adult homes. (Answer ¶¶ 16, 17; Murray Decl. Ex. 58 (N.Y. Const. Art. XVII, § 4); Raish Decl. Ex. 34 (18 N.Y.C.R.R. § 485.3(b)(1).) Additionally, they exert direct control over the availability of adult home beds for individuals with mental illness through the certificate of need process. Under state law, no one may operate an adult home facility without an operating certificate from DOH. (Raish Decl. Ex. 34 (18 N.Y.C.R.R. § 485.3(a)(3).) Operating certificates for adult homes must be reissued at least every four years. (Murray Decl. Ex. 60 (18 N.Y.C.R.R. § 485.5(c).) DOH may revoke, suspend or limit an adult home's operating certificate upon determining that this action would be in the public interest because it would conserve resources. (*Id*. § 485.5(m)(1)(i).) Hence, DOH has the authority to certify a need for fewer adult home beds, based on the availability of other programs in which mental health services are provided—including supported housing.

A state statute explicitly recognizes that state hospitals and other psychiatric inpatient facilities licensed by the State will use adult homes for discharges,

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[6] *See also* Murray Decl. Ex. 59 (OMH, *Table 1.A: Clients Served During Week Of 2005 Pcs, By Major Age Group By Program*, www.omh.state.ny.us/omhweb/pcs/survey05/state_tables/ny_t1.htm (last visited Dec. 3, 2007) (state survey data showed 4,865 individuals over 18 in state hospitals in 2005)).

(Murray Decl. Ex. 61 (N.Y. MENTAL HYG. LAW § 29.15(i)(2)(II) (amended as recently as L 2006, Ch. 534).) Additionally, state psychiatric centers directly operate mental health programs located inside the walls of some adult homes,[7] and State officials must approve contracts by which other providers undertake to do so in adult homes with significant numbers of people with mental illness (Murray Decl. Ex. 64 (18 N.Y.C.R.R. § 487.7(b), (c)(1); Tacoronti Dep. 18:17-23.)[8]

D. Adult Homes

Adult homes are segregated, institutional for-profit settings in which individuals with mental illness reside in close quarters entirely with other persons with disabilities and almost entirely with other persons with mental illness. (E. Jones Aff. Ex. A at 8; D. Jones Decl. Ex. A at 9; Sundram Aff. ¶ 7; Rosenberg Aff. ¶ 12; Kaufman Decl. Ex. A at 8.) The adult homes at issue in this case house resident populations numbering anywhere from 125 people to 427 people. (Raish Decl. Exs. 2, 31 (New York State DOH Adult Care Facilities Census Reports).) The most recent census data available for the homes at issue indicate that in 15 of the 21 homes, 95% or more of the residents have mental disabilities and in seven of these, more than 99% of residents have mental disabilities. (*Id*.)

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[7] *See* Defs.' Br. 5; Murray Decl. Ex. 62 (OMH, *South Beach Psychiatric Center*, http://www.omh.state.ny.us/omhweb/facilities/sbpc/facility.htm#inpatient); Murray Decl. Ex. 63 (OMH, *Creedmoor Psychiatric Center Outpatient Services*, http://www.omh.state.ny.us/omhweb/facilities/crpc/outpatient%5Fservices.htm); S.B. Dep. 151:4-15, 161:14-19; S.P. Dep. 16:23-17:11.

[8] In addition, oversight by the State Commission on Quality of Care and Advocacy for Persons with Disabilities, formerly the Commission on Quality of Care for the Mentally Disabled, includes the quality of mental hygiene services in such homes. (Murray Decl. Ex. 65 (N.Y. MENTAL HYG. LAW § 45.10(a)(1).)

In April 2002, a Pulitzer Prize-winning series of articles in The New York Times reported abuse, neglect, negligent supervision, inadequate medical care and chaos pervading New York City Adult Homes, referred to as "psychiatric flophouses" in the Times articles. (Murray Decl. Ex. 66 (Clifford J. Levy, *For Mentally Ill, Death and Misery,* N.Y. TIMES, Apr. 28, 2002, § 1); Murray Decl. Ex. 67 (Levy, *Here, Life Is Squalor and Chaos,* N.Y. TIMES, Apr. 29, 2002, at A1); Murray Decl. Ex. 68 (Levy, *Voiceless, Defenseless And a Source of Cash,* N.Y. TIMES, Apr. 30, 2002, at A1).) The revelations in the New York Times were old news to anyone familiar with adult homes in New York City. New York State and New York City officials referred to these adult homes as "de facto mental institutions" and "satellite mental institutions" over twenty-five years ago. (Murray Decl. Ex. 69 at 38 (Charles J. Hynes, *Private Proprietary Homes for Adults* (Mar. 31, 1979); Murray Decl. Ex. 70 at "Summary of Preliminary Findings" (New York City Council Subcommittee on Adult Homes, *The Adult Home Industry: A Preliminary Report* (1979).)

The large impacted adult homes at issue in this case severely limit residents' interaction with non-disabled people. (Kaufman Decl. Ex. A at 10-11; E. Jones Aff. Ex. A at 3, 8; D. Jones Decl. Ex. A at 9.) A manager of a private mental health agency in New York City, who spent much time in adult homes over two decades,[9] testified in his deposition that "[t]hese large homes tend to have institutional qualities such as lack of individualized services, little opportunity for residents to have input into the services and conditions in their home, minimal interaction between residents and the surrounding community and a lack of privacy." (Schwartz Dep. 298:25-300:9; *see also*

[9] Schwartz Dep. 15:24-16:6, 59:18-93:24.

id. at 297:24-298:14.) He stated that adult homes are for the most part "institutions for people with mental illness" (*id.* at 272:11-13), the "modern day back wards [of state hospitals]" where people are kept until they die (*id.* at 282:24-284:17). Defendants' experts have likewise concluded that adult homes are very much like psychiatric institutions. (Kaufman Decl. Ex. A at 8; Geller Decl. Ex. A at 26.)

People with mental illness who reside in adult homes spend the vast majority of their time with other people with mental disabilities, and opportunities for interactions with non-disabled persons are limited. (D. Jones Decl. Ex. A at 9.) Most aspects of residents' daily lives take place inside the homes. For example, many residents receive their medical care and medications, and attend mental health programs, all inside the homes.[10] (E. Jones Aff. Ex. A at 8, E. Jones Dep. 243:5-19; Baer Dep. 19:16-20:21; L.G. Dep. 39:10-14; B.J. Dep. 122:8-123:2.) Many residents also attend religious services inside the homes.[11] (S.B. Dep. 54:17-55:16; B.J. Dep. 28:21-24; J.M. Dep. 51:14-52:8; D.W. Dep. 150:7-18.)

While adult home residents would like to manage their own daily activities, (*see* R.A. Decl. ¶¶ 17-24; N.B. Decl. ¶¶ 31-33; A.C. Decl. ¶¶ 12-13; L.J. Decl. ¶¶ 25-30; B.R. Decl. ¶¶ 22-23; H.S. Decl. ¶¶ 20-22), adult homes either outright prohibit or actively discourage residents from doing their own cooking, laundry, housekeeping,

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[10] If residents attend day treatment programs outside the home, they go to the programs in vans or buses with other mentally ill residents of the same home (E. Jones Aff. Ex. A at 3, 8; G.H. Dep. 34:4-11, 245:6-247:5), spend the day with other people with disabilities, and then return to the home where they take their meals and share their rooms with other mentally disabled people.

[11] To the extent adult homes arrange outings, they are group outings attended entirely by people with disabilities and usually limited to as many people who can fit in a van. (E. Jones Aff. Ex. A at 3; L.G. Dep. 37:12-19; *see also* Levine Dep. 255:12-19; R.H. Dep. 49:16-20; S.P. Dep. 22:4-23:8.)

grocery shopping, and taking their own medication (Schwartz Dep. 319:9-320:3, 331:10-332:11; A.M. Dep. 95:25-96:9; S.P. Dep. 64:11-65:2; G.L. Dep. 202:13-212:20, Duckworth Dep. 142:8-21).

The homes impose an array of restrictions on the lives of people with mental illness who reside in them, including limitations on receiving visitors, lack of privacy, rigid schedules for meals, long lines for the administration of medications and the distribution of personal needs allowances, and repetitive program and recreational activities. (E. Jones Aff. Ex. A at 5-6; Schwartz Dep. 317:16-318:7.) Adult home residents have no choice in when they eat, what they eat or with whom they share a meal. (Geller Decl. Ex. A at 12-13 (citing Brooklyn Manor rules); B.R. Decl. ¶ 12 (residents with diabetes must take their meals with everyone else with diabetes, 30 minutes before others eat.); E. Jones Dep. 148:18-22 (visitors not permitted to join those they visit at meals at some adult homes).)

Adult homes have curfews and visiting hours. (G.L. Dep. 227:2-7; D.W. Dep. 132:4-14; E. Jones Aff. Ex. A at 3; Kessler Dep. 423:22-425:7; P.C. Dep. 98:19-25; Burstein Dep. 20:5-7; Schwartz Dep. 325:15-23.) Visitors must identify themselves and sign in and cannot join in meals or stay overnight. (D.W. Dep. 132:15-17; B.J. Dep. 115:12-15; E. Jones Aff. Ex. A at 3, 8; *see also* Geller Decl. Ex. A at 12-13 (citing Brooklyn Manor rules).)

Adult home residents have almost no privacy. Because at least two residents (both with mental illness) are generally assigned to live as roommates in the same room, residents usually have no private space in which to receive visitors except with their roommate's permission. (S.P. Dep. 134:24-136:9; O.J. Decl. ¶ 13; H.S. Decl. ¶

11; G.H. Dep. 128:21-25; E. Jones Aff. Ex. A at 5.) Residents receive visitors and share phones in noisy common areas (D.N. Dep. 238:17-241:16; S.B. Dep. 60:20-61:19; G.H. Dep. 159:14-24; E. Jones Aff. Ex. A at 3), and depend on calls coming through home switchboards and/or on extensions or payphones in common areas (B.J. Dep. 125:7-126:13; S.P. Dep. 68:15-69:10) that lack privacy and are often chaotic (L.G. Dep. 116:13-118:21; J.M. Dep. 53:22-54:20; D.N. Dep. 238:21-244:21). As a result, any friendships and romantic relationships that do exist typically predate admission to adult homes. (R.H. Dep. 96:12-97:9; G.H. Dep. 120:7-124:5, 126:24-128:9, 240:6-15; B.J. Dep. 53:5-25; D.N. Dep. 15:8-16:7, 29:6-31:8, 63:13-15.) Residents also see living in an adult home as a barrier to paid employment. (*See* A.M. Dep. 31:25-32:19.)

Throughout this litigation, residents of the adult homes have expressed their isolation as a result of being segregated in adult homes. (*See, e.g.*, R.A. Decl. ¶ 9 ("I feel stuck here."); N.B. Decl. ¶ 15 ("There isn't any opportunity to interact with people who aren't patients here."); A.C. Decl. ¶ 8 ("I want to see what life is like on the outside."); O.J. Decl. ¶ 16 ("The area over here feels deserted."); B.R. Decl. ¶ 18 ("I don't know anyone in the neighborhood outside of Garden of Eden"); T.M. Dep. 110:19-24 ("It's difficult to meet different people now . . . [because y]ou're in program, you're in home."); S.P. Dep. 58:9-15 (stating that he feels "isolated" living in his adult home because "they don't do anything [and e]verybody's like indoors on top of one another").

The State itself views adult homes as settings that are segregated from the community. It has acknowledged that because of a lack of housing, people with mental illness are "stuck in adult homes." (Murray Decl. Ex. 71 at 1 (New York State Office of

Mental Health, Guiding Principles for the Redesign of the Office of Mental Health Housing and Community Support Policies).)

E. Supported Housing

OMH Supported Housing is a category of housing for people with mental illness in which residents live in apartments that are generally "scattered-site," meaning that they are scattered throughout the community in regular apartment buildings rather than clustered in one building (Baer Dep. 109:4-8; 150:5-153:20; Schwartz Dep. 198:11-199:7; Tsemberis Dep. 20:12-20.) Supported housing is permanent housing. The residents either hold the lease to the apartment themselves or are sub-tenants of the housing provider. (Tsemberis Dep. 46:19-47:18.) Residents in supported housing can come and go at any hour of the day, maintain their own schedules for meals, have overnight visitors, and in most ways, live like any non-disabled member of the community and among non-disabled members of the community. (Schwartz Dep. 202:2-5.)

Services in supported apartments are flexible, so that residents may receive help with cooking, shopping, budgeting, medication management and making appointments as needed, but can do all of these things themselves if they are able (Schwartz Dep. 191:4-12, 193:22-194:15, 195:20-196:23, 288:13-24, 289:7-290:6l; Tsemberis 28:1-29:22; Duckworth Aff. Ex. A at 10.) The flexibility of services means that they can be increased or withdrawn as necessary and are usually more intensive when a person first moves in. (Baer Dep. 108:15-109:3; Schwartz Dep. 187:22-188:9.) Some residents receive only one or two visits per month from a case manager. Those who need more intensive services may have an Assertive Community Treatment (ACT) team, which consists of six to eight staff members from the fields of psychiatry, nursing, social

work, substance/alcohol abuse, vocational rehabilitation, and other areas of expertise. (Murray Decl. Ex. 72 (New York State Office of Mental Health, Assertive Community Treatment (ACT)).) OMH has promoted the use of ACT as an evidence-based, best practice for serving individuals with mental illness. (Duckworth Decl. Ex. A at 15; Murray Decl. Ex. 73 (New York State Office of Mental Health, Implementing Evidence-Based Practices and Quality Care in New York State).)

F. Numerous Adult Home Residents with Mental Illness Desire to Live in More Integrated Settings

Adult home residents with mental illness desire to live in the integrated setting of their own apartment rather than the highly segregated environment of the adult home. (*See* R.A. Decl. ¶ 9 ("I want to move out of this place. I feel stuck here."); N.B. Decl. ¶¶ 11-18; A.C. Decl. ¶ 8 ("I would like to move out of here. I want to see what life is like on the outside."); O.J. Decl. ¶ 7 ("I would like to move because I want to do my own cooking, cleaning, decorating, and shopping, and I want to handle my own money."); B.R. Decl. ¶ 6 ("I would like to move out. I want to experience being out in life again."); H.S. Decl. ¶¶ 10-11; S.B. Dep. 98:11-24, 111:12-16; L.G. Dep. 102:15-21; L.H. Dep. 121:25-122:11; G.H. 8:21-10:14; C.H. Dep. 127:25-129:13; I.K. Dep. 94:24-95:2; G.L. Dep. 101:25-102:6; D.N. Dep. 155:7-18; T.M. Dep. 98:8-13; S.P. Dep. 106:21-107:7, 137:18-137:21 ("I just want to get out. I want to get out. I don't like it. I want to get out of there, before anything else serious happens."); D.W. Dep. 144:3-9, 187:11-12.)

The results of a State-sponsored study of adult home residents with mental illness confirm that the majority of such residents desire to live in more independent settings, including in supported housing. The New York State Adult Home Assessment

Project, a $1.3 million study of 19 adult homes in New York City, concluded that approximately thirty-five percent of the residents with mental illness assessed stated that they wanted to move to their own apartment, and another 21.2% expressed a desire to move in with their family. (Bruce Dep. 94:23-95:6; *see also* Raish Decl. Ex. 7 (Adult Home Assessment Project Data Documentation, 2003-2005); Liebman Dep. 25:20-22 ("[P]art of the assessment process was to review to see if there were people who wanted to live in other settings."); Murray Decl. Ex. 118 (Analytic Plan for Adult Home Assessments).)[12] Examining these same data, and excluding four adult homes not a subject of this litigation, DAI's expert, Dr. Ivor Groves, concluded that of 2080 residents, "1,536 expressed either (A) explicit interest in living elsewhere, including in an apartment, in supported living, or with family and relatives, or (B) did not express a preference for living in the Adult Home where they were residing." (Groves Aff. Ex. A at 4.) These results confirmed the impressions of Lisa Wickens, the DOH official responsible for explaining the Assessment Project to residents at "town hall" meetings, who testified that residents repeatedly asked her "'When do I do the assessment, when can I leave?'" (Wickens Dep. 74:21-22.)

[12] The Adult Home Assessment Project, "greatly underestimates those who would want to move if given a meaningful choice." (Duckworth Aff. Ex. A at 14; *see also* E. Jones Aff. Ex. A at 10; Groves Aff. Ex. A at 4-5.) In answering questions about their housing preferences in the Adult Homes Assessment Project, residents "were never told about what alternatives would be available or what supports could be offered to meeting their needs in the community." (Duckworth Aff. Ex. A at 14; Bruce Dep. 97:12-18 ("Q. When people were asked that question about their own apartment, was any effort made [before] asking the question to educate them about the availability of supported housing as an option? A. No."); Groves Aff. Ex. A at 5 ("If more information regarding options were available and if a range of supports and living settings were available, a great majority of the current residents would choose to live elsewhere").)

DAI's expert, Elizabeth Jones, similarly found that roughly 90% of the adult home residents whom she interviewed expressed a desire to live somewhere else if there were options available. (E. Jones Aff. Ex. A at 3; E. Jones Dep. 130:4-13; *see also* Duckworth Aff. Ex. A at 14-16.) Even defendants' psychiatric expert, Dr. Jeffrey Geller, concluded that 67 out of 134 residents for whom he reviewed records that he sampled want to live some place other than the adult home. (Geller Dep. 209:2-6.)

Most residents of adult homes were not given a meaningful choice when they moved to an adult home. (Duckworth Aff. Ex. A at 15 ("[A]dult home residents I met were frequently given no choice about where to live. At best, if there were given a choice, it was between two adult homes."); E. Jones Aff. Ex. A at 9 ("Residents were admitted to the adult homes with little or no choice."); *see* H.S. Decl. ¶ 7 ("When they moved me out of Seaport, they didn't give me a choice about whether to go to an adult home or not. I had to go to an adult home."); B.R. Decl. ¶¶ 8-9; P.B. Dep. 30:16-17; M.B. Dep. 19:5-17; L.G. Dep. 9:25-10:12; G.H. Dep. 267:8-268:17; T.M. Dep. 28:23-29:6; J.M. Dep. 10:12-24; D.N. Dep. 13:6-11; S.P. Dep. 93:20-94:23; D.W. Dep. 192:9-193:23.)

G. Virtually All Adult Home Residents with Mental Illness Are Qualified for Supported Housing

Based upon his review of residents' records and in-person interviews, DAI's psychiatric expert Dr. Kenneth Duckworth concluded that "existing supported housing programs in New York could appropriately serve virtually all of the adult home residents with mental illness in the homes that are the subject of this litigation." (Duckworth Aff. Ex. B at 2; Duckworth Aff. Ex. A at 5 ("There are no material clinical differences between adult home residents and supported housing clients.").)

Based upon her interviews of approximately 180 residents of 23 of the adult homes at issue in this case, Ms. Jones found that the vast majority of them were qualified for supported housing with appropriate supports. (E. Jones Aff. Ex. A at 1, 3; E. Jones Dep. 78:15-84:11, 88:6-23, 93:20-94:10.) Dr. Ivor Groves's analysis of the Adult Home Assessment Project data reached a similar conclusion. Of the 2,080 residents in the adult homes of interest, "most, if not all, of the residents of Adult Homes could live in the community with appropriate levels of support." (Groves Aff. Ex. A at 4.)

Consistent with DAI's experts, the State's own analysis reflects that large numbers of residents of adult homes with mental illness can live more independently. The State recently reported that of the 1,688 residents examined in the Adult Home Assessment Project for whom mental health diagnoses and complete cognitive scores were available, 650 (39%) were judged to have sufficient cognitive functioning for independent living. (Murray Decl. Ex. 74 at 28 (Adult Home Assessments, PowerPoint Presentation-Draft (Nov. 2006).) Likewise, defendants' expert, Dr. Jeffrey Geller also concluded that 66.5% out of a group of 188 adult home residents are not in the most appropriate residential setting for their needs. (Geller Dep. 135:10-19; Geller Decl. Ex. A at 44.) In an analysis of a second group of 206 residents, Dr. Geller found that 134 out of 206, or 65% of the residents were eligible for OMH's community housing program. (Geller Decl. Ex. B at 6-7.) Of those 134 residents, 66 residents could leave the adult home and go into supportive housing, including 59 who could leave with over eleven hours of supportive case management or less, and seven who could leave after transitional housing. (Geller Dep. 196:10-199:22, 210:7-17.)

These opinions are consistent with the report issued by the Adult Home Workgroup, which concluded that 50% of residents of adult homes with mental illness could reside in more integrated setting and that most of these would move to OMH community housing.[13] (Raish Decl. Ex. 57 at 30 (Report of the Adult Care Facilities Workgroup (Oct. 2002); *see also* Murray Decl. Ex. 76 at 20 (Report of the Sub-Workgroup, New Models for Adult Care Facilities).) They are likewise consistent with the testimony of State officials that residents of adult homes with mental illness could live in more integrated settings (Wickens Dep. 46:8-11; Tacoronti Dep. 225:16-226:8; Reilly Aff. ¶ 25); and with the testimony of treatment professionals for adult home residents that most, if not all, the clients served could live in more independent, less restrictive settings (Levine Dep. 82:7-85:15).

H. Defendants Have Not Developed a Plan to Ensure that Persons with Mental Illness who Reside in Adult Homes Can Move to Integrated, Community-Based Settings

In 2002, New York established the Most Integrated Setting Coordinating Council ("MISCC") "[i]n order to ensure that the state of New York is in compliance with the requirements of the *Olmstead* decision" and "to develop and implement a plan to reasonably accommodate the desire of people of all ages with disabilities to avoid institutionalization and be appropriately placed in the most integrated setting possible." (Murray Decl. Ex. 76 (N.Y. EXEC. LAW § 700).) MISCC's Final Report called for each state agency to have "measurable standards by which the state agency can demonstrate its

[13] The Adult Home Workgroup was formed to develop recommendations for improving the quality of life in adult homes servicing people with mental illness in the wake of press reports of widespread abuse of adult home residents. (Raish Decl. Ex. 57 at ii.) DOH and OMH participated in formulating these recommendations, and then-Governor Pataki directed the group's work. (*Id.*; Wollner Aff. ¶ 23.)

accountability to MISCC general principles and guidelines." (Wollner Aff. Ex. BB at 23.) Among these general principles and guidelines, the Report listed specific data state agencies should collect in order to monitor and assure compliance with *Olmstead*. The MISCC Report stated that:

> "• Individuals living in institutions should be regularly assessed to explore opportunities that meet their service needs in the most integrated setting.
>
> • To appropriately plan for a community-based service system, it is important to maintain data on the service needs of individuals, service usage patterns and movement of people.
>
> • People should be able to access needed services at a reasonable pace and data should be collected to demonstrate that this outcome is achieved.
>
> • There should be ongoing reviews of data collected to ensure that there is adequate information to achieve "most integrated setting outcomes" for people with all disabilities of all ages."

(*Id.* at 13.)

New York has not undertaken these actions for mentally ill residents of adult homes. Since defendants do not regard adult home residents with mental illness as institutionalized, they exclude people with mental illness who reside in adult homes from the State's MISCC efforts. (Wollner Aff. ¶ 65 ("DOH does not consider adult home residents to be 'institutionalized' and therefore did not include them in providing data on this subject to the MISCC"); Kuhmerker Dep. 29:7-30:3, 30:21-31:7; *see also* Newman Dep. 180:19-181:17; 176:7-180:11.) They do not assess or ensure that others are assessing people with mental illness who reside in adult homes in order to explore opportunities that meet their service needs in the most integrated setting. (Tacoronti Dep. 30:6-35:19, 202:22-203:6; Defs.' Br. 34.) They do not maintain a waiting list for OMH-funded community housing (Wagner Dep. 70:13-71:2), and the governor recently vetoed a bill to require a waiting list. (*See* Murray Decl. Ex. 77 (S. 568, 2007-2008 Reg. Sess.

(N.Y. 2007); A. 3864, 2007-2008 Reg. Sess. (N.Y. 2007) (New York State Assembly counterpart); S. 568, Bill Summary, 2007-2008 Reg. Sess. (N.Y. 2007).) OMH collects no data to show that adult home residents access community housing at a reasonable pace. (*See* Wollner Aff. Ex. BB at 13.)

In adult homes, there is no expectation that people will move on, and there is no emphasis on skill maintenance or development. (E. Jones Aff. Ex. A at 3 ("[T]he adult homes are permanent placements. Comprehensive discharge planning is non-existent."); *see also* Duckworth Aff. Ex. A at 9; Duckworth Dep. 119:23-120:18.) The State itself views adult homes as settings that are segregated from the community and has acknowledged that people with mental illness are "stuck in adult homes" because of, among other things, a lack of housing. (Murray Decl. Ex. 71 at 1.)

The mental health program staff who serve adult home residents are ill-informed about supported housing. (Duckworth Aff. Ex. A at 14.) Some are decidedly unhelpful. (*See, e.g.*, Kessler Dep. 208:23-210:10; M.B. Dep. 96:25-97:3, 116:16-117:20, 118:21-121:5; L.G. Dep. 105:8-106:24; C.H. Dep. 119:14-25; A.M. Dep. 128:7-132:23.) Indeed, they may discourage residents from moving out. (*See, e.g.*, G.L. Dep. 102:7-103:21, 105:10-107:3, 123:11-124:12).

Some programs provided to adult home residents are grossly infantilizing (*see* M.B. Dep. 54:15-55:23; G.H. Dep. 73:8-20; G.L. Dep. 40:16-21; Mendel Dep. 43:14-43:6), or consist largely of watching TV (*see* S.P. Dep. 22:4-23:8, 24:4-28:25, 39:22-41:20). The continuing day treatment programs that enroll adult home residents are characterized by deficient treatment planning; group TV and movie watching; and art programs varying from high quality to provision of crayons, markers and coloring books.

(Murray Decl. Ex. 78 at 1-6, 13 (New York State Commission on Quality of Care and Advocacy for Persons with Disabilities, Continuing Day Treatment Review).) Although many residents were interested in finding work or learning skills for work, less than 20% of these programs' treatment plans reviewed in a study had treatment objectives for finding work, and only 14% had objectives for obtaining vocational training. (*Id.* at 13.)

Residents do not know about housing alternatives. (E. Jones Aff. Ex. A at 3, 10; *see also* Duckworth Aff. Ex. A at 10.) As a result, they are afraid to leave the adult home. (E. Jones Aff. Ex. A at 10; *see* H.S. Decl. ¶¶ 12-13 ("No one here is helping me move . . . No one has explained the different types of housing to me, or explained how to go about applying. No one has submitted any housing applications for me."); A.C. Decl. ¶ 11 ("No one at Garden of Eden is helping me to find another place to live."); N.B. Decl. ¶ 11 ("When I told the owner of Queens Manor I wanted to leave, he said I couldn't be released, so if I wanted to go, they would put me in the hospital. That's when they put me in Creedmore."), *id.* ¶ 29 ("Because of what happened at Queens Manor, I'm afraid that if I try to leave, they will put me back in the hospital."); R.A. Decl. ¶ 16 ("When I brought up the idea of moving out, the owner, Mr. Rosenfeld, told me that if I move out of here, I will lose my SSI."), *id.* ¶¶ 13-15; B.R. Decl. ¶¶ 20-21; D.N. Dep. 255:15-17 ("Q. Before this afternoon [of the deposition], did you know what an HRA 2000 form was? A. No, I didn't."); *see also* P.B. Dep. 175:4-12; S.B. Dep. 90:11-92:3; L.G. Dep. 105:25-107:21; G.H. Dep. 102:7-25; 144:17-145:6; S.P. Dep. 107:8-20, 110:19-24, 111:20-112:8; A.M. Dep. 134:15-136:6.) Indeed, Defendants' expert, Dr. Geller, confirmed that adult home residents are not adequately informed about what their

housing options are and that they therefore cannot make an informed choice. (Geller Dep. 181:15-21.)

I. Defendants Have Excluded Residents of Adult Homes from More Integrated Housing

Adult home residents are not able to access community housing at a reasonable pace. During the 18 month period from April 2005 to September 2006, 195 adult home residents with mental illness allegedly moved from adult homes to the OMH community housing programs in the entire State of New York, an annual rate of 130 persons per year. (*See* Reilly Aff. ¶ 29.) At that rate, it would take 97 years to place virtually all of the adult home residents with mental illness in more integrated OMH housing, and at least 48 years for only half of them to move.

Defendants have chosen not to reinvest money now spent on adult home residents with mental illness to develop more supported housing for them. The Adult Home Workgroup recommended that the state downsize adult homes and develop capacity to serve approximately 6,000 adult home residents statewide in more integrated settings. (Raish Decl. Ex. 57 at 26-28, 32; *see also* Murray Decl. Ex. 79 at 18 (New York State Commission on Quality of Care for the Mentally Disabled, Adult Homes Serving Residents with Mental Illness: A Study on Layering of Services (2003)) (recommending exploration of ways in which money state pays to fund services in adult homes could be better spent developing alternatives).) Rather than following these recommendations, defendants continue to support large numbers of individuals with mental illnesses in adult homes. (Wollner Aff. ¶ 46 ("State officials ultimately determined not to implement the recommendation for a number of reasons.").)

Neither OMH nor the other defendants have created more than a token amount of supported housing for individuals with mental illness who reside in adult homes. When OMH develops supported housing, it identifies a target population for the housing as a "priority." (Newman Dep. 65:23-66:4; Murray Decl. Ex. 128 at 2-3; Murray Decl. Ex. 55 at 3; Murray Decl. Ex. 56 at 1; Murray Decl. Ex. 80, at 5 (Supported Housing Implementation Guidelines).) Those not designated as a target population are effectively excluded from the beds. (Schwartz Dep. 103:24-104:16; Rosenthal Dep. 102:5-107:9; Lieberman Decl. ¶ 4.) Historically, adult home residents have not been a target group for supported housing. (Murray Decl. Ex. 80 at 5; Newman Dep. 80:2-16; Murray Decl. 128 at 2-3.) It was not until 2005 that OMH, for the first time, designated adult home residents as a target group—along with five other groups—but only for the new supported housing it was developing. (Murray Decl. 56 at 1.)[14] Even when OMH designates adult home residents as a target group for supported housing, the residents rarely get access. In practice, the beds go to other target groups, such as individuals coming out of psychiatric hospitals, prisons, or jails. (Raish Decl. Ex. 32 (Response to Davin Robinson's FOIL Request Dated Jan. 9, 2006); Lasicki Dep. 172:8-17.) Accordingly, very few former adult home residents reside in supported housing.[15] (Lieberman Decl. ¶¶ 5-8; Rosenthal Dep., July 12, 2005, 102:5-107:9.)

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[14] The total number of beds developed by the 2005 RFP was 318. *Id.* The legislature also funded a small number of supported housing beds—60 for the entire state—that were specifically reserved for adult home residents. (*See* Murray Decl. Ex. 81, at 3 (Request for Proposals: Supported Housing for Adult Home Referrals).)

[15] In 1990, 1999, and 2006, the State of New York and the City of New York concluded agreements to develop housing specifically targeted for homeless individuals with mental illness. (Murray Decl. Ex. 82, at 1-2 (Background Info on NY/NY and OMH Residential Resources); Murray Decl. Ex. 83 (Handout on NY/NY Criterion, The New York/New York Agreement to House Homeless Mentally Ill Individuals).) The first two "New York/New

J. The Relief in This Action

In this action, DAI seeks an order that will require the defendants to comply with their legal duty to provide services in the most integrated setting, by offering supported housing to qualified DAI constituents with mental illness.[16] (Zucker Decl. ¶¶ 19-20.)

The evidence shows that costs to the State would remain constant if the Court were to order such relief. There are significantly higher Medicaid costs for individuals with mental illness residing in adult homes than those residing in supported housing. (Murray Decl. Ex. 84 (2004-05 Medicaid Expenditures by Impacted Adult Home); Murray Decl. Ex. 85 (2004-05 Medicaid Expenditures by Diagnosis); D. Jones Decl. Ex.A at 21-22; D. Jones Decl. Ex. B at 3-6.) Higher Medicaid costs are common in highly institutional environments, such as adult homes, which encourage dependency on institutional care. (D. Jones Decl. Ex. B at 5.) They are likewise consistent with numerous reports indicating widespread fraud and overuse of Medicaid services in adult

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York" agreements created 5,105 units of supportive housing reserved for homeless individuals with mental illness. (Murray Decl. Ex. 83 at 1-2.) The third agreement will create 9,000 supportive housing principally for chronically homeless individuals, families in which the head of household is mentally ill, people with HIV/AIDS, and people with substance abuse disorder who are not mentally ill. (Newman Aff. Ex. C, at 5 (New York/New York III Supportive Housing Agreement).) Thus these 14,105 New York/New York supportive housing beds are totally unavailable to adult home residents.

In 2003, OMH developed 800 units of Service-Enriched Single Room Occupancy (SRO) housing in New York City for which adult home residents were one of the target populations. (*See* Murray Decl. Ex. 55 at 3.) SRO housing shares some features of supported housing but is not supported housing. Few adult home residents got access to these beds. (*See* Lieberman Decl. ¶¶ 6-8.)

[16] DAI does not ask the Court to decide which adult home residents are qualified for more integrated residential mental health services and desire to move. It is the defendants' duty to make these determinations, and DAI seeks an order compelling them to do so.

homes. (D. Jones Decl. Ex. B at 4-5; Murray Decl. Ex. 79; Murray Decl. Ex. 86 (Exploiting Not-For-Profit Care in an Adult Home); Murray Decl. Ex. 87 (A Review of Assisted Living Programs in "Impacted" Adult Homes).) Significantly, "the difference in Medicaid utilization between adult homes and supported housing does not appear to be linked to the severity of individuals' disabilities" because "[t]he State's data show higher Medicaid spending in adult homes whether one looks at only the most seriously mentally ill, the most medically involved, or those in both groups." (D. Jones Decl. Ex. B at 3; Murray Decl. Ex. 84; Murray Decl. Ex. 85; Asimakopoulos Dep. 75:11-76:21.)

Taking into account the higher Medicaid costs in adult homes, the comparative State costs for individuals with mental illness residing in adult homes and in supported housing are as follows:

Funding Source	**Adult Home Costs**	**Supported Housing Costs**
Stipend[17]	$0	$14,197
Medicaid[18]	$15,750	$8,234
SSI[19]	$7,692	$1,044
Total	$23,442	$23,475

In addition to the costs summarized in the table, the State incurs significant additional costs for adult home residents with mental illness which it does not incur for individuals residing in supported housing. From 2003 to 2007, the State spent approximately $10 million on a variety of adult home programs—including the Quality

[17] Myers Aff. ¶ 190.

[18] Murray Decl. Ex. 84 at DOH 0131663-0131664; Murray Decl. Ex. 129 (NYC Medicaid Expenditure Report for CY 2004).

[19] *See* Murray Decl. Ex. 91 (Office of Temporary and Disability Assistance, SSI Benefit Levels Chart effective January 1, 2007). The state's share of an SSI payment for an adult home resident is at the "Congregate Care Level 3" rate of $641 per month, while the state's share for a supported housing resident is at the "Living Alone" rate of $87 per month.

Incentive Program ("QUIP"), the ACF Infrastructure Initiative, the Case Management Initiative, and the Enhancing Abilities and Life Experience Program ("EnAbLE").[20] (D. Jones Decl. Ex. B at 1-3; Wollner Dep. 102:14-20; Wollner Aff. ¶¶ 36-38, 66-67 & Exs. H-P thereto.)

Thus, the record evidence shows that relief in this action will not impose additional costs to the State, as it would use resources now spent on providing services in adult homes to develop supported housing for the individuals residing in adult homes. The development of supported housing for specified populations has a long precedent in New York and can be done here. (Murray Decl. Ex. 82; Newman Aff. Ex. C; Madan Dep. 54:24-55:13, 57:13-59:8.)

[20] The Quality Incentive Payment Program (QUIP) offers a cash bonus to adult home operators who have not significantly violated DOH regulations. (*See, e.g.*, Murray Decl. Ex. 88, at DOH 007351, 007356 (2003 QUIP Funding Announcement).) The ACF Infrastructure grants are for improvements to the physical plant of adult homes, such as adding air conditioning. (*See, e.g.*, Murray Decl. Ex. 89, at DOH 0129146 (ACF Infrastructure Improvement Procurement).) The EnABLE program is intended to increase residents' skills. *See, e.g.*, Murray Decl. Ex. 90, at DOH 0130776 (Enhancing Abilities and Life Experience Program (EnABLE)—Request for Applications).

Argument

The Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), held that unnecessary segregation of individuals with disabilities is a form of discrimination that violates the ADA.[21] *Olmstead* requires states to administer their services to individuals with disabilities in the "most integrated setting appropriate" to their needs. 527 U.S. at 596-97; *see also* 28 C.F.R. § 35.130(d). According to the National Council on Disability, a federal agency, the "most integrated setting" is generally understood to be: (1) "a place where the person exercises choice and control," (2) "[a] home of one's own shared with persons whom one has chosen to live with, or where one lives alone," and (3) "living in the community with everyone else like everyone else." (Murray Decl. Ex. 92 at 9 (National Council on Disability, *Olmstead: Reclaiming Institutionalized Lives* (Sept. 29, 2003).)

The ADA allows a "fundamental alteration defense" to states that have developed a comprehensive and effectively working plan to serve individuals in the most integrated setting. *Frederick L. v. Dep't of Pub. Welfare*, 422 F.3d 151, 158-59 (3d Cir. 2005). To establish the defense, the state must show that affording plaintiffs the relief they seek would be inequitable, taking into account the resources available to the state and its responsibility to serve other individuals with mental disabilities. *Olmstead*, 527 U.S. at 604, 607. Additional cost alone does not establish a fundamental alteration defense. "If every alteration in a program or service that required the outlay of funds

[21] The Court reasoned that (1) institutionalization of individuals who could live in the community perpetuates unwarranted assumptions that these individuals are incapable or unworthy of participating in community life, and (2) confinement in an institution severely diminishes opportunities for everyday life activities such as social contacts, employment, economic independence, and educational advancement. 527 U.S. at 600-01.

were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed." *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1183 (10th Cir. 2003). Congress was clearly aware when it passed the ADA that "[w]hile the integration of people with disabilities will sometimes involve substantial short-term burdens, both financial and administrative, the long-range effects of integration will benefit society as a whole." *Id.* (quoting from H.R. Rep. No. 101-485, pt. 3, at 50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 473).

Under Rule 56(c) of the Federal Rules of Civil Procedure, summary judgment is proper only when "there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law." To support a motion for summary judgment, "the moving party [has] the burden of showing the absence of a genuine issue as to any material fact, and for these purposes the material it lodged must be viewed in the light most favorable to the opposing party." *Adickes* v. *S.H. Kress & Co.*, 398 U.S. 144, 157 (1970). A dispute about a material fact is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Not only "must there be no genuine issue as to the evidentiary facts, but there must also be no controversy regarding the inferences to be drawn from them." *Donahue* v. *Windsor Locks Bd. of Fire Comm'rs*, 834 F.2d 54, 57 (2d Cir. 1987).

As we now show, defendants cannot satisfy these standards.

I.

DAI HAS STANDING TO ASSERT ITS CLAIMS

DAI has standing to bring this action and to obtain the relief sought. DAI is a protection and advocacy agency ("P&A") that is authorized by Congress to advance

the rights of individuals with disabilities through litigation. 42 U.S.C. §§ 10801, *et seq.* It is well established that P&A organizations may bring lawsuits as plaintiffs on behalf of their constituents. *Monaco* v. *Stone*, No. CV-98-3386, 2002 WL 32984617, at *21 (E.D.N.Y. Dec. 20, 2002) ("Congress has authorized [P&A] organizations . . . to bring suit on behalf of their constituents if they can meet the traditional test of associational standing.").[22] Evidence in the record demonstrates that virtually all of the individuals with mental illness who reside in the adult homes in question themselves have standing to sue. Thus, DAI has standing to sue on their behalf.

Defendants' attack on DAI's standing is premised on errors of law and relies on facts that are in dispute. For example, defendants improperly conflate the merits

[22] *See also Doe* v. *Stincer*, 175 F.3d 879, 884 (11th Cir. 1999) ("[A]s the text of PAMII indicates, a protect[ion] and advocacy organization may sue on behalf of its constituents . . . ."); *Trautz* v. *Weisman*, 846 F. Supp. 1160, 1163 (S.D.N.Y. 1994) (same); *Univ. Legal Servs., Inc.* v. *St. Elizabeth's Hosp.*, No. Civ. 105CV00585TFH, 2005 WL 3275915, at *5 (D.D.C. July 22, 2005) (same); *Ohio Legal Rights Serv.* v. *Buckeye Ranch, Inc.*, 365 F. Supp. 2d 877, 883 (S.D. Ohio 2005) ("PAMII provides [P&A] systems with the independent authority to pursue legal remedies to ensure the protection of individuals with mental illness."); *Unzueta* v. *Schalansky*, No. 99-4162, 2002 WL 1334854, at *3 (D. Kan. May 23, 2002) ("Congress may grant an organization standing . . . . In this case, [the P&A organization] is acting under the auspices of [PAMII]."); *Risinger* v. *Concannon*, 117 F. Supp. 2d 61, 70 (D. Me. 2000) (Maine P&A has standing); *Brown* v. *Stone*, 66 F. Supp. 2d 412, 425 (E.D.N.Y. 1999) (New York P&A has standing), *aff'd. sub nom, Mental Disability Law Clinic, Touro Law Center* v. *Carpinello*, No. 04-6619-cv, 2006 WL 1527117 (2d Cir. May 31, 2006); *E.K.* v. *New York Hosp.-Cornell Med. Ctr.*, 158 Misc.2d 334, 337 (N.Y. Sup. Ct. 1992) (same); *Rubenstein* v. *Benedictine Hosp.*, 790 F. Supp. 396, 409 (N.D.N.Y. 1992) ("Given the broad remedial purposes of [PAIMI], and the statutory language apparently conferring a right upon entities such as DAI to pursue legal remedies such as those sought through the present lawsuit, the defendants' motion to dismiss DAI for lack of standing is denied."); *cf. Tenn. Protection & Advocacy, Inc.* v. *Metro. Gov't of Nashville & Davidson County*, No. 3-95-0793, 1995 WL 1055174, at *1 (M.D. Tenn. Nov.14, 1995) (holding that the Protection and Advocacy for Developmental Disabilities Act, similar to PAIMI, authorizes P&A standing); *Martin* v. *Voinovich*, 840 F. Supp. 1175, 1181 n.2 (S.D. Ohio 1993) (same); *Michigan Protection & Advocacy Serv., Inc.* v. *Babin*, 799 F. Supp. 695, 702 n.12 (E.D. Mich. 1992) (same); *Protection & Advocacy, Inc.* v. *Murphy*, No. 90 C 569, 1992 WL 59100, at *10 (N.D. Ill. Mar. 16, 1992) (same); *Goldstein* v. *Coughlin*, 83 F.R.D. 613, 614-15 (W.D.N.Y. 1979) (same).

of DAI's claims with standing to raise those claims: they ask this Court to rule that DAI lacks standing because, in their view, DAI's constituents have failed to establish all of the elements of their claims. But, as another court in this district has explained, "standing in no way depends on the merits of the plaintiffs' contention that particular conduct is illegal." *Brown* v. *Stone*, 66 F. Supp. 2d 412, 423 (E.D.N.Y. 1999) (quoting *Warth* v. *Seldin*, 422 U.S. 490, 500 (1975)). DAI has standing if the record contains evidence that would support standing if credited at trial. *Id*. That is clearly the case here.

A. DAI'S Enabling Statute Authorizes This Suit

DAI is authorized to bring lawsuits on behalf of its constituents—"individuals with mental illness"—by the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. §§ 10801 *et seq*.[23] (*See* Defs.' Br. at 35-36 ("A protection and advocacy organization (PAIMI), such as DAI, may bring claims . . . on behalf of its constituents . . . ."); *id*. at 42-43.)[24] PAIMI authorizes P&As such as DAI to "pursue administrative, *legal*, and other appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in the State." 42 U.S.C. § 10805(a)(l)(B) (emphasis added).[25]

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[23] DAI's mission statement echoes PAIMI. (*See* Murray Decl. Ex. 52 ("Since 1989, it has been the mission of Disability Advocates to protect and advance the rights of adults and children who have disabilities so that they can freely exercise their own life choices, enforce their rights, and fully participate in their community life.").)

[24] Reported decisions sometimes refer to the "PAIMI" program as the "PAMII" program, its prior name. The program was renamed in 2000. *See* Protection and Advocacy for Individuals with Mental Illness Act of 2000, Pub. L. No. 106-310 § 3206, 114 Stat. 1193, 1193-94.

[25] Defendants do not contest that DAI's constituents are "individuals with mental illness" as the term is used in PAIMI.

Defendants argue that subsection (B) of 42 U.S.C. § 10805(a)(1) does not authorize P&As to bring actions on behalf their constituents. (*See* Defs.' Br. at 43 (arguing that subsection (C) is "the only provision [of § 10805(a)(1)] that authorizes PAIMI groups to bring actions 'on behalf' of its constituents").) But not a single court has endorsed defendants' view of the statute, and decisions in the Southern and Eastern Districts of New York have explicitly rejected it. *Brown*, 66 F. Supp. 2d at 425 (finding that plaintiff P&A had standing under § 10805(a)(1)(B) to sue on behalf of current residents of state hospital); *Trautz*, 846 F. Supp. at 1163 ("[I]f Congress merely intended for state systems to act as advocates [and not as a plaintiff] on behalf of mentally [ill] individuals, it would not have included (a)(l)(B) in the statute in addition to (a)(1)(C).").[26]

B. DAI Meets The Requirements For Associational Standing

1. DAI Has Identified Numerous Constituents With Standing

In evaluating whether a P&A has associational standing in a particular case, courts rely on the analysis in *Hunt* v. *Washington State Apple Advertising Commission*, 432 U.S. 333 (1997). *See, e.g., Mink*, 322 F.3d at 1109. Under *Hunt*, DAI has standing to sue if (1) at least one constituent has standing to sue on his own; (2) the interest DAI seeks to protect is germane to its purpose; and (3) neither the claim asserted

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[26] *Univ. Legal Services*, 2005 WL 3275915, at *5 ("PAIMI authorizes organizations like ULS to pursue claims for system-wide change on their own behalf as an advocacy organization under § 10805(a)(l)(B)."); *Oregon Advocacy Ctr.* v. *Mink*, 322 F.3d 1101, 1113 (9th Cir. 2003) (citing subsection (B) of the statute and holding that "Congress clearly intended PAIMI to confer standing on [P&As] to litigate on behalf of those suffering from mental illness."); *N.J. Protection & Advocacy* v. *Davy*, No. Civ. 05-1784, 2005 WL 2416962, at **l-3 (D.N.J. Sep. 30, 2005) (standing on behalf of one thousand individuals "who are currently confined in psychiatric hospitals"); *Monaco*, 2002 WL 32984617, at *25 (standing on behalf of individuals currently facing civil commitment); *Risinger*, 117 F. Supp. 2d at 69-71 (standing on behalf of children with mental illness).

nor the relief requested requires the participation of individual members in the lawsuit. *Id.* (*See* Defs.' Br. at 36 ("to establish associational standing, a PAIMI organization must show that at least one of its constituents would have standing to bring a claim in his own right . . . ." (emphasis omitted).)[27]

Defendants' sole argument under *Hunt* is under prong (1)—defendants assert that DAI has not established that a single resident has standing to sue in his or her own right.[28] (Defs.' Br. at 36.) Contrary to defendants' argument, however, beyond establishing that a single resident has standing to sue in his or her own right, DAI has put forth substantial evidence demonstrating that well over a thousand of its constituents are suffering injury as a direct result of the State's policies, procedures and activities. Indeed, defendants *concede* elsewhere in their brief that DAI has identified 1,536 residents who are qualified to move to more integrated housing but remain stuck in adult homes.[29] (Defs.' Br. at 65.) Thus, it is clear that defendants' attack on standing is simply

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[27] *Hunt* addresses situations in which there is no Congressional enactment explicitly bestowing standing on an organization. Here, however, Congress has statutorily bestowed standing on DAI, as it is authorized to do under Article III. U.S. Const., Art. III, § 2 ("The judicial Power shall extend to all Cases, in Law and Equity, arising under . . . the laws of the United States."); *United Food & Commercial Workers Union* v. *Brown Group, Inc.*, 517 U.S. 544, 558 (1996) (noting that by its enactment of the WARN Act Congress authorized unions to sue on behalf of their members, and that in so doing it abrogated the third prong of the *Hunt* test).

[28] Defendants explicitly concede that prong (2) is satisfied here, namely, that suing to ensure that constituents receive services in the most integrated setting is germane to DAI's purpose. (Defs.' Br. at 36 n.52.) Moreover, defendants appear to concede that prong (3) is satisfied as well. Defendants make no argument that it is essential that constituents participate as parties in this case.

[29] There are numerous other sources of substantial evidence in the record—from both sides—that many of DAI's constituents are able to live and receive services in more integrated settings and would choose to do so if given the opportunity, but remain stuck in segregated adult homes. (*See, e.g.*, E. Jones Aff. Ex. A at 11 (all of the 179 residents she interviewed were qualified for supported housing with appropriate supports); Raish Decl. Ex. 57 at 30 (estimating that 6,000 persons with mental illness residing in adult homes could be moved to

an attack on the merits of DAI's claims. But whether or not DAI ultimately prevails on the *merits* does not deprive it of *standing*. *See Monaco,* 2002 WL 32984617, at *21 ("Whether or not plaintiff Law Clinic can produce evidence to establish the liability of defendant . . . is the 'very heart of the matter in [this] case and does not implicate standing.'" (alteration in original)); *Brown,* 66 F. Supp. 2d at 423 ("[S]tanding in no way depends on the merits of the plaintiff's contention that particular conduct is illegal." (quoting *Warth* v. *Seldin,* 422 U.S. 490, 501 (1975))).

The injuries of DAI's constituents are a direct result of the manner in which defendants administer New York's mental health service system. *See* Section II, *infra* pp. 43-54. Defendants administer New York's service delivery system in a manner that denies DAI's constituents the opportunity to live in integrated settings. DAI seeks an order compelling ***defendants*** to take the action needed to allow adult home residents to live and receive services in more integrated settings. *See International Union, United Auto., Aerospace & Agr. Implement. Workers of America* v. *Brock*, 477 U.S. 274, 283-84 (1986) (plaintiff union had associational standing because it did not seek Court's determination that benefits are due each of its members, but rather an order compelling defendant to correctly determine such benefits). Clearly such an order will redress the injuries of DAI's constituents. (Rosenberg Aff. ¶ 11 ("If ordered to do so by this Court, defendants could . . . secure for DAI's constituents the relief they seek . . . ."); D. Jones Decl. Ex. A at 31 ("New York is entirely capable of developing sufficient capacity in its supported housing program . . . .").)

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supported housing)); Bruce Dep. 111: 8-25 (people assessed in the New York Adult Home Assessment Project could and wanted to live in their own apartment, such as supported housing)); Raish Decl. Ex. 33; *see also supra* pp. 17-27.)

Defendants' argument that those of DAI's constituents who have not submitted HRA applications do not have standing is likewise without merit. (Defs.' Br. at 37-38.) Standing to bring an ADA integration claim does not depend on whether a plaintiff has submitted an application for an agency program, service, or activity. *See Olmstead*, 527 U.S. at 601-03 (requiring community-based care for those qualified and unopposed to it, defining "qualified" as able to "meet[] the essential eligibility requirements" to receive community-based services with or without reasonable accommodation); *see also infra* pp. 67-68.

Further, the record here indicates that, despite defendants' protestations to the contrary, participation in the HRA 2000 application process is not a prerequisite for obtaining more integrated residential services. (Raish Decl. Ex. 50.) Individuals are placed in OMH housing, which includes supported housing, without completing an HRA 2000 application. (*See* Tsemberis Dep. 32:8-36:9; Schwartz Dep. 146:15-147:10, 167:6–17.)

Moreover, the record evidence shows that, for virtually all of DAI's constituents, filing an HRA application would be a futile act. As defendants have conceded, vacancies in supported housing are far outstripped by demand for those vacancies. (*See* Schafer Hayes Aff. ¶ 58; Madan Aff. ¶ 14; Wagner Dep. 67:9-21.) Standing under the ADA is not dependent on futile gestures. *See, e.g.*, *Small* v. *General Nutrition Cos., Inc.*, 388 F. Supp. 2d 83, 88-90 (E.D.N.Y. 2005) (plaintiff has standing to sue an inaccessible store in his immediate neighborhood, and need not make a futile gesture of seeking to enter a store which is known to be inaccessible).

Finally, defendants assert that 807 adult home residents have submitted HRA applications and that, in defendants' own sampling of 1,536 adult home residents identified by DAI's expert Dr. Groves, approximately 9% filed HRA 2000 applications. (Defs.' Br. at 37.) Thus, DAI has standing even if defendants' argument with respect to HRA applications had any merit. *See, e.g.*, *Mink*, 322 F.3d at 1112 (P&A has standing where 7 constituents identified); *Univ. Legal Servs.*, 2005 WL 3275915, at *4 (P&A standing found where 2 constituents identified); *Aiken* v. *Nixon*, 236 F. Supp. 2d 211, 224 (N.D.N.Y. 2002) (1 constituent identified).[30]

2. DAI Has Standing to Seek Systemic Relief

Defendants argue that DAI does not have standing to seek system-wide relief, but its argument is based on the conflation of two discrete and distinct issues—(1) whether DAI has standing to seek injunctive relief and (2) the scope of the relief ultimately ordered. Indeed, none of the cases cited by defendants is on point. Instead, in an attempt to assert an argument that has no support in the law, defendants string together

[30] The cases defendants cite are not on point. *Shotz* v. *Gates*, 256 F.3d 1077 (11th Cir. 2001) involved plaintiffs who had no plans to visit an inaccessible court house and only alleged past discrimination. *Id.* at 1082. This is totally unlike the instant case, where hundreds of individuals with mental illness are currently stuck in adult homes and desire immediate access to more integrated residential mental health services. *Mclnnis-Misenor* v. *Maine Medical Center*, 211 F. Supp. 2d 256 (D. Me. 2002), denied standing to a woman who was denied access to an inaccessible maternity ward during her pregnancy, because it was "conjectural" that she would become pregnant again and need access to the facility. *Id.* at 260. As discussed above, here there is ample evidence that there is nothing "conjectural" about the adult home residents' qualifications and desire for more integrated residential mental health services. *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555 (1992) holds that plaintiffs raising only an abstract "generally available grievance" about government conduct, based only on "citizen[s'] interests," do not have Article III standing. *Id.* at 573-74. DAI raises no such abstract claim here: it sues on behalf of individuals who are denied access to integrated residential mental health services.

cases concerning standing that have nothing to do with system-wide relief and cases concerning system-wide relief that have nothing with standing.

For example, *Lewis* v. *Casey*, 518 U.S. 343 (1996), did not concern whether plaintiff had standing to prove that it was entitled to system-wide relief—it concerned whether there was sufficient evidence at trial to warrant the relief that was ordered by the trial court. *Id*. at 359. DAI does not dispute that the ultimate relief in this case must be commensurate with the evidence presented at trial. But that in no way compromises DAI's standing to seek the relief requested in this case. *Warth* v. *Seldin*, 422 U.S. 490, 515 (1975) (declaratory and/or injunctive relief are prospective in nature, and "it can reasonably be supposed that the remedy, if granted, will inure to the benefit of those members of the association actually injured.").

The other cases cited by defendants are equally inapposite. They concerned whether plaintiff had standing to seek *any* injunctive relief against the particular defendants at issue, not whether that relief could be system-wide. In *Small* v. *General Nutritional Companies, Inc.*, 388 F. Supp. 2d 83 (E.D.N.Y. 2005), a case in which plaintiffs alleged discrimination based on the inaccessibility of a retailer's stores to wheelchair users, the court found that plaintiff association failed to satisfy the first prong of the *Hunt* test because it failed to allege that a single constituent had encountered barriers in the retailer's stores or would have been likely to visit those stores in the future but for those barriers. *Id*. at 97; *see also Clark* v. *Burger King Corp.*, 255 F. Supp. 2d 334, 345 (D.N.J. 2003) (plaintiff failed to allege when any constituent visited restaurant and when any constituent planned to return); *City of Los Angeles* v. *Lyons*, 461 U.S. 95, 105-06 (1983) (plaintiff lacked standing to seek prospective injunctive relief; fact that he

was illegally stopped by police and choked on one occasion did not establish an immediate threat that he would in the future be stopped and illegally choked).[31]

Unlike the cases cited by defendants which involved only isolated instances of injury or the mere uncertain possibility of future injury, there is substantial evidence in the record in this case that defendants' violation of federal law is both ongoing and system-wide. Hundreds if not thousands of persons with mental illness are not in the most integrated setting appropriate to their needs because of defendants' conduct. *See supra* pp. 17-27.

Finally, DAI is not attempting to "evade" Federal Rule 23, as defendants suggest.[32] (Defs.' Br. at 40.) By its very nature, P&A standing is a substitute for class certification. The cases upholding associational standing so hold. *See, e.g.*, *International Union* v. *Brock*, 477 U.S. 274, 289 (1986) (permitting a union, as plaintiff, to assert claims on behalf of its members and recognizing that the "pre-existing reservoir of expertise and capital" that an association can bring to the litigation may make an individual action by an association superior to a class action). Hence, P&As are regularly allowed to bring cases as plaintiff on constituents' behalf without seeking class

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[31] In *Clark* v. *McDonald's Corp.*, 213 F.R.D. 198 (D.N.J. 2003), the court did find that the associational plaintiff had standing to assert its claims for injunctive relief based on the fact that it established that one constituent had standing. *Id*. at 215-16. It expressed no opinion regarding whether organization could prove its claims as to more constituents in later stages of the litigation. *Id.* at 216.

[32] Defendants' argument that DAI cannot obtain injunctive relief because its constituents cannot be bound by the judgment is without merit. It is well-established that DAI may obtain injunctive relief that inures to the benefits of its constituents without naming those constituents. *McDonald's Corp.*, 213 F.R.D. at 207 ("It is almost a bright-line rule 'that requests by an association for declaratory and injunctive relief do not require participation by individual association members.'" (quoting *Hosp. Council of W. Pa.* v. *Pittsburgh*, 949 F.2d 83, 89 (3d Cir. 1991))). Indeed, defendants cite no case in support of their argument.

certification. *See, e.g., Mink*, 322 F.3d at 1116; *Davy*, 2005 WL 2416962 at *3; *Univ. Legal Servs.*, 2005 WL 3275915 at *5; *Aiken*, 236 F. Supp. 2d at 224; *Risinger*, 117 F. Supp. 2d at 71; *Brown*, 66 F. Supp. 2d at 425; *Trautz*, 846 F. Supp. at 1166 n.7 ("[S]hould DAI prevail in its suit for injunctive relief, the practical effect may be indistinguishable from that of a successful class action for injunctive relief."); *Tenn. Protection & Advocacy*, 1995 WL 1055174 at *1. Here, as in *Brock*, defendants have "given [the Court] absolutely no reason to doubt the ability of [the plaintiff organization] to proceed on behalf of its aggrieved members, and has . . . fallen far short of meeting the heavy burden of persuading [it] to abandon settled principles of associational standing." 477 U.S. at 290.[33]

II.

DAI'S CLAIMS ARE PROPERLY BROUGHT UNDER TITLE II OF THE ADA

DAI seeks to end discrimination by defendants in the administration of their service system for individuals with mental illness. DAI's claims do not challenge adult homes' failure to comply with the ADA, as defendants contend. Instead, DAI challenges defendants' decision to rely on adult homes, rather than the more integrated setting of supported housing, to provide residential and treatment services to individuals

[33] None of the cases cited by defendants requires DAI to fashion its claims as class claims, rather than individual ones. *Tennessee Protection and Advocacy, Inc.* v. *Board of Education of Putnam County, Tennessee*, 24 F. Supp. 2d 808 (M.D. Tenn. 1998), merely emphasizes the first requirement of the associational standing: that at least one "member" be identified. *Id.* at 816. *Pennsylvania Protection and Advocacy, Inc.* v. *Houston*, 136 F. Supp. 2d 353 (E.D. Pa. 2001), merely repeats the proposition that a P&A organization identify at least one constituent for which it seeks relief, and that the claims of this constituent must not be moot or unripe. *Id.* at 363-68. The court in *Autism Society of Michigan* v. *Fuller*, No. 05:05-CV-73, 2006 WL 1519966 (W.D. Mich. May 26, 2006), found that the P&A plaintiff in that case lacked standing because the restraint policy at issue was not a "real and immediate" threat to the constituent it identified. *Id.* at *7.

with mental illness. The *Olmstead* decision imposes an obligation on the state agencies responsible for providing services, not on the facilities in which service recipients are needlessly segregated. *Olmstead v. L.C.*, 527 U.S. 581 (1999).

It is defendants' deliberate policy choices that have resulted in DAI's constituents receiving services in adult homes. (Rosenberg Aff. ¶¶ 7-9; Sundram Aff. ¶¶ 8-9.) Defendants determine the settings used in the mental health service system. Statement of Facts, *infra* at pp. 7 to 11; Raish Decl. Ex. 17 (N.Y. MENTAL HYG. LAW § 5.07); Raish Decl. Ex. 36 (18 N.Y.C.R.R. § 485.5); Raish Decl. Ex. 56 at 12.)

Defendants cannot evade their responsibility for ensuring New York's compliance with the ADA by making use of privately operated programs to deliver services to individuals with mental illness. The service system at issue in *Olmstead* itself was partially operated by private providers. Numerous courts have applied the ADA's integration mandate to state service systems that unnecessarily segregate individuals with disabilities in private facilities. *E.g.*, *Radaszewski v. Maram*, 383 F.3d 599, 614 (7th Cir. 2004); *Townsend v. Quasim*, 328 F.3d 511 (9th Cir. 2003); *Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175 (10th Cir. 2003).

A. DAI Challenges Discrimination by Defendants in their Own State Programs and Activities

DAI challenges discrimination by defendants in their own state programs and activities. DAI does not, as defendants suggest, challenge conduct of the adult homes themselves. Instead, DAI complains of defendants' failure to ensure that their service system affords individuals with mental illness the opportunity to receive services in the most integrated setting appropriate to their needs. Defendants have chosen to plan, structure, and administer their state mental health system to deliver services to thousands

of individuals with mental illness in large segregated adult homes rather than in more integrated settings. Due to defendants' policy choices, adult homes are the only option available to many individuals with mental illness, even though such homes are not the most integrated setting appropriate to their needs.

Defendants completely misconstrue the nature of DAI's claims. DAI's claims do not seek to force adult homes to reinvent themselves as community settings. Rather, they seek to compel defendants to change the way they operate their service delivery system by avoiding unnecessary reliance on segregated adult homes to provide treatment and housing to individuals with mental illness. Thus, DAI does not contend that defendants fail to force adult homes to comply with the ADA's integration mandate, but that *defendants* violate the integration mandate.

The Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), required the state Department of Human Resources—not the state *hospital* where plaintiffs were institutionalized—to comply with the ADA's integration mandate. Because the Department ran a service system that delivered services in segregated state hospitals as well as integrated community settings, it had an obligation to ensure that the plaintiffs were not unnecessarily hospitalized when they could be served instead in the community—unless doing so would fundamentally alter the service system. *Olmstead*, 527 U.S. 581. This obligation had nothing to do with whether the Department directly operated the institutional and community facilities or made use of private facilities in its disability service system. Indeed, the community facilities that were part of the state's service system in *Olmstead* were privately operated. *See infra* at II.C. Numerous federal courts have also recognized that *Olmstead* applies to states' administration of service

systems that segregate individuals with disabilities in private as well as public institutions. *Id*.

By contrast, the cases on which defendants rely are completely inapposite. These cases stand simply for the proposition that the ADA imposes no duty on a public entity to force the businesses it licenses to comply with the *licensees'* obligations under the ADA. *See, e.g., Tyler v. City of Manhattan*, 849 F. Supp. 1429, 1441-42 (D. Kan. 1994) (city had no duty under ADA Title II to force restaurants and stores that it licensed and inspected to comply with their ADA obligation to provide wheelchair access); *Reeves v. Queen City Transportation, Inc.*, 10 F. Supp.2d 1181, 1183-88 (D. Colo. 1998) (public utility commission had no duty under ADA Title II to force bus company it certified to comply with its obligations under the ADA); *Alford v. City of Cannon Beach*, 2000 WL 33200554, No. CV-00-303-HU (D. Or. Jan. 17, 2000) (city had no duty under ADA Title II to force restaurants and stores that received city building permits to comply with the ADA, nor a duty to force entities receiving city permits for social events to comply with the ADA); *cf. Blum v. Yaretsky*, 457 U.S. 991, 1005-10 (1982) (actions of nursing home in transferring or discharging residents did not constitute state action simply because state required nursing home to complete forms and could impose penalties). These cases have no applicability to *Olmstead* claims, which concern public entities' obligation to make reasonable modifications to their service systems to enable individuals with disabilities to receive services in the most integrated setting appropriate. *Olmstead* has nothing to do with a public entity's failure to correct discriminatory conduct on the part of service providers it licenses. Furthermore, defendants' view that the ADA's integration mandate does not apply to choices a public entity makes regarding its service delivery system, but

only to the conduct of facilities that the public entity operates, is flatly contradicted by the *Olmstead* decision itself.

B. The Unnecessary Segregation of DAI's Constituents in Adult Homes Results from Defendants' Policies and Choices in Administering Programs and Activities

The State plans, oversees, funds and regulates programs, services and activities for persons with mental illness in a way that leaves thousands of people with mental illness isolated in segregated adult homes. Defendants administer a system of mental health care, including residential and treatment services provided by public and private entities. *See* Statement of Facts, *infra*, pp. 7-11. OMH administers both residential services (*see* Defs.' Br. at 6 n.5 ("Housing Programs")), and treatment services, such as case management, clinic treatment programs, and continuing day treatment programs. It directly provides treatment services to individuals with mental illness in adult homes (Defs.' Br. at 24), and approves contracts by which others do so. (*See* Murray Decl. Ex. 64 (18 N.Y.C.R.R. §§ 487.7(b), (c)(1)) (OMH approves service agreements between mental health providers and operators of impacted homes).)[34]

These programs and activities fall squarely within the scope of Title II of the ADA. Title II bars public entities from discriminating on the basis of disability in their programs, services and activities, 42 U.S.C. § 12132, and covers all programs, services and activities of a state or local government entity "*without* any exception." *Pennsylvania Dep't of Corrections v. Yeskey*, 524 U.S. 206, 209 (1998); *see also Innovative Health Systems, Inc. v. City of White Plains*, 117 F.3d 37, 45 (2d Cir. 1997)

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[34] *See also* Murray Decl. Ex. 94 (DAI's Supplemental Responses and Objections to Defendants' Third Set of Interrogatories, dated Mar. 27, 2006).

("programs, services, or activities" is a "catch-all phrase that prohibits all discrimination by a public entity, regardless of the context").

Defendants have responsibility for New York's mental health services, programs and activities under state law, which requires them to create a state system of services for individuals with mental illnesses, including residential and treatment services, and to plan for how and where these services will be delivered. (Raish Decl. Ex. 17 (N.Y. MENTAL HYG. LAW § 5.07(b)); Raish Decl. Ex. 36 (N.Y. MENTAL HYG. LAW § 7.07).) State law provides that:

> It shall be the policy of the state . . . to develop a comprehensive, integrated system of treatment and rehabilitation services for the mentally ill. Such a system . . . should assure the adequacy and appropriateness of residential arrangements . . . and rely upon . . . institutional care only when necessary and appropriate. . .

(Raish Decl. Ex. 36 (N.Y. MENTAL HYG. LAW § 7.01).)[35]

It is defendants who determine what settings will be developed and funded as part of the state's system. To fulfill their responsibilities, defendants engage in a planning process to determine what needs exist, what types of settings will be used to meet those needs, what resource allocations should be prioritized, and whether resources should be reallocated. OMH, for example,

> formulate[s] a statewide comprehensive five-year plan for the provision of all state and local services for the mentally ill . . . [which shall] identify needs and problems . . . ; specify time-limited goals to meet those needs; identify resources to achieve the goals, including but not limited to resource reallocations; [and] establish priorities for resource allocation . . .

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[35] "The office [of mental health] . . . shall . . . develop an effective, integrated, comprehensive system for the delivery of all services to the mentally ill and . . . create financing procedures and mechanisms to support such a system of services . . . [and] shall make full use of existing services in the community including those provided by voluntary organizations." (*Id*.)

(Raish Decl. Ex. 17 (N.Y. MENTAL HYG. LAW § 5.07(b)(1).) This plan must include a description of "the available community-based . . . community support services," a determination of unmet need, and information on "new or expanded programs or services that may be required" to meet unmet need[s] . . . ." (*Id.* § 5.07(b)(2)(e), (f).)

OMH openly acknowledges the state's role in determining the settings in which individuals with mental illness live and receive services. (Raish Decl. Ex. 56 at 12.) Its Statewide Comprehensive Plan for Mental Health Services emphasizes OMH's accountability for the functioning of the service system—"coordinated, comprehensive networks of providers [that] deliver a balanced array of medical, self-help, social, supportive and rehabilitative services and programs"—as well as its role in coordinating the system. (*Id.* at 4-5.) These descriptions belie defendants' assertions that they are merely licensing and inspecting entities with no responsibility for, or role in determining where, individuals with mental illness live or receive services.

Defendants' insistence that "there is no existing State program, service or activity which provides housing referral services or placement in alternative housing to adult home residents" (Defs.' Br. at 49) is patently false, as defendants' own brief makes clear. (*Id*. at 23 (referencing "activities and programs that are designed to help adult home residents . . . access [OMH] Housing for Persons with Mental Illness").) For example, OMH recently issued a request for proposals for supported housing beds targeted specifically for residents of adult homes.[36] The problem is not a total lack of

[36] Murray Decl. Ex. 81 (OMH Request for Proposals, Supported Housing for Adult Homes, Jan. 2007). In addition, OMH has taken steps to refer adult home residents to appropriate housing when adult homes have closed. (*See, e.g*., Wagner Dep. 86:24-88:9; Tacaronti Dep. 53:18-57:8.)

activity, but that defendants have not taken the steps necessary to ensure that adult home residents' *Olmstead* rights are respected.[37]

Defendants have conducted these programs and activities in a manner that results in little choice for many individuals with mental illness other than to receive needed services in the unnecessarily segregated setting of an adult home. Defendants' administration of residential services and treatment to DAI's constituents in the unnecessarily segregated setting of adult homes is not an accident; it is the direct result of state policy choices. (Rosenberg Aff. ¶¶ 7-9**;** Sundram Aff. ¶¶ 8-9.)

Adult home operators themselves have recognized that it is defendants' exercise of this role that ensures the state's reliance on adult homes to serve individuals with mental illness. A 2003 lawsuit filed against the state by adult home operators alleged that "New York has established a special arrangement with private adult care facilities" to "provide shelter, food and mandated services" to adult home residents, "as set forth in the extensive laws and regulations governing adult care facilities." (Murray Decl. Ex. 132 (*Peluso v. New York*, No. 03119529 (NY Sup. Ct., filed Nov. 12, 2003), Complaint at ¶ 13).) The suit claims that "the State of New York needs" adult homes "in

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[37] Defendants' contention that "in recent years only a small percentage of patients discharged from State hospitals have moved to adult homes" is irrelevant, as DAI's claims concern defendants' administration of the state service system for individuals with mental illness in a manner that makes adult homes the only option available to many individuals; whether the state makes actual placement determinations is not central to DAI's claims. Defs' Brief at 48. Similarly, defendants' contention that adult home placements are "voluntary" is irrelevant, as DAI's evidence shows that adult homes are the only option available to many of its constituents, not that they are involuntarily confined in these homes. *See, e.g.*, *Radaszewski v. Maram*, 383 F.3d 599, 614 (7th Cir. 2004); *Fisher v. Oklahoma Health Auth.*, 335 F.3d 1175 (10th Cir. 2003); *Townsend v. Quasim*, 328 F.3d 511 (9th Cir. 2003); *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995), *cert. denied*, 516 U.S. 813 (1995) (state policies ensuring that only segregated options are available for individuals with disabilities in state's service system may violate the integration mandate, even if placement in the segregated settings is voluntary).

order to gain access" to federal SSI payments, which are not available for individuals in publicly operated institutions. (*Id*. at ¶ 12.)

In discharging their responsibilities to administer a comprehensive system of care, defendants have made, and continue to make, choices that ensure that adult home beds are the only available option for large numbers of people with mental illness. (Rosenberg Aff. ¶¶ 7-9; Sundram Aff. ¶¶ 8-9.) Defendants have chosen to accept adult homes as a treatment and residential setting for thousands of individuals with mental illness who could live in more integrated settings. (*See* D. Jones Decl. Ex. A at 5 ("New York by policy and practice has sanctioned and heavily utilized adult homes as a setting for persons with serious mental illness[,] . . . has done virtually nothing to ensure that adult home residents with mental illness are offered the choice to live in more integrated, non-institutional settings that would afford them the ability to live a normal life . . . [, and] has continued to accept adult homes as a large part of its mental health system.").)[38] As Mr. Jones reported, "New York made a policy decision to utilize adult homes as a major source of placement for persons with mental illness" as part of its effort to downsize its state psychiatric centers. (D. Jones Decl. Ex. A at 6; *see also* Murray Decl. Ex. 57 at 1 (Adult Home Workgroup, THERE'S NO PLACE LIKE HOME: RECOMMENDATIONS FOR IMPROVING THE QUALITY OF LIFE IN ADULT HOMES SERVING PEOPLE WITH MENTAL ILLNESS).)

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[38] OMH's Statewide Comprehensive Plan for Mental Health Services for 2004-2008 reflects that in 2002 there were 12,586 recipients of mental health services lived in adult homes. (Raish Decl. Ex. 56 at 69.) This is more than twice the number of individuals who were served in New York's state hospitals in 2005. (*See* Murray Decl. Ex. 59 (OMH, *Table 1.A: Clients Served During Week of 2005 Pcs by Major Age Group by Program*) (state survey data showed 4,865 individuals over 18 in state hospitals in 2005).)

Not only have defendants declined to use money now spent on adult homes to develop more appropriate housing, despite recommendations for such action, (s*ee, e.g.*, Murray Decl. Ex. 79 at 18; Raish Decl. Ex. 57 at 26-28, 32 (Report of the Adult Care Facility Workgroup)), but defendants have also declined to exert influence over the number of adult home beds. DOH has authority to revoke, suspend or limit an adult home's operating certificate in the public interest—to conserve resources:

> by restricting the number of beds . . . to those . . . actually needed, after taking into consideration the total number of beds necessary to meet the public need, and the availability of facilities or services such as ambulatory, home care or other services which may serve as alternatives or substitutes for the services provided by . . . [an] adult home.

(Murray Decl. Ex. 60 (18 N.Y.C.R.R. § 485.5(m)(1)(i).) DOH could certify that fewer adult home beds are needed to support a shift in funds from adult homes to supported housing.[39] Instead, defendants have continued to support the existence of large adult homes.

As the above discussion shows, the discrimination of which DAI complains stems from programs and activities administered by the defendants here. They have, *inter alia*, refused to plan and develop more integrated settings for adult home residents, shift funds from adult homes to more integrated settings, or use the certificate of need process to facilitate the delivery of services in integrated settings. As a result, thousands of DAI's constituents are unable to live and receive services in the most integrated setting appropriate to their needs.

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[39] The ADA forbids a public entity from administering a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability. 28 C.F.R. § 35.130(b)(6).

C. A State's Use of Private Entities to Deliver Services in its Mental Health System does not Negate the State's Obligation to Comply with the ADA's Integration Mandate

Defendants incorrectly contend that they can eliminate any obligation to comply with *Olmstead* by simply making use of private entities to deliver services in the state's mental health system. The mere fact that the State arranges with private facilities to deliver services as part of its mental health system, however, does not eliminate the State's obligation to operate its mental health system in compliance with the ADA. Indeed, the community service system in *Olmstead v. L.C.* made use of privately operated facilities, as do virtually all state mental health and developmental disabilities service systems. *See* Brief of Respondents in *Olmstead v. L.C.*, 1999 WL 144128, at *5 (noting that Georgia had restructured its system of delivering community services to make use of private providers). Yet this did not mean that these community services were not part of the state's service system or that Title II of the ADA was inapplicable.

In fact, four federal circuit courts have applied the ADA's integration mandate in cases where the state's service system unnecessarily segregated individuals with disabilities in privately operated facilities.[40] *See, e.g., Radaszewski v. Maram*, 383 F.3d 599, 614 (7th Cir. 2004) ("If the State would have to pay a private facility to care for Eric . . . and the cost of that placement equaled or exceeded the cost of caring for him at home, then it would be difficult to see how requiring the State to pay for at-home care

[40] Three of these cases did not specifically discuss whether the nursing homes at issue were or could have been private facilities. However, the decisions clearly view *Olmstead* as applicable to individuals in privately operated nursing homes, which constitute the overwhelming majority of nursing homes. (*See, e.g.*, Murray Decl. Ex. 95 at 20 (NURSING FACILITIES, STAFFING, RESIDENTS, AND FACILITY DEFICIENCIES, 1995-2001) (in 2001, only 6.4 percent of Medicaid- and Medicare-certified nursing homes across the country were government-operated).)

would amount to an unreasonable, fundamental alteration of its programs and services."); *Townsend v. Quasim*, 328 F.3d 511 (9th Cir. 2003) (state's decision to fund nursing services for certain Medicaid recipients only in nursing homes would violate ADA unless state could demonstrate that offering nursing services for these individuals at home or elsewhere in the community would fundamentally alter the state's Medicaid program); *Fisher v. Oklahoma Health Care Auth*., 335 F.3d 1175 (10th Cir. 2003) (state's decision to fund more prescription drugs in Medicaid-covered nursing homes than in its Medicaid home and community-based waiver program would violate ADA unless state could demonstrate that funding comparable prescription drug coverage in the waiver program would fundamentally alter the state's Medicaid program);[41] *Helen L. v. DiDario*, 46 F.3d 325, 328 (3d Cir. 1995), *cert. denied*, 516 U.S. 813 (1995) (pre-*Olmstead* case finding violation of ADA's integration mandate where state public welfare department ran "two different programs that provide physically disabled persons with assistance in daily living"—nursing homes and attendant care provided in an individual's own home—and plaintiffs were unnecessarily institutionalized in nursing homes). Other courts have ruled similarly. *Martin v. Taft*, 222 F. Supp. 2d 940, 946 (S.D. Ohio 2002) (denying motion to dismiss claims against state in *Olmstead* case where plaintiffs were institutionalized in both public and private institutions); *Rolland v. Cellucci*, 52 F. Supp. 2d 231, 237 (D. Mass. 1999) (finding it immaterial for purposes of *Olmstead* claim against state that

[41] Defendants' attempt to distinguish *Fisher* is unavailing. Like DAI's constituents in this case, the *Fisher* plaintiffs were not placed by state officials in nursing homes or directly required by state policy to enter nursing homes. Instead, the state's policy of funding more prescription drugs in the nursing homes than in the community left many individuals little choice but to enter nursing homes. *Id.* at 1179. Similarly, in this case, state policies have left DAI's constituents little choice but to live in adult homes.

many of the plaintiffs lived in private rather than public nursing facilities).[42] In each of these cases, *Olmstead*'s requirements were triggered by the state's choices in administering its service system for people with disabilities. Who owned the facilities where individuals were segregated was irrelevant.

Thus, it is clear that defendants cannot evade their responsibilities under *Olmstead* simply by arranging to use privately operated facilities as part of the state service system for individuals with mental illness.

III.

DAI'S CONSTITUENTS ARE NOT IN THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS

The ADA and the Rehabilitation Act forbid unnecessary segregation and require defendants to serve individuals with mental illness, including adult home residents, in "the most integrated setting" appropriate to their needs.[43] Defendants must adhere to this requirement in *all* of their programs, services, and activities, including the provision of treatment and residential services to adult home residents.

The record evidence in this case demonstrates persuasively that defendants' delivery of services to residents of large adult homes—where nearly all residents have been diagnosed with one or more severe mental illnesses—violates the ADA's requirement that services be provided in the most integrated setting. Residents

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[42] The Justice Department has recognized that *Olmstead* applies to state service systems that segregate individuals in facilities that are not state-operated. (*See* Murray Decl. Ex. 96 (Findings of Department of Justice, Civil Rights Division, Re: Laguna Honda Hospital and Rehabilitation Center) (concluding that state violated integration requirement by among other things failing to develop sufficient community services to afford choice to residents of nursing home operated by a locality).)

[43] Defendants' obligations under Title II of the ADA and the Rehabilitation Act are the same. (Defs.' Br. at 32 n.50 (the subtle differences between the two statutes are "not relevant here").) *See, e.g., Henrietta D.*, 331 F.3d at 272.

have little opportunity for interaction with nondisabled adults: they live with other disabled individuals, eat and take medication on regimented schedules, and are subjected to curfews and other restrictions that limit interactions outside the homes. As adult home residents themselves have testified, living in an adult home is in many respects like living in a psychiatric institution. (*See* A.M. Dep. 154:25-155:23; Statement of Facts, *infra* pp. 6 to 29; DAI's Response to Defendants' Statement Pursuant to Local Civil Rule 56.1 ¶¶ 3, 6-9, 22-25; *see also* Defs.' Br. at 61 (adult homes "have some institution-like qualities").) This testimony is supported by DAI's experts and other witnesses, who have explained in depth why adult homes are not the most integrated setting for DAI's constituents—and why supported housing is less isolating, providing far richer opportunities for interactions with non-disabled individuals. (*See, e.g.*, Duckworth Aff. Ex. A at 7-14; D. Jones Decl. Ex. A at 8-13; E. Jones Aff. Ex. A at 4-7.)

Defendants' reading of the ADA eviscerates the statute: they argue that adult homes are "integrated" because residents have *some* opportunities for contact with people who are not disabled. This contention misapprehends key provisions of the ADA and ignores the text of implementing regulations embraced by the Supreme Court in *Olmstead*. Moreover, defendants' description of the record ignores compelling evidence—much of it their own—that adult homes in fact isolate and segregate residents, limiting opportunities for interactions with nondisabled adults. Although it is true that some residents leave these facilities, travel by public transportation, and sometimes hold part-time or volunteer jobs, this simply reflects the extent of residents' ability and desire to be more integrated into their communities—not that they live and receive services in the most integrated setting. Significantly, nowhere do defendants assert that adult homes,

even when they offer opportunities for outside contact, provide greater or equal opportunity than does supported housing.

A. The ADA And Rehabilitation Act Contain An Expansive Integration Mandate

Title II of the Americans with Disabilities Act prohibits discrimination against individuals with disabilities by state and local governments. 42 U.S.C. § 12132. Among the forms of discrimination prohibited by the ADA are the isolation and segregation of individuals with disabilities. (*See* Defs.' Br. at 52 ("The ADA identifies isolation and segregation . . . as forms of discrimination.")); 42 U.S.C. § 12101(a)(2) ("[H]istorically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such . . . discrimination . . . continue[s] to be a serious and pervasive social problem.").

To combat isolation and segregation, Congress outlawed through the ADA governmental activity that unjustifiably circumscribes opportunities available to people with disabilities for "full [societal] participation, independent living, and economic self-sufficiency." *Id.* at § 12101(a)(8). Unjustified institutionalization is one such form of discrimination. *Olmstead*, 527 U.S. at 600. By its very nature, it isolates individuals with disabilities, denies social and other opportunities, and "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.*[44]

[44] As the Court in *Olmstead* noted, the ADA was enacted against the backdrop of—and was intended to bolster—earlier efforts to end the unnecessary segregation of persons with disabilities. 527 U.S. at 599.

The Department of Justice has issued regulations implementing Title II of the Act, applicable to state and local governments.[45] In recognition of Congress's expansive mandate, these regulations require, among other things, that public agencies "administer services, programs and activities *in the most integrated setting* appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. 35.130(d) (emphasis added). "Most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons *to the fullest extent possible*." 28 C.F.R. § 35.130(d), App. A (emphasis added). The Court in *Olmstead* "tacitly endorsed this definition." (Defs.' Br. at 52); *see Olmstead*, 527 U.S. at 597-98.

In an effort to justify the State's actions, defendants excise important concepts from the regulation. They suggest that under *Olmstead* the ADA's integration mandate is satisfied when "qualified individuals with mental illnesses [are] moved from institutional settings to more integrated settings," (Defs.' Br. at 51), and that "the key is whether persons with disabilities have opportunities for contact with nondisabled persons, rather than the number of actual contacts" (*id.* at 52-53). But this interpretation reads the terms "*most* integrated setting" and "interact . . . *to the fullest extent possible*" out of the law. These terms are crucial to a correct understanding of the State's obligations.

The law is clear. Various settings provide persons with disabilities with varying degrees of integration. Some settings are more integrated than others. The proper approach is not one that views the world through a binary, integration-versus-segregation lens. Under the ADA, providing services in settings with some opportunities

[45] *See* 42 U.S.C. § 12134(a) (requiring DOJ to issue regulations enforcing Title II).

for interaction is unlawful if another appropriate setting would provide more opportunities, and the individual in question does not oppose the more integrated setting.

As *Olmstead* and the DOJ regulations instruct, and as defendants would have this Court forget, the ADA integration mandate is not limited to people confined behind the walls of state hospitals or "State-run residences." (Defs.' Br. 60.) The integration regulation simply states that "public entities are to provide 'services, programs, and activities in the most integrated setting appropriate' for a qualified person with disabilities." *Fisher* v. *Oklahoma Health Care Authority*, 335 F. 3d 1175, 1181 (10th Cir. 2003).

Thus, for example, in *Townsend* v. *Quasim*, the Ninth Circuit reversed a lower court's grant of summary judgment against plaintiffs challenging Washington State's policy of requiring certain Medicaid recipients with disabilities to receive services in nursing homes rather than more community-based settings. 328 F.3d 511, 517 (9th Cir. 2003). The court flatly held that, in absence of a fundamental alternation defense, Washington's policy "violates the ADA." *Id.* at 520. Similarly, the Third Circuit has ruled in favor of a nursing home resident who was "not asserting a right to community care or deinstitutionalization per se" but instead complaining that defendant's "failure to provide [attendant care] services in the 'most integrated setting appropriate' to her needs . . . violates the ADA." *Helen L.* v. *DiDario*, 46 F.3d 325, 336 (3d Cir. 1995).

The facts of *Olmstead* itself further confirm this principle. *Olmstead* plaintiff L.C. had some opportunities for contact outside the hospital. As her condition improved while in the state hospital, she

> receive[d] a wide variety of community-care services[,] . . . leaving [the hospital] during the day . . . via public transportation for persons with

> disabilities, to attend a daily community-based program that included social activities, vocational opportunities, and field trips; L.C. returned on the bus each evening to the institution.

Reply Brief at 17-18, *Olmstead* v. *L.C.*, 527 U.S. 581 (1999) (No. 98-536), 1999 WL 220130.

It was on this record that the Supreme Court permitted the plaintiffs' ADA integration claim to go forward: the fact that L.C. had some opportunities to interact outside the hospital with people without disabilities did not end the matter. L.C.'s demand to be placed in a setting that was *more* integrated than the hospital was a cognizable ADA claim. *See Olmstead*, 527 U.S. at 607.

The evidence establishes that supported housing is far more integrated and far less isolating than are adult homes. Hence, under the ADA, when supported housing is appropriate for an adult home resident, the resident must be given the opportunity to receive services in that setting. Tellingly, nowhere in defendants' papers do they claim that adult homes are the ***most*** integrated setting appropriate to the needs of adult home residents—only that these homes are integrated to some degree. Under the ADA, as construed in *Olmstead*, that is not enough.

B. Supported Housing is Far More Integrated Than Adult Homes

By their nature, adult homes limit interaction with individuals without disabilities. There is abundant evidence that adult homes are institutional in nature and pose significant barriers to social interaction. Additionally, there is plentiful evidence that supported housing is far more integrated than adult homes. At the very least, the evidence creates a genuine issue of fact concerning whether DAI's constituents are being served in the most integrated setting.

1. Substantial Evidence Supports DAI's Contention that Adult Homes are Segregated Institutions that Impede Interaction with Non-Disabled Adults

Adult homes are large institutional facilities in which scores of people with mental illness reside together under one roof, have virtually no opportunities to interact with nondisabled persons, and must adhere to rules, restrictions and rigid schedules controlling most aspects of their daily lives. (*See* Statement of Facts, *infra* pp. 11 to 16; DAI's Response to Defendants' Statement Pursuant to Local Civil Rule 56.1 ¶¶ 3, 6-9, 22-25). Both sides' experts agree that in almost all respects, adult homes are akin to psychiatric institutions. (D. Jones Decl. Ex. A at 9-10; E. Jones Aff. Ex. A. at 8; E. Jones Dep. 159:17-161:4; *see also* A.M. Dep. 154:25-155:17 (adult home no different from state hospital except that he could leave the grounds).)

Defendants' expert Alan G. Kaufman, who ran New Jersey's mental health system, found that

> By virtue of the populations served, as well as the physical size and logistics associated with day-to-day operations, Adult Homes appear to share certain characteristics with inpatient psychiatric facilities. Noteworthy among them is that significant numbers of residents suffer from serious mental illness and share similar histories of psychiatric hospitalization. The number of beds in many larger Adult Homes, as well as their physical layout, furnishings, and decorations, also give an appearance similar to that of an institutional setting.

(Kaufman Aff. Ex. A at 8.) Institution-like routines:

> include areas such as inflexible schedules for meals and other daily activities; assigned dining room seating; assigned roommates; rigid medication administration procedures and medication dispensing lines; routinized program and recreational activities; public address announcements; and the constant presence of medical and mental health staff. Moreover, provision by the Adult Home of laundry services, food services, housekeeping, and other daily living services — and the resident's lack of choice in performing these tasks him/herself — is characteristic of mental health institutional settings.

(*Id.* at 8-9.)

Mr. Kaufman concluded that "a large Adult home setting coupled with a high proportion of residents with mental illness can artificially limit the interactions of residents and constrict the diversity of friends and acquaintances." (*Id.* at 10; *see also* Schwartz Dep. 297:24-298:14, 298:25-300:15; Rosenberg Aff. ¶¶ 6, 12 ("The adult homes that are the subject of this case are large, segregated institutions"; "[They] are more like institutions than community settings[, and] they impede the community integration of people with mental illness."); S.P. Dep. 58:9-15 ("Everybody's like indoors on top of one another.").)

Life in the home is highly regimented, and residents have very little control over the activities in their daily lives, most of which occur within the walls of the adult homes. (*See, e.g.*, Schwartz Dep. 317:16-318:7, 325:15-23; Kessler Dep. 423:22-425:7; Geller Decl. Ex. A at 12-13 (citing Brooklyn Manor rules); B.R. Decl. ¶ 12; G.L. Dep. 227:2-7; D.W. Dep. 132:4-14; E. Jones Aff. Ex. A at 3, 8; E. Jones Dep. 243:5-19; B.J. Dep. 115:16-21, 121:19-122:7.) The homes limit residents' ability to interact and maintain relationships with nondisabled individuals. (*See, e.g.*, N.B. Decl. ¶¶ 15-16, 19-20; A.C. Aff. ¶¶ 9-10; B.R. Aff. ¶¶ 16-18; E. Jones Aff. Ex. A at 3, 8; D. Jones Decl. Ex. A at 9; Kaufman Aff. Ex. A at 10-11; Schwartz Dep. 297:24-298:14, 298:25-300:15.)

Defendants cite regulations that require adult homes to assist residents to maintain family and community ties and to provide and encourage participation in community-based activities; they also contend that DOH inspectors monitor compliance with these regulations. (Defs.' Br. at 58 (noting that DOH is supposed to monitor compliance with N.Y.C.R.R § 487.7(g) & (h)).) But the record shows the activities

undertaken by the homes are not meaningful. (*See* Statement of Facts *supra* at 23 to 24; DAI's Response to Defendants' Statement Pursuant to Local Civil Rule 56.1 ¶¶ 3, 6-9, 22-25; N.B. Decl. ¶¶ 19-20; B.R. Decl. ¶¶ 16-18; A.C. Decl. ¶¶ 9-10.) In fact, the record evidence shows that many programs available to adult home residents are infantilizing and conduct virtually no activities relating to daily living skills. (*See* M.B. Dep. 54:15-55:23; G.H. Dep. 73:14-19; E. Jones Aff. Ex. A at 3, 5; Duckworth Aff. Ex. A at 9; Duckworth Dep. 119:23-120:18, 142:8-21.) But even if homes made required efforts, they could not overcome the institutional qualities inherent in a large facility. *See* E. Jones Aff. Ex. A at 4 (noting that in adult homes "[t]he physical environment is institutional"; adult homes "are designed to manage or control large numbers of people. . . . by eliminating choice and personal autonomy, establishing inflexible routines for the convenience of staff, restricting access, implementing measures that maximize efficiency, and penalizing residents who break the rules"); Kaufman Aff. Ex. A at 8 ("[S]ignificant numbers of [adult home] residents suffer from serious mental illness . . . . The number of beds in many of the larger Adult Homes, as well as their physical layout, furnishings, and decorations, also give an appearance similar to that of an institutional setting.").) Furthermore, better enforcement will never make the homes *more* integrated than the supported housing that DAI seeks.

2. Supported Housing is a Far More Integrated Setting than an Adult Home

Supported housing is far more integrated than an adult home. Scattered-site apartments are in apartment buildings where people without disabilities live. (*See* Schwartz Dep. 188:11-25, 198:11-199:7.) Most are apartments for only one client; if they are shared, they are shared with only one or two other people, some of whom may

be family members. (*See id.* at 179:18-180:24; Tsemberis Dep. 101:21-102:12; *see also id.* at 109:16 (noting "[i]t's real housing").)

Clients set their own schedules. There is no regimentation: none is required, they are not living as part of a large group. There are no restrictions on visiting. Clients usually have their own phones. Clients leave their apartments for activities of daily living—to buy food and other necessaries, do laundry, and see a doctor, among other things. In other words, they interact routinely with non-disabled members of their community. (*See* E. Jones Dep. 231:10-25.)

For all of these reasons, it is unsurprising that the experts, as well as a former top official in New York's mental heath system, agree that supported housing is more integrated than adult homes. (*See* D. Jones Decl. Ex. A at 25 ("Supported housing . . . is a home, not a residential treatment setting."); Duckworth Aff. Ex. A at 8 ("In contrast to the apartments in the supported housing model, adult homes have the look and feel of large custodial institutions."); Rosenberg Aff. ¶ 12 ("Without question, supported housing is a more integrated setting than an adult home.").) For the same reasons, it is unsurprising that many adult home residents would prefer supported apartments. *See* Statement of Facts *supra* at 17-19.

As shown above, the focus of the ADA and *Olmstead* is on the "most" integrated setting and interaction with nondisabled individuals "to the fullest extent possible." At the very least, a factual dispute exists over whether adult homes satisfy these obligations, particularly in light of the existence in New York of supported housing as an alternative setting.

IV.

DAI'S CONSTITUENTS ARE QUALIFIED FOR SUPPORTED HOUSING

There is substantial evidence that large numbers of the residents of New York City's large adult homes are qualified to live and receive services in supported housing. (*See, e.g.* Duckworth Aff. Ex. A at 2 ("existing supported housing programs in New York could appropriately serve virtually all of the adult home residents with mental illness in the homes that are the subject of this litigation"); E. Jones Aff. Ex. A at 3, 9 (virtually all of the 179 residents she interviewed were qualified for supported housing with appropriate supports); Groves Aff. Ex. A at 4 (most, if not all, residents of adult homes could live in the community with appropriate supports); Raish Decl. Ex. 57 at 31-32 (estimating that 6000 persons with mental illness residing in adult homes could be moved to supported housing); Bruce Dep. 111:8-25 (people assessed in the New York Adult Home Assessment Project could and wanted to live in their own apartment, such as supported housing); Geller Dep. 196:10-199:22, 210:7-17 (finding that in a sample of 206 adult home residents, 134 were eligible for OMH's community housing program and 66 could live in supportive housing); Murray Decl. Ex. 74 at 28 (Nov. 2006 Powerpoint presentation (finding that of 1,688 residents assessed in the New York Adult Home Assessment Project 39% had sufficient cognitive function for independent living); Tacoronti Dep. 225:16-226:8 (there are a number of residents of adult homes who could live in supported housing); Wickens Dep. 46:8-11, 119:15-120:4 (there are people in adult homes who could live in more integrated settings). DAI's evidence is more than adequate to satisfy DAI's burden under *Olmstead*. *See Olmstead*, 527 U.S. at 602. At the very least, it creates a genuine issue of material fact.

Defendants take three different approaches to this evidence, none of which has merit. First, they argue that some of the evidence should be disregarded because of "methodological" problems: this Court, defendants argue, should not rely on DAI's experts' findings because they did not conduct "in-person clinical examinations" of the residents. (Defs.' Br. at 67.) However, as shown in DAI's opposition to defendants' motion in limine, DAI's experts, each of whom has extensive experience in the mental health field, employed rigorous and reliable methodologies in reaching their opinions in this case. *See* Memorandum of Law in Opposition to Defendants' Motion to Exclude Testimony, Reports and Opinions of Plaintiff's Expert Witnesses at 3-13. There is no support for defendants' assertion that in-person clinical examinations and assessments by multi-disciplinary treatment teams were necessary to an opinion of whether individuals are qualified for supported housing. *Id.* Indeed, defendants did not require Dr. Geller to conduct such examinations before opining on whether sample residents were qualified to move.[46] (*See* Geller Dep. 51:20-56:14.)[47]

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[46] DAI's experts reviewed all individual records reviewed by Dr. Geller. (Duckworth Dep. 209:15-210:12; E. Jones Dep. 266:18-268:5.)

[47] Defendants claim that they have never assessed the "capacity" of any of the adult home residents to move to supported housing. (Defs.' Br. at 66.) This is tantamount to an admission of noncompliance with the *Olmstead* integration mandate. *See Frederick L. v. Dep't of Public Welfare*, 157 F.Supp.2d 509, 540 (E.D. Pa. 2001) ("*Olmstead* does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with mental disabilities."); (Murray Decl. Ex. 97 at 7 (Letter of Timothy M. Westmoreland, Director, Center for Medicaid and State Operations Health Care Financing Administration and Thomas Perez, Director, Office for Civil Rights, United States Department of Health and Human Services, to State Medicaid Directors) (to effectively prevent or correct unjustified institutionalization, state must have reliable sense of how many individuals with disabilities are currently institutionalized and are eligible for services in community-based settings).)

Second, defendants claim that DAI's constituents are not "qualified" to be in supported housing because they do not meet "essential eligibility standards." (Defs.' Br. at 65-66.) Yet defendants do not even define or identify those eligibility requirements, or which of those requirements are essential. Their motion should be denied on that basis alone. There is nothing in defendants' Rule 56.1 statement identifying the eligibility standards for supported housing, let alone those standards properly considered "essential."

Not every eligibility requirement is an "essential eligibility requirement." Whether an eligibility requirement is essential turns on its purpose and whether those who seek access can be accommodated without altering the fundamental nature of the service or activity. *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 688 (2001). The defendants have failed to show that DAI's constituents failed to meet the "essential" eligibility requirements for supported housing.

Instead of identifying the essential eligibility standards for supported housing, defendants claim that DAI's constituents fail to meet two alleged requirements that are neither essential nor imposed: that supported housing clients must need only a "minimal" level of support and that they must have completed an HRA 2000 application. (Defs.' Br. at 37-38 and 66.)

The evidence shows that individuals may participate in supported housing in New York if they need more than "minimal" support, and OMH has admitted it.[48]

[48] Defendant OMH has stated: "Supported Housing provides access to affordable, independent housing and support services based on the needs and desires of the resident. Recipients of Supported Housing may be able to live in the community with a minimum of staff intervention from the sponsoring agency. Others may need the provision of additional supports such as an Assertive Community Treatment (ACT) team of Blended Case

Supported housing clients are provided the level of support they need, and it is frequently more than minimal support. (*See* Duckworth Aff. Ex. A at 7-8; Tsemberis Dep. 48:15-25; Lasicki Dep. 70:3-6.) Residents may receive help with cooking, shopping, budgeting, medication management and making appointments as needed, but can do all of these things themselves if they are able. (Schwartz Dep. 191:4-12; 193: 22-194:15, 195:20-196:23, 288:13-24, 289:7-290:6. Lasicki Dep. 70:5-6.) Services are flexible; can be increased, decreased, or withdrawn as necessary; and are usually more intensive at first. (Baer Dep. 108:15-109:3; Schwartz Dep. 187:22-188:9; Lasicki Dep. 68:3-10.) Twenty-one percent of supported housing residents have case managers to assist them in addition to the case management provided by the supported housing provider. (Lasicki Dep. 99:24-100:2) Defendants admit that ACT teams are available to residents of supported housing, which is a very intensive form of community support available in New York. (Defs.' Br. at 24, 31; *see also* Rosenberg Aff, ¶ 13; E. Jones Dep. 35:21-37:15; Tsemberis Dep. 51:2-4.) In their brief, defendants misrepresent supported housing in New York.[49]

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management (BCM) services. Many recipients will be coping with co-occurring substance abuse disorders and be a various stages of recovery . . . . Services provided by the sponsoring agency will vary, depending upon the needs of the recipient. Supported Housing staff will encourage and assist recipients to develop natural community supports, use community resources and pursue an individualized path towards recovery. Staff will help the individual to establish a household and facilitate the resolution of landlord-tenant issues. It is expected that the need for services provided by the sponsoring agency will decrease over time as the recipient is more fully integrated in the community." (Murray Decl. Ex. 81 at 5-6.)

[49] Defendants claim that they permit some of the supported housing providers to serve only the cream of the crop by excluding individuals who need more than "minimal" support, although the OMH Supported Housing Implementation Guidelines, the RFPs for Supported Housing, the eligibility regulation and the eligibility statute make such individuals eligible for services. This is no defense because defendants, who contract for and pay for these services, can require the providers to serve all eligible individuals. Also, under the ADA, defendants cannot serve only the least disabled eligible persons. *See Hahn Barta* v. *Linn County, IA*, 130 F.Supp.2d 1036, 1050 (N.D. Iowa 2001) (regulations promulgated under both the RA and the

Certainly, defendants have not, as required by *Martin, supra,* demonstrated that permitting individuals who need greater than minimal support would fundamentally alter supported housing or their mental health service system.

Additionally, completing an HRA 2000 is not an essential precondition for obtaining OMH housing. Individuals often enter OMH housing without completing an HRA 2000. (Tsemberis Dep. 32:8-36:9.) And even if the HRA 2000 were a precondition to obtaining OMH housing, it is not an "essential" eligibility requirement as that term is used in the ADA. It is but a step in a bureaucratic process, unrelated to the characteristics of an individual that render him or her suitable for supported housing. *See Olmstead,* 527 U.S. at 602; *Henrietta D.* v. *Bloomberg*, 331 F.3d 261, 277 (2d Cir. 2003). Moreover, a significant number of DAI's constituents have actually completed HRA 2000's.[50] (*See* Defs.' Br. at 37.) As part of the relief in this action, defendants can assist those constituents who have not yet done so to complete HRA 2000 applications. Certainly, defendants have not, as required by *Martin, supra,* demonstrated undisputed facts showing that providing supported housing to individuals who have not yet completed an HRA 2000 application would fundamentally alter their program or activity.

Finally, defendants argue that DAI's constituents are not qualified for supported housing because the records of "some" of the 1,536 residents identified by DAI "reflect[] that the mental health providers who actually treat . . . these residents have concluded they are ***not*** qualified to move from their adult homes." (Defs.' Br. at 67.)

ADA clearly prohibit discrimination based upon severity of disability), and cases cited therein.

50 "From January 1, to January 26, 2006, HRA received 807 applications from adult home residents." Defendants' Rule 56.1 Statement, ¶ 54.

Defendants identify only six such residents,[51] and substantial evidence contradicts defendants' characterization of their records. For example, in October 2000, it was determined that resident M.M (Hathaway Aff. Ex. L) was "ready for housing placement" and that he would "do well in supportive housing." Murray Decl. Ex. 98 (Psychosocial summary for M.M.) Indeed, defendants' expert examined the records of four of the six residents and determined that three were appropriate for supported housing. (*See* Murray Decl. Ex. 99 (Evaluation of Residences for AH Residents for M.M.); Murray Decl. Ex. 100 (Evaluation of Residences for AH Residents for P.W.); Murray Decl. Ex. 101 (Evaluation of Residences for AH Residents for E.R.); Murray Decl. Ex. 102 (Evaluation of Residences for AH Residents for L.B.).)

Plainly, whether the constituents are qualified involves material facts in dispute, and thus defendants are not entitled to summary judgment.

V.

DEFENDANTS HAVE NOT PROVED THEIR "FUNDAMENTAL ALTERATION" DEFENSE

Defendants bear the burden of proving their "fundamental alteration" defense. *E.g., Townsend*, 328 F.3d at 520. As DAI demonstrated in its motion for partial summary judgment, defendants are foreclosed from asserting this affirmative defense because they have failed to develop an *Olmstead* plan. *Frederick L.* v. *Dep't of Public Welfare*, 422 F.3d 151, 157 (3d Cir. 2005). In their motion for summary judgment, defendants make clear they have not undertaken even the most basic step required to develop such a plan—namely, to identify the individuals in adult homes who could be

[51] Defendants offer no evidence that the records reflect "reasonable assessments," as required for deference under *Olmstead*. 527 U.S. at 602.

served in more integrated settings. (Defs.' Br. at 76 (it would be a "new program" for defendants to identify adult homes residents who could live in more integrated settings); *id.* at 78 (it would be impractical to maintain a list of adult home residents who desire supported housing).)[52] Their brief underscores that whatever "plan" defendants may have lacks "reasonably specific and measurable targets" for adult home residents moving to more integrated settings. *Frederick L.*, 422 F.3d at 158, and has no "time-frame," *id.* at 160.

If the Court is not inclined to grant DAI's motion for partial summary judgment, it should deny defendants' motion for summary judgment based on its fundamental alteration defense. Whether the relief DAI seeks in this case would work a "fundamental alteration" is a "complex fact-intensive" inquiry particularly inappropriate for summary judgment. *Martin* v. *Taft*, 222 F. Supp. 2d 940, 986 (S.D. Ohio 2002); *see also Fisher* v. *Oklahoma Health Care Auth.*, 335 F.3d 1175, 1183 (10th Cir. 2003) (fact that outlay of funds is required is not "tantamount to a fundamental alteration"). Moreover, as shown below, defendants have not established that "transferring" adult home residents would increase the State's costs, unjustly impact other programs, or otherwise work a fundamental alteration of their service delivery system.

A. Defendants Have Not Demonstrated That Their Costs Would Increase as a Result of the Relief in this Action

Defendants assert that the relief DAI seeks "would dramatically increase the State's costs." (Defs.' Br. at 72.) Yet, defendants have <u>*never*</u> formulated <u>*any*</u> actual

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[52] One way for the State to identify adult home residents who can live in more integrated settings would be to follow up on the assessments done by New York Presbyterian Hospital. (*See* Defs.' Br. at 20-21.) Instead, defendants asked New York Presbyterian not to use its data to identify residents who could live in more integrated settings. (Bruce Dep. 54:8-55:9.)

estimate of what it would cost to serve qualified adult home residents in supported housing. (Tenenini Dep. 51:13-52:2, Schaefer-Hayes Dep. 188:12-16; *see* D. Jones Decl. Ex. A at 21 ("New York has not done any detailed fiscal analysis on the relief sought.").)

DAI's expert Dennis Jones identified what formulating such an estimate would entail. At a minimum, defendants would: "1) identify adult home residents with the ability and interest (with meaningful choice) to live in an integrated setting, 2) estimate the service needs of the population, e.g. through sampling methodology, 3) evaluate the relative costs for this target population, by comparing current costs of the adult home to the costs of a community-integrated setting for similar individuals, 4) analyze the results, and 5) formulate an implementation plan and cost out the plan." (D. Jones Decl. Ex. A at 22.) Defendants' own expert agreed with Mr. Jones on this point. (Kipper Dep. 24:15-25:14.) Yet, defendants have never performed this analysis.[53]

While defendants have done some analysis of some of the relevant costs—albeit only after this litigation was initiated—DAI's experts have shown that defendants' cost analysis is seriously flawed. (*See, e.g.*, D. Jones Decl. Ex. A at 21; D. Jones Decl. Ex. B at 1-6; D. Jones Dep. 313:15-317:25; *see also supra* Statement of Facts, Section J.) For example, defendants did not properly take into account savings from the Medicaid program. DAI's expert Dennis Jones explains in his report that such savings would be substantial, perhaps as much as $16,000 per adult home resident. (D. Jones Decl. Ex. A at 21; D. Jones Decl. Ex. B at 3-5; D. Jones Dep. 290:18-293:7; *see also*

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[53] Contrary to defendants' protestations (Defs.' Br. at 74 n.128,) it was not for lack of a list of adult home residents who could move to supported housing. DAI produced a list of residents identified as qualified to move to supported housing. (*See* Groves Aff. Ex. B at 4-5; Murray Decl. Ex. 103 (Revised Data Runs—March 2005 Database).) In fact, one of defendants' experts used the list to select a sample of residents. Geller Decl. Ex. A at 2.

Murray Decl. Ex. 84; Murray Decl. Ex. 85.) Defendants claim that Mr. Jones' conclusions are "wholly speculative." (Defs.' Br. at 73.) But substantial evidence supports Mr. Jones conclusion. *See* Murray Decl. Ex. 79 (showing inflated Medicaid costs for adult home residents); Murray Decl. Ex. 104 (Adult Home Payment Sub-Workgroup Report) (acknowledging same).[54]

In addition, defendants' cost analysis assumes both that (a) adult home beds currently occupied by residents with mental illness would be filled when DAI's constituents move to supported housing and (b) as a result, the State's overall costs would increase. However, New York is under no obligation to maintain adult homes at their census, and the State could limit admissions, as has been done in similar "deinstitutionalization" contexts. (D. Jones Dep. 15:17-21, 318:9-14.)[55] Also, assuming the vacated beds would be filled, this would not necessarily increase the State's costs. The actual impact would depend on the costs of the prior placements of the individuals filling the beds, and defendants have offered no evidence regarding what the costs would be.

DAI expert Dennis Jones, former OMH senior deputy commissioner Linda Rosenberg, and former NYS Commission on Quality of Care Commissioner Clarence Sundram have all attested that, taking all relevant factors into account, the relief DAI

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[54] Defendants' expert Mr. Kipper admitted that he failed to evaluate the impact of Medicaid savings, Kipper Dep. 26:22-27:3, but justified this omission based on his "intuitive sense" that such savings would not occur, *id.* at 27:19-29:10, 33:9-34:13.

[55] For example, New York law allows DOH, through a certificate of need process under 18 N.Y.C.R.R. § 485.5(c), to revoke, suspend or limit an adult home's operating certificate upon determining that such action would be "in the public interest" because it would "conserve resources" (*i.e.*, support a state shift in funds from adult homes to supported housing). (Murray Decl. Ex. 122 (18 N.Y.C.R.R. § 485.5(m)(1)(i)).)

seeks can be implemented without increasing the state's costs. (D. Jones Decl. Ex. A at 21-22; *accord* Rosenberg Aff. ¶ 14 ("[I]t would be less expensive for defendants to serve current and future adult home residents in supported housing instead of adult homes."); Sundram Aff. ¶ 12 ("[T]he true cost of segregating persons with mental illness in adult homes is approximately the same as providing them with supported housing in the community[.]").) Defendants may strongly disagree with their analysis, but that disagreement merely creates a factual dispute, not a basis for summary judgment.

Defendants' assertion that an analysis of savings is limited to only OMH's budget, rather than taking into account all the State's savings, flies directly in the face of *Olmstead*. In *Olmstead*, the Supreme Court instructed the trial court on remand to conduct an assessment of the state's actual savings from implementing the relief plaintiffs sought. 527 U.S. at 604-07 & n.16 (rejecting simple comparison of cost of community-based care with cost of institutional care, in favor of analysis of actual fiscal impact). Case law since *Olmstead* has been faithful to this command: a trial court must consider the actual cost of the relief plaintiffs seek. *See, e.g.*, *Frederick L.*, 364 F.3d at 496; *Townsend*, 328 F.3d at 520; *Martin*, 222 F. Supp. 2d at 986 (fundamental alteration analysis requires consideration of "vast array of evidence" including evidence on available resources to cover the costs of more integrated services).

The cases cited by defendants do not support defendants' assertion that this Court must limit its examination to OMH's budget, ignoring the actual fiscal impact of the relief DAI seeks. Those cases treated the "mental health budget" as including more than the budget of the state's mental health department. Each considered, in addition, other state expenditures on individuals with mental illness. *Bryson* treated

Medicaid costs as part of the state's mental health budget. *Bryson* v. *Stephen*, No. 99-CV-558-SM, 2006 WL 2805238, at *7-8 (D.N.H. Sep. 29, 2006). *Bruggeman* did the same, permitting an inquiry into the state's efforts to obtain Medicaid funding for the services at issue. *Bruggeman* v. *Blagojevich*, 219 F.R.D. 430, 434-35 (N.D. 111. 2004). *Frederick L.* viewed the mental health budget as including *all* state funding with a nexus to mental health services. 364 F.3d at 496-97 n.6. The above cases make clear that it is entirely appropriate to consider both Medicaid and other relevant factors in examining the fiscal impact of the relief DAI seeks, instead of limiting the analysis to OMH's budget.

Defendants' own conduct confirms that limiting analysis to OMH's budget makes no sense here. Typically, when defendants conduct fiscal analyses of changes in the delivery of services to individuals with mental illness, they consider the budgets of both OMH and DOH.[56] The budget of DOH is considered because it includes (among other things) the Medicaid program, which is a major source of funding for services provided to OMH clients. (Tenenini Dep. 40:16-41:7; Schaefer-Hayes Dep. 98:11-16.)[57] In essence, defendants in their motion ask the Court to conduct a fiscal analysis using an approach that they themselves reject in making budget decisions.

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[56] For example, to increase funding for mental health services, OMH has developed a variety of initiatives to maximize federal reimbursements under the Medicaid program for services to persons with mental illness. This technique, known as Medicaid maximization, shifts state dollars from OMH's budget to DOH's budget, using the state dollars to generate additional federal dollars. Medicaid maximization, by its very nature, requires treating the DOH budget as part of the state's mental health budget. (*See, e.g.*, Schaefer-Hayes Aff. ¶¶ 72-78; Schaefer-Hayes Dep. 76:5-17; Murray Decl. Ex. 105 at 123 (Portion of OMH 2003-2004 Executive Budget); Murray Decl. Ex. 106 at 145 (Portion of OMH 2002-2003 Executive Budget); Murray Decl. 107 at 4 (OMH Aid to Localities 2003-04 Enacted Budget).)

[57] *See also* Murray Decl. Ex. 108 (Jeffrey A. Buck, Ph.D., Medicaid, Health Care Financing Trends, and the Future of State-Based Public Mental Health Services, Psychiatric Services 54:969-975 (2003).)

B. Defendants Have Not Demonstrated that Other Individuals Would Be Adversely Affected by the Relief Sought in this Action

Because serving adult home residents in supported housing would result in savings, (D. Jones Decl. Ex. A at 21-22), it will not require cuts in programs or prejudice other persons who seek supported housing (D. Jones Decl. Ex. B at 1-6; Rosenberg Aff. ¶ 14.) DAI is not asking defendants to use money now designated for other needy populations to fund a remedy in this case. To the contrary, DAI requests here that funds *currently spent* on adult home residents be spent in another way—to serve DAI's constituents in more integrated settings.

This is precisely the kind of relief anticipated by *Olmstead*. The *Olmstead* plaintiffs asked that the money Georgia was spending on serving them at the hospital be spent instead on serving them in a community residence. The Supreme Court approved their request, but subject to a more searching inquiry than had earlier been conducted; the Supreme Court directed the trial court to examine what it would *actually* cost Georgia to facilitate plaintiffs' move, including savings generated by reduced hospital census. 527 U.S. at 603-07. This case requires a similar analysis.[58]

Redirecting spending—the relief approved in *Olmstead*—is a nationally accepted approach to promoting community integration. (D. Jones Dep. 261:5-262:2.) This approach is often referred to as "money follows the person." (Murray Decl. Ex. 109 (Money Follows the Person Federal Rebalancing Demonstration Grant Summary (March 2007).) It has been used in New York, as well as other states, to facilitate the movement of individuals from segregated to more integrated settings. (*See* Schaefer-Hayes Dep.

[58] The *Olmstead* Court acknowledged that Georgia had no obligation to provide plaintiffs mental health services; however, once Georgia chose to provide services, the ADA required the services be provided in the most integrated setting. 527 U.S. at 603 n.14.

89:20-92:17 (through its community reinvestment program, OMH has reinvested money from state-operated facilities into community services since the mid-1990's by budgeting census reductions in state-operated facilities and commensurately increasing funding for community services); D. Jones Decl. Ex. A at 23 ("this reinvestment [may] occur within the same budget year with money following the consumer as she/he moves to the community.").)

If, as DAI's evidence shows, redirecting money now spent on adult home residents is sufficient to fund the remedy in this case, there will be no prejudice to other individuals served by the State. (D. Jones Decl. Ex. A at 22 (concluding that it would be less expensive to serve adult home residents in supported housing).) No money from "other" programs is required. Defendants have not shown otherwise.

In addition, the relief DAI seeks will not disadvantage others seeking supported housing. DAI is not proposing that supported housing now earmarked for others be redirected to adult home residents. Instead, DAI is proposing to increase the pool of supported housing, with monies currently spent on adult home residents. The evidence indicates that New York can develop additional supported housing for adult home residents, while continuing with whatever plan New York may now have to develop supported housing for other populations. (D. Jones Decl. Ex. A at 31 ("New York is entirely capable of developing sufficient capacity in its supported housing program"); Rosenberg Aff. ¶ 11 ("If ordered to do so by this Court, defendants could . . . secure for DAI's constituents the relief they seek. . . ."); Tsemberis Dep. 238:11-22 (Pathways could create 1,000 supported housing beds over next 5 years if state asked); Schwartz Dep. 225:21-226:19 (Venture House will "certainly knock on the door again"

when state makes funds for supported housing available); Lasicki Dep. 203:7-9 (director of association of community-based housing providers serving over 20,000 people with severe mental illnesses did not "have any doubt that [her] member organizations could serve any client who's in an adult home with mental illness").) The recent response of New York City providers to a Request for Proposal for supported housing underscores that the potential supply of such housing is far greater than what the defendants have sought to tap. When, in 2005, defendants issued an RFP for providers to develop 318 supported housing beds, 44 providers responded with plans to develop 1500 beds. (*See* Murray Decl. Ex. 56 at 3; D. Jones Dep. 148:11-21 (noting response to request for proposals).) Similarly, when defendants recently issued an RFP for 60 additional supported housing beds, OMH received seven proposals but accepted only three. (*See* Murray Decl. Ex. 81 (Request for Proposals, Supported Housing for Adult Home Referrals) and responsive letters; Murray Decl. Ex. 110 (Letter from OMH to Comunilife); Murray Decl. Ex. 111 (Letter from OMH to Transitional Services for NY); Murray Decl. Ex. 112 (Letter from OMH to Postgraduate Center for Mental Health); Murray Decl. Ex. 113 (Letter from OMH to Baltic Street Mental Health Board); Murray Decl. Ex. 114 (Letter from OMH to Center for Behavioral Health Services); Murray Decl. Ex. 115 (Letter from OMH to Federation of Organizations); Murray Decl. Ex. 116 (Letter from OMH to SI Behavioral Network).)

The above evidence makes clear that defendants can provide supported housing to DAI's constituents without prejudicing others the State may be planning to serve.

C. Defendants Have Not Demonstrated that Relief in this Action Would Require Alteration of the State's Programs

Defendants make a number of arguments suggesting that DAI's requested relief would change the nature of defendants' service delivery program. These arguments are not supported by law or record evidence.

Defendants argue that, to the extent they are required to assess and place adult home residents in more integrated housing, "it would create a new program that does not exist, along with an obligation to staff and fund it." (Defs.' Br. at 76.) This contention misapprehends the law: defendants *must* assess and place adult home residents in more integrated housing if it would be more appropriate to their needs and not objectionable to them. (*See Olmstead*, 527 U.S. at 605-06 (court may order community placement for plaintiffs if state lacks plan for meeting ADA's mandate); *Townsend*, 328 F. 3d at 519 ("[P]olicy choices that isolate the disabled cannot be upheld solely because offering integrated services would change the segregated way in which existing services are provided."); *Frederick L.* v. *Dep't of Pub. Welfare*, 157 F. Supp. 2d 509, 540 (E.D. Pa. 2001) ("*Olmstead* does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with mental disabilities."). Moreover, defendants' assertion that they have no program for assessing and placing adult home residents in more integrated settings is at odds with their contention that, under their *Olmstead* plan, they ensure that qualified adult home residents who desire supported housing are identified and helped to move. (Defs.' Br. at 23, 77-79.)

Defendants also argue that DAI seeks to change the nature of supported housing. (Defs.' Br. at 76.) In their brief and affidavits, defendants describe supported housing in New York as a service for individuals with little need for support. Record

evidence contradicts this assertion. (*See* Tsemberis Dep. 48:8-25; Rosenberg Aff. ¶ 13 ("Intensity of services is adjusted based on clients' needs. More services are provided in times of greater need, and fewer services are provided in times of lesser need."); Murray Decl. Ex. 81 at 5 (recognizing that supported housing residents "may be able to live in the community with a minimum of staff intervention" while "[o]thers may need the provision of additional supports").) Moreover, DAI's evidence shows that virtually all adult home residents can successfully live in the supported housing as it is presently configured in New York. (*See* D. Jones Decl. Ex. A at 10-13; E. Jones Aff. Ex. A at 11-12; Duckworth Aff. Ex. A at 18-19; Groves Aff. Ex. A at 4; Rosenberg Aff. ¶ 14; *see also* supra Point IV.)

Defendants contend that providing mental health services to the adult home residents in the most integrated setting appropriate would create an "entitlement" that does not now exist. (Defs.' Br. at 76.) But this is an exercise in semantics: DAI does not seek a new entitlement to treatment or residential services; it seeks only that New York provide services in the most integrated setting to individuals who are already receiving services from New York's mental health system.

Finally, defendants argue that a "set-aside" of housing for a designated population would be "contrary to OMH policies." (*Id.*) But record evidence shows that New York regularly sets aside beds for designated populations. One example is the "New York/New York III agreement," in which OMH designated 9,000 new community housing beds for homeless individuals with mental illness. (*See* D. Jones Dep. 258:12-25, 260:7-14; Lasicki Dep. 85:7-15.) Another is OMH's designation of "priority populations" for supported housing beds developed since 1990. (Defs.' Br. at 78

n.131.)[59] Ironically, there is also an example of defendants' making precisely the type of "set-aside" that DAI seeks here. Recently OMH issued a Request for Proposals for the development of 60 supported housing beds specifically for adult home residents. (Murray Decl. Ex. 81.)

VI.

DAI'S THIRD AND SIXTH CLAIMS FOR RELIEF

DAI's third and sixth claims for relief allege discrimination by the defendants in their methods of enforcement and administration—that is, by failing "to take adequate measures to redress continued poor conditions in impacted adult homes that . . . they do not tolerate in adult homes and facilities that primarily serve individuals with physical disabilities." (Complaint ¶¶ 137-142, 158-165.) Defendants seek summary judgment with respect to these claims. (Defs.' Br. 79-81.) Discovery has shown that since the filing of this case defendants have increased their efforts to redress poor conditions in impacted adult homes. Therefore, DAI is prepared to drop its third and sixth claims for relief.

VII.

THE GOVERNOR IS A PROPER PARTY TO THIS LITIGATION

Defendants ask that Governor Spitzer be dismissed from this litigation because "full relief [can] be provided by the four other named defendants," the Commissioners of DOH and OMH and those agencies themselves. (Defs.' Br. at 82-83.)

As New York's chief executive officer, Governor Spitzer is responsible under federal law for ensuring that New York operates its mental health service systems

[59] Although Defendants tout this policy, the designation of adult home residents as a "priority population" is all but meaningless in practice. *See supra* Statement of Facts, Section I.

in conformity with the ADA and the Rehabilitation Act. No more is needed to show he is an appropriate defendant. *Roland* v. *Celluci*, 52 F. Supp. 2d 231, 243 (D. Mass. 1999) (where governor is responsible for directing, supervising and controlling the executive departments of state government, "there appears to be no dispute that [he is an] appropriate defendant[] with regard to the ADA").

Here, in addition to his general role as chief executive of the state, the record shows that the governor is actively involved in addressing adult home issues. According to a former senior staffer, the governor's office has a direct role in such matters as drafting regulations regarding adult care facilities, (Wollner Dep. 32:21-33:11), issuing requests for proposals and associated departmental recommendations relating to adult home residents, *id.* at 33:8-17, proposing legislation and other initiatives relating to adult homes, *id.* at 33:18-35:12, determining funding for the Office of Mental Health's case management and peer support services, (*id.* at 88:1-9), working with the Interagency Task Force on Housing for People with Special needs to increase access to existing housing and support service programs, (*id.* at 143:1-144:15), initiating the Adult Care Facilities Workgroup and reviewing, modifying, and implementing the Workgroup's recommendations; (*id.* at 145:6-146:2), and directing the governor's capital budget to various housing initiatives relating to special populations. (*Id.* at 49:13-50:10). In addition, the governor appoints and receives reports from state most integrated setting coordinating council. Murray Decl. Ex. 76 (N.Y. Exec. Law §§ 702(1); 703(4).) In short, the governor's office not only plays a key role in shaping the mental health policies of this State but also has access to resources, such as the governor's capital budget, unavailable to the other defendants that could potentially be used to provide relief to

DAI. Without the cooperation of the governor's office, the other defendants in this matter may well be unable to provide DAI with the full relief it seeks in this matter.

If anything, the case relied upon by defendants, *Committee for Public Education and Religious Liberty* v. *Rockefeller*, 322 F. Supp. 678 (S.D.N.Y. 1971), *confirms* that the Governor is an appropriate defendant in this litigation. In that case, involving a constitutional challenge to a statute providing public funding to sectarian schools, the court dismissed the governor as a defendant only because the officials expressly charged by the legislature with "sole responsibility" for administration of the statute were not appointees of the governor, and thus, not subject to the governor's authority. *See id.* at 686 (noting that the Commissioner of Education is appointed by the Board of Regents, which is appointed by the legislature "without gubernatorial approval" and that the Comptroller is elected). Here, in stark contrast, both Commissioner Daines and Commissioner Hogan are appointees of Governor Spitzer and thus part of his administration. *See* Murray Decl. Ex. 133 (N.Y. PUB. HEALTH LAW § 204); Murray Decl. Ex. 134 (N.Y. MENTAL HYG. LAW § 5.03).) Indeed, by statute, the Mental Health Commissioner "serves at the pleasure of the Governor." Murray Decl. Ex. 134 (N.Y. MENTAL HYG. LAW § 5.03.)

Rule 21 provides that parties may be dropped only "on such terms as are just." Because dropping the governor as a defendant at this stage of the case has the potential to limit the relief available to DAI and because defendants identify no specific prejudice they will suffer if the governor remains a defendant, the interests of justice require that the governor remain a defendant.

Conclusion

For the foregoing reasons, DAI respectfully requests that the Court deny defendants' motion for summary judgment.

Dated: New York, New York
December 3, 2007

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