UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

DISABILITY ADVOCATES, INC.,

Plaintiff,

v.

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

Defendants.

03 Civ. 3209 (NGG) (MDG)

DISABILITY ADVOCATES, INC.'S RESPONSE TO DEFENDANTS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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Plaintiff Disability Advocates, Inc. ("DAI") respectfully submits this Response to the Proposed Findings of Fact and Conclusions of Law 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 of the State of New York (collectively, "defendants" or "the State").

Introduction

1. Defendants submitted findings of fact that lack record support and ignore controlling law. They hinge their contentions on conclusory assertions without any evidentiary support. (*See, e.g.*, Defs.' PFF ¶¶ 132–133, 169.) They ignore extensive evidence, including evidence from their own documents and witnesses, that contradict their assertions. (*See*, *e.g.*, Defs.' PFF ¶¶ 45, 51, 53; S-33; P-590.) They distort evidence in the record. (*See, e.g.*, Defs.' PFF ¶¶ 15–27, 169.) They cite materials that are not in evidence. (*See* Defs.' PFF ¶ 65 (citing S-21) and notes 2, 5, 6, 9, 16, 17, 34, 39, 51, 68 (citing deposition transcript excerpts that have not been designated).) And they raise issues that are irrelevant to the claims in this case, or were previously rejected by the Court in its Order resolving the parties' motions for summary judgment. (*See* Defs.' PFF ¶¶ 182–185.)

2. But these tactics cannot conceal what the record evidence conclusively shows:

Adult Homes are Institutions in Which People with Mental Illness Are Segregated

3. Adult Homes are institutions. Throughout these proceedings, defendants and their experts engaged in a semantic exercise, arguing that, while Adult Homes are

institutional, they are not institutions.[1] But, when not staking out a litigation position, defendants themselves acknowledge—as do Adult Home staff and many other people involved in the New York mental health services system—that Adult Homes are in fact institutions.[2]

4. Adult Homes are segregated settings. Virtually every aspect of the lives of Adult Home residents is conducted with scores of other people with mental illness. (*See* DAI's PFF ¶¶ 14, 18, 22.) Although residents are permitted to leave the facilities, their daily life activities are managed and controlled by Adult Home staff who impose rules and regimentation in order to maximize the efficiency of these large, congregate facilities. (*See id.* ¶¶ 18, 20.) Meals, medication, phone calls and mail deliveries are announced over a public address system, and medical and mental health staff are a constant presence. (*See id.* ¶ 19.) Adult Homes have inflexible schedules for meals, taking medication and receiving public benefits. (*See id.* ¶ 18.) Residents are assigned roommates and seats at the cafeteria table, and line up to receive their medications and personal needs allowance at scheduled times. (*See id.*) These and many other characteristics described more fully below and in DAI's Proposed Findings of Fact and Conclusions of Law restrict and impede the opportunity for DAI's constituents to interact with nondisabled persons and to be integrated in their communities.

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[1] *See* Defs.' PFF ¶ 44 ("[A]dult homes are not institutions, although they have some institutional qualities."); Tr. 2897: 10-13 (Kaufman) ("So on balance, while I thought that they shared characteristics with inpatient psychiatric facilities, I did not think that they were actually mental health institutional settings per se."); *see also* Tr. 2357 (Geller).

[2] *See* P-59 (OMH Guiding Principles); P-284 (OMH Guiding Principles); P-142 (Hynes Report) at DAI 2906; P-170 (Adult Home Industry Report) at DAI 3571; Tr. 642:25-643:2 (Rosenberg); Tr. 289:21-290:9 (Tsemberis); Tr. 2045:21-22, 2051:1-5, 2052:16-20, 2053:7-9 (Burstein); Tr. 2241:21-2242:14 (Bear).

5. Supported housing is a far more integrated setting than Adult Homes and enables interactions with nondisabled persons to the fullest extent possible. In supported housing, people with mental illness receive services in apartments scattered throughout the community. (Tr. 236:12–15 (Tsemberis).) Recipients of supported housing have the same freedoms as other apartment tenants do; they can control their own daily lives, maintain their privacy, and have visitors whenever and wherever they like. (DAI's PFF ¶¶ 41–42, 49–51.) Compared to Adult Home residents, supported housing residents have far greater opportunities to interact with nondisabled persons and participate in their communities.

DAI's Constituents Are Qualified for Supported Housing

6. Throughout these proceedings, defendants characterized supported housing in a manner completely inconsistent with their own guidelines, practices and public statements. Defendants asserted that supported housing is solely for individuals who are largely independent and need no more than minimal support. (Defs.' PFF ¶¶ 52–55, 63.) But their own guidelines and requests for proposals explicitly state that while "recipients of supported housing may be able to live in the community with a minimum of staff intervention from the sponsoring agency … [o]thers may need the provision of additional supports such as Assertive Community Treatment (ACT) team, or Blended Case Management (BCM) services." (S-33 (2007 OMH) at OMH 42726–27.) Defendants similarly argued that individuals with mental illness must proceed through a "linear continuum" of settings before they may "graduate" to supported housing. (Defs.' PFF ¶¶ 45–50.) But the public statements of State officials proved that this is false. (*See infra* ¶¶ 34-40.) Indeed, the evidence showed that defendants issued requests for

proposals in which they *required* mental health service providers to accept persons with mental illness directly from psychiatric hospitals and prisons. (*See*, *e.g. infra* ¶ 36.) Thus, the evidence conclusively established that supported housing can and does serve individuals with a wide variety of support needs.

7. The evidence established that DAI's consituents are qualified for supported housing. As DAI's experts concluded, virtually all Adult Home residents can be appropriately served in supported housing. (*See* DAI's PFF ¶¶ 57–72.) None of defendants' attacks on DAI's experts has any merit. Each of DAI's experts has decades of experience overseeing the provision of services to people with serious mental illness in the community, and each expert based his or her opinions on reliable methodologies and extensive research, including numerous visits to Adult Homes, conversations with dozens of Adult Home residents, and reviews of thousands of pages of mental health records and numerous documents relating to defendants' supported housing program and support services. (*See infra*, ¶¶ 209-215.) Not only were the opinions of DAI's experts based on sound methodologies and reliable data, they were entirely corroborated by the other evidence in the record. (*See* DAI's PFF ¶¶ 73–106.)

Defendants Failed to Prove that the Relief Sought Would Constitute a Fundamental Alteration

8. Because of the way defendants administer their mental health service system, DAI's constituents have been systematically excluded from supported housing. (*See id.* ¶¶ 175–183; *infra*, ¶¶ 126-131.) But far from developing a plan to enable DAI's constituents to receive services in integrated settings, the evidence at trial showed that defendants are committed to maintaining the status quo reliance on Adult Homes as settings in which to provide services to people with mental illness. In fact, defendants

admit they have no *Olmstead* plan for Adult Home residents. (*See infra*, ¶¶ 134-149.) Thus, defendants failed to show any attempt, genuine or otherwise, to comply with the integration mandate, and their fundamental alteration defense therefore fails.

9. Additionally, while defendants assert that the relief sought by DAI would impose additional costs on the State, they failed to conduct an analysis to support that assertion and failed to consider several relevant components of the cost to the State of providing services to people with mental illness. (*See* DAI's PFF ¶ 196; *infra*, ¶¶ 150-174.) In fact, the evidence showed that providing services to DAI's constituents in supported housing would cost the State less than providing services to them in Adult Homes. (DAI's PFF ¶¶ 201–26.) Thus, the relief sought would not adversely affect other needy individuals, or work a fundamental alteration of the State's system of care. It also would not alter the nature of the State's mental health programs. DAI simply seeks access to the State's existing supported housing program for all of its qualified constituents.

10. For these reasons, and the reasons set forth more fully below and in DAI's Proposed Findings of Fact and Conclusions of Law ("DAI's Proposed Findings"), DAI respectfully requests that the Court find in DAI's favor and order the relief requested by DAI.

RESPONSE TO DEFENDANTS' PROPOSED FINDINGS OF FACT

I. DAI's Constituents Are Not in the Most Integrated Setting

11. Defendants propose that the Court find that the large, institutional, dependency-based Adult Homes at issue in this case are every bit as integrated as supported housing apartments in which individuals with mental illness reside on their

own or with a roommate in apartments scattered throughout the community. In doing so, defendants ignore reams of evidence from their own witnesses and documents, quote snippets of testimony from Adult Home residents taken out of context, and ignore extensive resident testimony concerning the regimented, segregated, and restricted lives they lead in Adult Homes.

A. Adult Homes Are Institutions

12. While DAI need not prove that Adult Homes are institutions, the overwhelming evidence adduced at trial conclusively established that Adult Homes are, in fact, institutions. Defendants claim that DAI's contention that Adult Homes are institutions is based on a particular set of practices, such as the fact that residents are forced to wait on lines to receive their medications rather than being permitted to self-administer their own medication. (*E.g.*, Defs.' PFF ¶¶ 38.) To the contrary, Adult Homes are institutions for all the many reasons that they are considered to be so by the current OMH Senior Deputy Commissioner for Adult Services, the former Senior Deputy Commissioner of OMH, a former deputy attorney general, a former New York City councilmember, the assistant director of the Jewish Board of Family and Children's Services, the Executive Director of Pathways to Supported Housing and Adult Home residents.[3] They are large, congregate facilities that house dozens of mentally disabled

[3] *See* P-142 (*Private Proprietary Homes for Adults: A Second Investigative Report* (the "Hynes Report")) at DAI 2906 (referring to Adult Homes as "de facto mental institutions"); P-170 (*The Adult Home Industry: A Preliminary Report*) at DAI 3571 (referring to Adult Homes as "satellite mental institutions"); P-59 (OMH Guiding Principles) at 1 ("many people with a mental illness are 'stuck' in . . . institutional settings" including "adult homes"); Tr. 642:25–643:2 (Rosenberg) (calling Adult Homes "mini institutions"); Tr. 289:21–290:9 (Tsemberis) (testifying that Adult Homes have "absolutely an institutional feel. . . institutional look . . . [and] institutional manner"); Tr. 2241:21–2242:14 (Bear) (stating that Adult Homes are

individuals and impose restrictive rules and practices that impede opportunities for interactions with non-disabled persons.[4] (*See* DAI's PFF ¶¶ 9–37.)

13. Defendants attempt to downplay many of the restrictions imposed on Adult Home residents. They acknowledge that homes "require residents to sit in assigned seats at mealtimes" (Defs.' PFF ¶ 42), but they urge this Court to disregard it, because occasionally a resident has managed to get his assigned seat changed *to another assigned seat*. (*Id.*) Defendants trivialize the loss of freedom that is imposed by assigned seating, which impairs the ability to freely interact with others, and which insures that it is virtually impossible to have dinner with a non-disabled guest.[5]

14. Many Adult Home residents cannot freely choose their medical providers, because Adult Homes usually hold their Medicaid cards. (Defs.' PFF ¶ 41; P-542 (L.G. Dep.) 101:8–17; P-569 (G.H. Dep.) 170:21–171:22 ("Q. Can you choose your own doctors if you want to? A. Ha ha. Good luck. Q. What do you mean by that? A. In other words, we can't change them ourselves. They give them to us, and, as they leave, somebody else comes in.").) While acknowledging residents generally do not keep their Medicaid cards, defendants urge the Court to disregard that fact because "it is not true for

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"much like the psychiatric centers where [Jewish Board's] consumers lived for so long"); P-546 (A.M. Dep.) 153:17–155:14) (stating that his Adult Home is "like an institution to me").

[4] Defendants' expert, Dr. Geller, admitted that living in an Adult Home diminishes one's work options and social contacts. (Tr. 2374:8-14.)

[5] Defendants offered no evidence that such restrictions on socialization at meals are imposed even in a locked psychiatric hospital, and several witnesses testified that this is not the practice in psychiatric hospitals. (DAI's PFF ¶ 18.) Defendants, who license Adult Homes and heavily regulate their operation, have not enacted rules or regulations which insure the right to eat meals with persons of one's choosing in a seat of one's choosing, or the right to have meals with guests.

all" residents. (Defs.' PFF ¶ 41 (citing an example of one former resident who managed to keep his Medicaid card) (emphasis added).) Defendants minimize the loss of autonomy and the potential for exploitation that result from the lack of choice of a medical treatment provider. Because they generally cannot hold their Medicaid cards, residents must ask the Adult Home for permission to access community-based medical care, which certainly chills access to integrated medical care. Many Adult Home operators have a financial interest in controlling who provides medical care to residents.[6] As a result, many residents are steered to medical providers who have a business relationship with the Adult Homes. This practice both inflates Medicaid costs and deprives residents of opportunities to obtain medical care in an integrated setting.[7]

15. Defendants admit that most Adult Home residents are not permitted to administer their own medication,[8] but contend that "the decision about whether a resident

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[6] Tr. 1405:3–1407:10 (Reilly) (Adult Homes often rent office space to medical providers at inflated rates which amount to referral fees, and residents are "lined up" to see the medical providers, raising concerns about over utilization of Medicaid).

[7] Defendants have not enacted rules or regulations which insure the right to hold one's Medicaid card.

[8] Tr. 1387:6–1388:2 (Reilly) (acknowledging that medication management is an important skill, but that many Adult Homes do not afford residents the opportunity to demonstrate that skill); *see also* P-546 (A.M. Dep.) 91:16–93:20 (lack of autonomy concerning medication and health decisions), 94:9–18 (regimented medication schedule), 95:2–8 (long medication line), 95:25–96:9 (did not look into self administration because he was told staff must administer medication), 163:6–23 (could not get his medication if he missed the scheduled time); P-538 (B.J. Dep.), 60:12–62:15 (adult homes impose rigid schedules for meals and medications); P-536 (D.N. Dep.) 88:23–89:23 (Adult Home prohibits/discourages residents from taking their own medication); P-545 (J.M. Dep.) 76:9–79:13 (describing medication lines and difficulty getting permission to take one's own medication); Tr. 471:16–23 (G.L.) (resident was not allowed to administer his own medicine while in the Adult Home); Tr. 66–67 (E. Jones) (describing waiver form from Mermaid Manor authorizing Home to retain Medicaid card and to assist resident with medication, regardless of

administers his own medication is not made by the adult home but rather by a physician." (Defs.' PFF ¶ 138.) This mischaracterizes the medication administration procedures imposed by the Adult Homes. Adult Homes generally require residents to sign a waiver form upon admission to the home, which provides the Adult Homes with authority over medication assistance, whether or not the resident is capable of self-administration. (*See*, *e.g.*, P-166 (consent to accept assistance in medication administration). Thus, it is Adult Homes, not physicians, that make the decision to deem all residents presumptively incapable of managing their own medication.

16. Defendants also attempt to minimize this fact by noting that "some" Adult Home residents have managed to regain their right to hold their own medications. (Defs.' PFF ¶ 39.) Given that residents must repeatedly return to the facility for medication, this restriction severely limits the ability to be fully integrated in the community.[9] Thus, defendants' assertion that Adult Homes do not have rules that limit residents' time outside the facility (Defs.' PFF ¶¶ 176–177) is simply not accurate.

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ability to administer medication); P-542 (L.G. Dep.) 70:24–71:9 ("they give you a hard time if you hold you[r] medications").

[9] Defendants, who heavily regulate the operation of Adult Homes, have not enacted rules or regulations which prohibit Adult Homes from presuming that residents cannot manage their medication. Under New York Law, all adults are presumed competent to handle their own affairs unless they have been adjudicated incapacitated in a guardianship proceeding. N.Y. Ment. Hyg. § 33.01 (McKinney's 2009) ("Notwithstanding any other provision of law, no person shall be deprived of any civil right, if in all other respects qualified and eligible, solely by reason of receipt of services for a mental disability . . . ."); *see generally* N.Y. Ment. Hyg. Art. 81 (McKinney's 2009) (guardianship statute requiring due process and court hearing before a person can be deprived of control over one's own affairs). Thus Adult Home residents should be presumed to have the capacity to administer their own medication, to choose whom they eat with, and to hold their Medicaid card and other valuable papers.

17. While there is no formal privilege system, many of the rules and practices of the Adult Homes limit opportunities to leave the facility and to interact with persons outside. And while defendants are able to muster one example of a resident, I.K., who successfully fought to maintain control of her own medication,[10] and one example of a resident, G.L., who was able to hold his Medicaid card after "insist[ing]" that he do so,[11] these isolated examples do not in any way rebut the overwhelming evidence that most residents have not been permitted to retain that autonomy and that the very nature of Adult Homes deprives residents of autonomy and control over most aspects of their daily lives. (*See* DAI's PFF ¶¶ 17–21.) And what is more, both I.K. and G.L., despite having succeeded in maintaining some control over their lives in Adult Home, testified that since moving to supported housing, they finally have freedom in their own lives. (Tr. 501:22–502:13 (G.L.); Tr. 2751:16–25 (I.K.).)

18. Defendants state that unlike psychiatric hospital patients (1) Adult Home residents are not prohibited from smoking at certain times of day or carrying matches; (2) Adult Home residents are not precluded from accessing their mail;[12] and (3) Adult Home residents are not subject to the same privilege system that is applied to psychiatric patients. However, these facts do not refute the overwhelming evidence that Adult

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[10] Tr. 2685:22–2686:9 (I.K.) (explaining that she chose one Adult Home over another because she had "a dispute between [her] and the people who managed the first home I interviewed at about whether or not I would be able to manage my medications, which I had always done").

[11] Tr. 543:7-12 (G.L.).

[12] While Adult Homes may not preclude residents' access to mail, numerous residents testified that Adult Home staff open their mail before they receive it. (D-391 (D.W. Dep.) 114:9–116:16; P–541 (S.B. Dep.) 70:10–72:18; P-540 (P.B. Dep.) 85:4–86:2 (Defendants object to this testimony pursuant to Fed. R. Civ. P. 602, 701, 802); P-545 (J.M. Dep.) 100:2–12.)

Homes are institutions and that they are far less integrated than supported housing. (*See* DAI's PFF ¶¶ 17,18,30–32, 34.)

B. Adult Home Residents Are Not Integrated in the Community

19. Defendants assert that "adult home residents are in an integrated setting." (Defs.' PFF at 8 (Heading II).) In an effort to support this assertion, defendants selectively quote testimony taken out of context and rely on testimony that is not in the record. For example, defendants cite a selection of testimony of Adult Home resident, P.B., for the proposition that many homes "permit [ ] residents to come and go as they please." (Defs.' PFF ¶ 15 & n.5.) But P.B. testified that the Adult Home would probably prevent her from leaving if she were to try to leave at certain hours. (P-540 (P.B. Dep.) 66:20–67:9.) Similarly, defendants cite testimony of S.B. for the proposition that residents "spend time at the houses of religious leaders" (Defs.' PFF ¶ 20), but S.B. testified that Adult Home staff told him to stop going to his minister's house (P-541 (S.B. Dep.) 57:11–59:18). As defendants concede, many Homes have curfews and lock the doors at a certain hour, after which residents must be admitted by staff. (Defs.' PFF ¶ 15; P-538 (B.J. Dep.) 69:5–13; P-545 (J.M. Dep.) 159:5–7; P-541 (S.B. Dep.) 57:11–58:9 84:7–85:17; P-536 (D.N. Dep.) 170:22–24 (every time resident leaves the facility she has to tell the staff where she is going).) Additionally, because of the rigid schedules for meals and medication administration, residents are limited in the times and duration they can be absent from the facilities. (Tr. 142:16–19 (E. Jones) ("People have to be back, for example, for the medicine line. They have to be back for lunch at a specific time. They have to be back to meet the regulations of the adult home, which says that the doors are locked at a certain time.").)

20. Defendants rely extensively on the testimony of G.H. for the proposition that "every resident living in his adult home eats outside the home at least twice per week, every resident walks around the neighborhood, almost every resident goes out of the home to go shopping approximately ten to fifteen times a year . . . ." (Defs.' PFF ¶ 18 (citing P-569 (G.H. Dep.) 136–145).) In the testimony cited by defendants, however, G.H. explained that while he goes out of the facility to get food, he does "most of [his] eating in the building up in [his] room," and that residents eat out to the extent their monthly funds allow it because the quality of food at the facility is so bad. (P-569 (G.H. Dep.) 136:5–137:15.) He also testified that no more than three residents go to parks outside the Home (*id.* at 140:12–142:8), and that residents go outside the facility to shop for toiletries and other items roughly 10 to 15 times over the course of a year (*id.* at 137:16–138:13). He also testified that all residents leave the facility to go to clinic, which he described as a "Medicare mill." (*Id.* at 139:17–23.)

21. Defendants maintain that "[r]esidents visit their families, sometimes staying overnight, and family, friends and others visit residents at the homes." (Defs.' PFF ¶ 23.) To the contrary, the evidence showed that there are significant restrictions on receiving visitors, such as visiting hours and requirements that visitors sign in. (DAI's PFF ¶ 20.) As the administrator of Park Inn testified, only about 10% of the residents visit family outside of the facility. (Tr. 2069:9–14 (Burstein).) G.L. testified that his stepfather visited him in the Adult Home but that his stepfather and others visit him more frequently now that he is in supported housing because in the Adult Home there was nowhere to have a private conversation, the visiting areas were small, guests could not join in meals, guests had to sign in, guests were not allowed to stay overnight, and

visiting hours ended at 8 p.m. (Tr. 477:20–479:25, 482:12 483:16 (G.L.).) In contrast, G.L. described the holiday dinners and barbeques he has hosted since living in supported housing and testified that he would never opt to go back to an Adult Home because he can now have visitors any time. (Tr. 483:18–485:21, 502:1–11 (G.L.) ("I can have people stay overnight. I can entertain. I couldn't do that in the adult home. Q. Anything else? A. Visitors can come any time. Q. And that means something to you? A. Yes.").)

22. Defendants also assert that six residents, A.M., J.M., D.W., M.B., B.J., and L.H. have met acquaintances outside the Homes. But L.H. testified that she does not know people "on the outside" of her Adult Home. (P-534 (L.H. Dep.) 57:21–58:14.) And while A.M. testified that he once met a woman walking her dog and had played chess with a man in the neighborhood, he has no other friends who live outside the Home (P-546 (A.M. Dep) 80:17–22) and lost touch with his family for a period of time because he did not receive his messages from calls received on the Adult Home's phone (*id.* at 74:15–75:14). While J.M. testified that he talked to people in the neighborhood and visited a woman in her home, he never saw other residents of his Adult Home speaking to people in the neighborhood. (P-545 (J.M. Dep.) 71:11–20 ("I never seen any other resident talking to peoples that live in the neighbor[hood]. They would be going to the store and they come right back.").) J.M. further testified that he has seen only a handful of residents leave the facility to go shopping, go to the park, or attend religious services. (*Id.* at 50:23–51:6, 51:14–52:8.) Many other residents testified that they do not have relationships with people outside the Homes. B.J. testified that when people in the neighborhood find out where she's from, they avoid her. (P-538 (B.J. Dep.) 50:7–19.) P.B. testified that she has no friends who are not Adult Home residents. (P-540 (P.B.

Dep.) 45:18–21.) L.G. testified that she receives no visitors other than family members (P-542 (L.G. Dep.) 78:17–19), and that they cannot spend time with her at the Home because the aides get in the way (*id.* 164:23–165:15). R.H. testified that he has no friends outside the Adult Home and has lost touch with his family. (P-543 (R.H. Dep.) 96:12–97:9.) Many residents testified that they lack friends outside the Home, and to the extent friendships exist, they often predate their admission to the Home. (Tr. 593:21–598:15 (S.P.); P-535 (T.M. Dep.) 35:21–23; P-569 (G.H. Dep.) 120:7–16, 123:11–18, 126:24–127:3.)

23. While it is true that Adult Home residents are not locked in the facilities, the fact that a few residents may leave the facility to buy food when they receive their personal needs allowance, or walk along the boardwalk to escape the crowds in the Adult Homes, or occasionally visit a family member, or that a handful of residents have had jobs, does not by any measure rebut the evidence that Adult Homes are segregated settings that impede interaction with nondisabled persons. As defense witness Susan Bear wrote, Adult Homes are "psychiatric ghettos" in which groups of people with mental illness are "located in a community but never helped to become a part of it." (P-673 (Letter from S. Bear to J. Reilly, Jan 9, 2004) at JBFCS 354).) The only inference that can be fairly drawn from the testimony cited by defendants is that there are many residents who are capable of living in more independent settings. (Tr. 143:19–144:21 (E. Jones) (the people who come and go from the homes can live in apartments and require little support); Tr. 2333:7–11 (Geller) ("But there are certainly some percentage who are, you know, about on their own going places who were just never there when they did the assessment. We would think that these people might be highly likely to be able to go to

supported housing."); Tr. 2384:2–6 (Geller) ("Q. And I think you also testified earlier that residents who get out and about are highly likely to be able to live in supported housing. Was that your testimony? A. Yes.").)

24. Defendants' own witnesses agree that Adult Homes are segregated settings and that supported housing is more integrated. Defendants' Director of Housing Programs, Michael Newman, admitted that 120 people living in a congregate setting in which everyone is seriously mentally ill is a "segregated setting" (Tr. 2162:9–16) and that a scattered site apartment is more integrated than an Adult Home (Tr. 2169:7–2170:5). Similarly, defendants' expert Alan Kaufman testified that "[a]s a whole, I believe that people in supported housing are participating or feel more integrated in the community than those that are in group homes." (Tr. 2915:2–2916:4.) Another of defendants' experts, Dr. Geller, admitted that Adult Homes are, in some ways, segregated settings. (Tr. 2371:15–17.)

25. Defendants claim that DAI's experts "attempt to paint a bleak picture of adult home life, but it is not borne out by the testimony of residents who actually live there." (Defs.' PFF ¶ 33.) To the contrary, the observations of DAI's experts were entirely borne out by the testimony of the residents who live in Adult Homes. (*See, e.g.,* Tr. 389:20–21 (S.K.) ("[I] don't think anybody should live like that; it's warehousing people."); Tr. 2734:23–25 (I.K.) ("[T]he adult home fosters complete dependency upon them to do everything for you, discourages independence . . . ."); P-546 (A.M. Dep.) 153:17–155:23 ("[W]hen you go to an adult home, number one, you're treated like a little kid. And if you stay there long enough, you're going to act like a little kid and you ain't going to want to leave because you being taken care of . . . it's like an institution to me

. . . . The hospital I was in was a lot better than [the Adult Home].”); P-541 (S.B. Dep.) 45:6–22 (“Sometimes when you’re in an adult home, you have to—you have to deal with a lot of things. You know, sometimes you have to deal with people that get very nonprofessional at times.”); P-536 (D.N. Dep.) 236:13–23 (describing the public address announcements that blare loudly throughout the day and night directly outside her door, waking her up); P-569 (G.H. Dep.) 260:20–22 (“[T]he first seven years I lived at [the Adult Home] I basically gained 135 pounds feeding my loneliness.”); P-545 (J.M. Dep.) 27:6–8 (referring to Adult Home as a “concentration camp”); P-535 (T.M. Dep.) 111:3–112:2 (“You’re in program, you’re in home. All your energy is surrounded with the home, so it’s hard to meet different people.”).)

26. Defendants also assert the baseless claim that “Elizabeth Jones’s testimony that Adult Homes are not integrated settings is not credible,” (Defs.’ PFF at 19, (Subheading 1)), and that her opinions are based on conversations with a limited sample of Adult Home residents (Defs.’ PFF ¶¶ 34–37). Ms. Jones based her observations and conclusions on visits to 23 impacted Adult Homes in New York City—more than the number of Homes visited by defendants’ experts combined and certainly more than the number of Homes visited by State witnesses who had never set foot in an impacted Adult Home in New York City. (Tr. 45:4–48:22 (E. Jones); Tr. 2377:7–2378:24 (Geller); Tr. 2916:9–1917:2 (Kaufman); Tr. 1499:24–1500:1 (Madan); Tr. 1579:3–5 (Campbell).) Additionally, while defendants’ experts visited Adult Homes only on pre-announced, formal tours attended by attorneys for both sides and DOH officials, Ms. Jones visited Adult Homes informally and unannounced, and revisited several Homes on many occasions. (Tr. 45:4–48:22 (E. Jones).) Moreover, contrary to defendants’ assertions,

Ms. Jones did not limit her conversations to residents who were known by MFY Legal Services; she had extensive conversations with many other residents and, in total, spent 75 hours in the Homes speaking with 179 residents. (S-151 (E. Jones Report); Tr. 45:4–48:22 (E. Jones).)

27. Defendants' claim that Ms. Jones's observations were contradicted by resident testimony is equally baseless. As they do in their Proposed Findings of Fact, defendants selectively excerpted testimony from a handful of Adult Home residents and in their questioning tried to obtain Ms. Jones's agreement on broad-brush conclusions based on those excerpts. But as Ms. Jones explained when asked repeatedly to agree that "[n]othing precludes residents from leaving the adult home . . . to go out into the neighborhood":

> I think that paints a very deceptive picture and I'm very reluctant to say, yes, to what you are saying. What you have forgotten in asking me that question is the impact of living in an adult home with a hundred to four hundred other people and what that does to you in terms of exercising independence and being able to initiate what your day or what your life is like[.] [T]he literature going back to the old days when the institutions looked like adult homes, the literature is replete with examples of how living in that type of situation, the fear of authority and the reluctance to take initiative.

(Tr. 142:25–143:13.)

28. Ms. Jones is not alone in her conclusion that Adult Homes are not integrated settings. As discussed in DAI's Proposed Findings of Fact, OMH's Director of Housing Programs, OMH's former Senior Deputy Commissioner, and defendants' expert Alan Kaufman, among others, agree with Ms. Jones's observations. (*See* DAI's PFF ¶ 13.)

C. "Rehabilitative" Mental Health Services Available to Adult Home Residents Do Not Facilitate Integration

29. Defendants assert that "rehabilitative" services available to Adult Home residents "facilitate" integration (Defs.' PFF ¶¶ 11–14, 28–32), but the evidence established that the exact opposite is true. While Adult Home residents leave the facility to attend continuing day treatment or other mental health programs, attending these programs contributes to residents' isolation and separation from the mainstream of community life. Residents are generally transported together in a bus or van. (*E.g.*, S-151 (E. Jones Report) at 3.) While at the programs, they spend their time with other persons with mental illness. (*Id.*; Tr. 601:25–602:9 (S.P.).)

30. Moreover, the mental health programs that residents attend—both in and outside the Adult Homes—are at odds with current practices and principles in the field of mental health. These programs often have little focus on skill development. (Tr. 897:25–898:11 (Duckworth).) A 2006 review of continuing day treatment programs by the New York State Commission on Quality of Care for the Mentally Disabled noted "a disconnect" between participants' life goals of gaining independent living and job skills and the goals that the programs had set for them. (P-93 (NYS Commission on Quality of Care, Continuing Day Treatment Review) at 13.) To the extent that these programs aim to teach residents independent living skills, such as cooking, budgeting, and grocery shopping, residents have little or no opportunity to practice those skills in their present living situation. (S-152 (Duckworth Report) at 6–7 & n.5; Tr. 67:22–69:6, 170:7–21 (E. Jones) (explaining that the most effective way for people with mental illness to recover and retain skills is to practice them in the environment in which they actually live).) While residents of supported housing can learn and practice these skills in their own

homes, residents of the Adult Homes derive little benefit from this type of training. (S-152 (Duckworth Report) at 7–8; Tr. 870:7–10 (Duckworth) (residents unlikely to learn to cook in Adult Home environment simply because a kitchen is installed); Tr. 2360:9–2361:1 (Geller) ("the system needs to have that person exist in an environment where they can use the skills"); Tr. 412:14–413:5 (S.K.) (describing day treatment program in which residents learned to make cakes by being told what ingredients to put in a pan and having staff "do the rest"); P-569 (G.H. Dep.) 198:4–9 ("Q. Do you feel you've gained confidence in your abilities while you've lived at [the Adult Home]? A. It's tough to say because I've never been able to utilize them. I don't know.").) Linda Rosenberg observed that OMH is now trying to close some of these "old fashioned" programs. (Tr. 720:10–15, 749:24–750:8 (Rosenberg); *see also* Tr. 3317:1–3318:7 (Schaefer-Hayes) (OMH Chief Fiscal Officer testifying that defendants are directing monies away from continuing day treatment programs because they are outdated).)

31. It is not only residents' day programs that limit their opportunities to maintain or learn living skills; Adult Homes discourage, and generally outright prohibit, residents from cooking, cleaning, doing their own laundry, and administering their own medication. (Tr. 481:3–9 (G.L.); Tr. 553:16–555:10, 559:25–560:14 (S.P.); S-54 (Kaufman Report) at 9; P-541 (S.B. Dep.) 81:13–25; P-542 (L.G. Dep.) 70:24–71:9; P-534 (L.H. Dep.) 59:18–21; P-546 (A.M. Dep.) 91:16–93:20, 95:25–96:9; P-536 (D.N. Dep.) 89:14–23,[13] 94:12–95:9; Tr. 54:19–55:1 (E. Jones); Tr. 376:10–377:8 (S.K.); Tr. 862:4–863:1 (Duckworth); *see also* Tr. 2917:3–2918:4 (Kaufman) (testifying about his observations that Adult Home staff were not "up-to-date" and "could benefit from

[13] Defendants have objected to lines 89:20–23 of this testimony pursuant to Fed. R. Civ. P. 602. The Court has not yet ruled on that objection.

education as to what is going on in the field," what expectations are possible, and "what services could be provided, and that treatment centers and treatment programs were reorienting"); Tr. 3425:11–13 (D. Jones) (testifying that Adult Homes are a "residency-based model which means the goal there is not really to promote independence, it's to promote dependence and sustain dependency").) In this and other ways, the Adult Homes foster what both DAI's and defendants' experts have referred to as "learned helplessness." (Tr. 2358:21–23 (Geller); S-152 (Duckworth Report) at 8–9; Tr. 257:20–259:21 (Tsemberis); D–182 (2009–2010 Mental Health Updated Executive Budget testimony) at OMH 43462; Tr. 2734:21–2735:2 (I.K.); P-546 (A.M. Dep.) 153:17–154:14, 211:13–213:5.)[14]

32. Additionally, while residents are taken on trips outside the Adult Homes, these outings contribute little to residents' integration into the community. The residents generally travel as a group, in a bus or van, and interact mainly with each other. (P-542 (L.G. Dep.) 37:20–38:5; P-543 (R.H. Dep.) 49:12–50:20; P-545 (J.M. Dep.) 43:10–44:11; Tr. 2061:4–10; Tr. 2104:19–2105:16 (Burstein); S-151 (E. Jones Report) at 3.) At Park Inn Home for Adults, for example, residents are taken on shopping excursions in the Home's van for as many residents as can fit. (Tr. 2061:4–10 (Burstein).) The Home also organizes monthly restaurant and movie outings for groups of residents transported in ambulettes. (Tr. 2104:19–2105:16 (Burstein).) Residents of Riverdale Manor Home for Adults are taken by a mental health provider, the Federation of Employment and Guidance Services ("FEGS"), on "field trips" to museums and libraries, but the visits are

[14] Defendants have objected to the following portions of this testimony: to lines 153:17–154:14 pursuant to Fed. R. Civ. P. 804; to lines 211:23–212:3 pursuant to Fed. R. Civ. P. 602; and to lines 212:4–9 pursuant to Fed. R. Civ. P. 701.

after hours when the facilities are closed to the general public. (Tr. 2560:9–16 (Waizer).) Thus, the activities described in Defendants' Proposed Findings of Fact do nothing to alter the institutional and segregated nature of Adult Homes.

II. DAI's Constituents Are Qualified for Supported Housing

33. Defendants propose that this Court find that DAI failed to establish at trial that its constituents meet the "essential eligibility requirements" for supported housing. Defendants' Proposed Findings of Fact on this issue not only ignore much of the voluminous testimony and evidence on this issue that DAI adduced at trial and set forth in its own Proposed Findings of Fact (*see* DAI's PFF ¶¶ 52–141), they also in many cases mischaracterize that evidence that they do discuss.

A. Defendants Have Abandoned the Linear Continuum Model

34. In support of their contention that supported housing cannot serve individuals coming directly from institutional settings, defendants continue to maintain, despite the overwhelming evidence at trial to the contrary, that DAI's constituents must proceed through a "linear continuum" of gradually less restrictive service settings before they may "graduate" to supported housing. (*See* Defs.' PFF ¶¶ 45–50.) Although defendants ask the Court to find that "many" mental health professionals and providers (although they cite only three) continue to employ this "continuum" model (*id.* at ¶ 50), glaringly absent from defendants' Proposed Findings of Fact is any suggestion that *defendants themselves* endorse the "continuum" approach in its residential programs.

35. In fact, as demonstrated in DAI's Proposed Findings of Fact, OMH has abandoned this obsolete model both in policy and practice. (*See* DAI's PFF ¶¶ 125–34.) OMH's own commissioner recently testified to the legislature that the "continuum" approach is "inherently problematic" and does not reflect current OMH policy. (P-590

(2008–2009 Executive Budget Recommendation Highlights Testimony) at 4.) OMH's former Senior Deputy Commissioner testified that the linear continuum approach was being abandoned by OMH when she left in 2004. (Tr. 755:4–13 (Rosenberg).) As early as 1990, defendants, in their Supported Housing Implementation Guidelines, expressed concerns that the continuum approach had "limitations," particularly that "[p]eople do not want to move each time they make progress in their rehabilitation." (S-11 at OMH 37268; *see also* P-59 (OMH Guiding Principles for the Redesign of the OMH Housing and Community Support Policies ("OMH Guiding Principles")) at 2 ("[m]ost people want permanent, integrated housing that is not bundled with support services (housing as housing)").) Even defendants' expert Dr. Geller testified, on direct examination, that "there's no such thing as a linear continuum of residential programs." (Tr. 2319:23–2320:7.) Dr. Geller explained that residential programs "don't line up saying I can go from A to B to C to D and I'm going progressively less restrictive more integrated." (*Id.*)

36. Nor does OMH follow the continuum model in practice. Several of OMH's recent RFPs for supported housing specifically target individuals being discharged from institutional settings. (*E.g.*, P-748 (2009 RFP) at 4 (targeting current residents of OMH psychiatric centers who have resided there for one year or longer); S-67 (2008 RFP) at OMH 43108 (targeting psychiatric center patients, prison inmates, individuals with AOT orders); S-17 (2005 RFP) at OMH 37306 (targeting psychiatric center patients, prison inmates, acute psychiatric unit patients, individuals with AOT orders).) These RFPs received numerous responses from supported housing providers eager to serve these populations. (Tr. 3478:10–3479:4 (D. Jones) (30 to 40 providers

proposing roughly 1,500 beds responded to 2005 RFP); *see also* Tr. 1060:23–1065:12 (D. Jones) (identifying numerous RFP responses).)

37. Defendants cite to Dr. Tsemberis to support their contention that some providers continue to use the "linear continuum" approach. (Defs.' PFF ¶ 51.) But in fact Dr. Tsemberis strongly disagreed that the linear continuum is the dominant model in New York. Dr. Tsemberis testified that, while there may be "some" providers who still use it, the clinicians he is aware of do *not* agree with the linear continuum approach. (Tr. 299:13–300:6 (Q. Would you agree that most clinicians prefer the linear model of housing for persons with serious mental illnesses? A. Certainly not the ones that I know. I think that probably was true ten years ago when we first introduced [Pathways to Housing]. . . . I think, today [the Pathways to Housing approach] is a very widely accepted kind of approach to working with people with severe mental illnesses. I think there has been a real [sea] change in that opinion.").)

38. Defendants also misrepresent the testimony of DAI's expert Dennis Jones regarding the "linear continuum" model. Simply put, Mr. Jones did not testify, as defendants assert in their Proposed Findings of Fact, that the linear continuum model is "widely utilized" in New York. (*See* Defs.' PFF ¶ 51.) Quite the opposite: when defense counsel asked him to agree that the model was "widely utilized," Mr. Jones declined to do so, conceding only that New York "still had a range of different housing options." In his answer to counsel's previous question about the "linear continuum," Mr. Jones had testified that at the time he wrote his report, "New York was very much in the process of moving to . . . supported housing for people with a variety of needs." (Tr. 1140:21–1141:7.) Then, in response to a question from the Court asking when the continuum

model was considered standard practice, Mr. Jones testified that it was used "in the 1970's and eighties." Mr. Jones elaborated on why and how the model became obsolete:

> That was kind of the time period and then 1990's came around and then from there on forward is really when the field began to question because of, one, you know, costly when you develop where you have 24-hour staff who are there. That was one factor. The other was consumer input saying, you know, you put me in these temporary residences and then, you know, I have to keep graduating. When do I get my own home? So, I think there was that recognition.
>
> The other thing was that providers have gotten smarter about the fact that, you know, we can do things on-site. So, the availability which came in the early 1990's as the Medicaid rehab option which allowed for services to be provided out of clinics and in actual locations where people existed was a huge boon to the field to, if you will, catch up with where consumers, what they said they wanted. So, all three of those I think really worked to develop really more of a what I would call a contemporary model.

(Tr. 1143:6–25.)

39. In light of these facts, that a handful of supported housing providers may still follow an "defunct" and "archaic" approach to rehabilitation (Tr. 871:10–11 (Duckworth); Tr. 1140:1–6 (D. Jones)) in no way rebuts DAI's showing that its constituents are qualified to receive services in OMH-funded supported housing.

40. Indeed, defendants' inability to counter DAI's overwhelming evidence that OMH has abandoned the "linear continuum" approach is also dispositive of their claim that supported housing is only for people who need "minimal supports." If New York does not expect or require institutionalized individuals to transition through more restrictive service settings before moving into supported housing, it must follow that New York does not limit its supported housing programs to individuals who have "minimal" support needs.

B. Supported Housing Is Intended for Individuals Needing Varying Levels of Support

41. At trial, and as set forth in its Proposed Findings of Fact, DAI established that New York's supported housing program can appropriately serve individuals with a wide variety of support needs, from those with minimal support needs—the bulk of DAI's constituents—to the small number of DAI's constituents who will need more intensive supports. Each of DAI's three experts testified to the flexible nature of supported housing, as did Dr. Tsemberis of Pathways to Housing and OMH's own former Senior Deputy Commissioner. Indeed, OMH's own documents demonstrate that it is official OMH policy to target supported housing to those with high needs for support. (*See* DAI's PFF ¶¶ 52–141.)

42. Nevertheless, defendants propose that the Court find that New York's supported housing programs are incapable of serving individuals with more than the most minimal needs for support. (*See* Defs.' PFF ¶ 53.)

43. As an initial matter, defendants' apparent premise that most of DAI's constituents could not be served in a setting that required individuals to have only "minimal needs" is false. In its Proposed Findings of Fact, DAI set forth extensive evidence that Adult Home residents "by and large have similar characteristics" to residents of supported housing. (Tr. 709:8–12 (Rosenberg); *see also* DAI's PFF ¶¶ 99–106.) DAI's expert Elizabeth Jones, after visiting with 179 Adult Home residents, concluded that "many people" in Adult Homes could move to supported housing with "little or no support." (Tr. 83:24–84:9 (E. Jones).) The data gathered by defendants' own New York Presbyterian Hospital Assessment Project (the "Assessment Project") showed that Adult Home residents are "not a seriously impaired population in the vast

majority," with few residents having severe cognitive deficits or significant problems with daily living skills. (Tr. 3072:7–17 (Groves); *see also* DAI's PFF ¶¶ 86–98; Tr. 1048:9–1050:12 (D. Jones) (explaining that the Assessment Project data demonstrated that the vast majority of Adult Home residents assessed would need only a low level of support).) These conclusions are fully consistent with the admission criteria for Adult Homes, which do not permit admission of people requiring high levels of assistance with daily living or significant medical care, or who pose a danger to themselves or others. (S-141 (18 N.Y.C.R.R. § 487.4).)

44. As for those who would need more extensive supports, the evidence at trial established that such supports are available, and in fact routinely provided by supported housing providers. In alleging the contrary, defendants simply ignore the overwhelming evidence DAI adduced on this issue at trial.

45. Most strikingly absent from defendants' Proposed Findings of Fact on this issue is any mention whatsoever of OMH's own requests for proposals (RFPs) to create supported housing beds and supported housing providers' responses to those RFPs. As DAI set forth its Proposed Findings of Fact, OMH's recent RFPs all describe supported housing as capable of offering "varying" levels of supports and, further, expressly contemplate that, while *some* residents of supported housing may have minimal support needs, others may require extensive supports, including Assertive Community Treatment (ACT) or intensive case management. (*See* DAI's PFF ¶¶ 55, 108.) Indeed, a number of OMH's RFPs for supported housing specifically target residents of various institutional settings, such as psychiatric centers, Article 28 hospitals, and prisons—not to mention Adult Homes themselves—demonstrating that OMH can and does already serve in

supported housing precisely the populations it claims in this litigation cannot be served in supported housing. (*See* DAI's PFF ¶ 131.) These RFPs are the best evidence of what kinds of individuals OMH in practice expects supported housing providers to serve.

46. The responses to those RFPs by supported housing providers confirm that there are numerous supported housing providers in New York that are not only willing, but *eager* to serve even highly institutionalized populations, such as long-term residents of psychiatric centers, hospitals, and the Adult Homes themselves. As set forth in DAI's Proposed Findings of Fact, when OMH was forced by the legislature to issue an RFP for 60 supported housing beds for Adult Home referrals, it received proposals from seven different supported housing providers wishing to serve DAI's constituents in supported housing. (*See* DAI's PFF ¶ 119.) Three of those providers were awarded contracts and are now serving at least 45 Adult Home residents, with another 15 residents in the process of filling the remaining beds. (*See* DAI's PFF ¶ 120.)

47. Also conspicuously absent from defendants' Proposed Findings of Fact is any mention of the fact that defendant OMH's own former Senior Deputy Commissioner, Linda Rosenberg, based on more than three decades of experience working with adult homes and adult home residents, testified that virtually all Adult Home residents could be appropriately served in New York's supported housing programs. (DAI's PFF ¶¶ 73–77.) According to Ms. Rosenberg, Adult Home residents "by and large have similar characteristics" to residents of supported housing, and are placed in Adult Homes by "luck of the draw" rather than any clinical determination that it is an appropriate placement. (Tr. 709:2–12.) Ms. Rosenberg was a disinterested third-party witness: she described OMH as "a very good place to work" that was "very good to me." (Tr.

772:16–18.) Her only motive in testifying was "improving the lives of people with serious mental illness." (Tr. 772:20–23.) Defendants' Proposed Findings of Fact offer no reason why the Court should disregard Ms. Rosenberg's persuasive and unimpeached testimony.

48. Ignoring completely the above evidence, defendants in their Proposed Findings of Fact cite to purported evidence that they claim demonstrates that supported housing can only serve those with minimal needs. (Defs.' PFF ¶ 53.) None of this evidence proves what defendants say it does; indeed, some of it shows precisely the opposite.

49. The very first document that defendants cite as evidence of their "minimal needs" contention is Exhibit S-11, OMH's 1990 Supported Housing Implementation Guidelines. (*Id.*) Defendants provide no pin-cite showing where they contend the Guidelines say that supported housing is for people with minimal needs. Nor could they, as the Guidelines say no such thing. What the Guidelines *do* say is that supported housing is a program created in "recognition" of the fact that "[p]eople do not want to move each time they make progress in their rehabilitation." (S-11 at OMH 37268; *see also* S-101 (Supported Housing Implementation Guidelines, reformatted 2005) at OMH 37514.) It is instead a program of "permanent" housing in which residents receive "recipient-specific support services designed to assist people in succeeding in their housing." (*Id.*) The Guidelines further identify as a target population of supported housing "individuals discharged from psychiatric centers" (S-11 at OMH 372270)—a highly institutionalized population with significant needs. (*See* Tr. 229:2–10 (Tsemberis) (person just discharged from the hospital would likely need daily or even twice daily

visits); 310:20–311:8 (recently hospitalized individual would need help "disengaging from the perceived need for services") (Tsemberis); 2560:2–4 (Waizer) (describing newly discharged patients from psychiatric hospital as "very disabled").) The Guidelines thus make clear that supported housing is designed to serve individuals with varying levels of need.

50. In support of their implausible "minimal needs" assertion, defendants also cite to S-60 and S-19, documents produced by FEGS, a supported housing provider, and the testimony of a former Federation of Organizations ("Federation") employee, Frances Lockhart, who testified regarding Federation's 25-bed supported housing program. (*See* Defs.' PFF ¶ 53.) Defendants' citation to the FEGS documents is inexplicable: S-60 is a document outlining eligibility criteria for a FEGS *apartment treatment* program, not a supported housing program, and S-19 provides brief descriptions of FEGS residential programs with no mention of eligibility requirements.

51. As for Ms. Lockhart's testimony about Federation's small supported housing program, she acknowledged that Federation has previously accepted Adult Home residents (Tr. 2640:9–10) and even individuals from state psychiatric centers (Tr. 2670:25–2671:3) directly into its supported housing program; that, despite her view that supported housing was only for individuals who are substantially independent (Tr. 2639:19–2640:6), some Adult Home residents could live in supported housing (Tr. 2636:19–21); and that, with at least one new supported housing resident she was aware of, case managers visited the apartment twice-daily to assist with the transition to supported housing (Tr. 2672:8–21).

52. In any event, FEGS and Federation are only two of dozens of service providers in New York City offering supported housing. As DAI noted in its Proposed Findings of Fact, the fact that some supported housing providers may provide fewer supports in their programs does not rebut DAI's showing that there are many other providers willing and able to serve individuals with much higher needs. (*See* DAI's PFF ¶ 109 n.8.)

53. Incredibly, defendants also cite for their "minimal needs" contention the testimony of Dr. Sam Tsemberis of the Pathways to Housing supported housing program—a program that *specializes* in serving individuals with very high needs. (Tr. 247:8–11 (Tsemberis).) In asserting that Dr. Tsemberis testified that "clients graduate into supported housing because it has minimal supports" (Defs.' PFF ¶ 53; *see also id.* ¶ 63), defendants mischaracterize Dr. Tsemberis's testimony. What Dr. Tsemberis actually said was, "[y]ou can put someone with severe mental illness in supported housing and it doesn't matter the degree of severity of illness as long as you match the supports to what they need." (Tr. 265:15–267:25.)

54. Aside from the self-serving trial testimony of OMH employees—which, as noted above and in DAI's Proposed Findings of Fact, is contradicted by OMH's own RFPs, its own former Senior Deputy Commissioner, and numerous other OMH documents (*see, e.g.*, DAI's PFF ¶¶ 55 (Supported Housing Guidelines and RFPs), 81–82 (Adult Care Facilities Workgroup Report (the "Workgroup Report")), 93 (Assessment Project), 108 (RFPs), 130 (testimony of OMH Commissioner Stone))—the only evidence cited by defendants that actually uses the term "minimal support" in reference to supported housing is a document prepared by a third-party, Center for Urban Community

Services (CUCS), which purports to describe various "supportive housing models for people with mental illness and other special needs." (*See* S-40 (CUCS, *A Guide To Supportive Housing Models for People With Mental Illness and Other Special Needs*), at JG 250; S-70 (CUCS, *Supportive Housing Options NYC* (2009 ed.) at OMH 43225 (updated version of S-40).) As DAI's expert Dennis Jones explained at trial, this document describes supported housing in terms that are "inconsistent" with OMH's stated approach to supported housing in numerous other documents. (Tr. 1154:5–6.) Kathleen Kelly, the witness from HRA, testified that HRA does not rely on the eligibility criteria set forth by CUCS in approving individuals for supported housing. (*See* Tr. 1892:21–1893:25 (Q. So does your group rely on the eligibility criteria set forth by CUCS? A. No. We—the eligibility criteria is set up by, in this particular case, by, say, for NY/NY III I think six or seven agencies signed on to that . . . Q. Does HRA rely on the eligibility criteria set forth by CUCS? A. No.) And even the CUCS document acknowledges that "in practice and over time, variations with [each housing] model have developed." (S-40 at JG 244; S-70 at OMH 43219.)

55. Defendants claim in their Proposed Findings of Fact that to live in supported housing, individuals must be capable of seeking assistance and taking their medication independently, must demonstrate "a significant period of psychiatric stability," must be able to "meet their own daily needs" and "maintain their apartment" with "minimal assistance," and, in many cases, must even maintain their sobriety. (Defs.' PFF ¶ 54.) But the record shows that people who have difficulties with each of these issues are successfully served by New York's supported housing providers every day. (*See*, *e.g.*, Tr. 82:16–23 (E. Jones) (although "not many" Adult Home residents would

need medication management or health-related services in supported housing, those supports "are nothing unfamiliar to what's commonly found in a mental health system today"); Tr. 316:19–317:15 (Tsemberis) (explaining the "whole range of options" to assist supported housing residents with medication); S-101 (Supported Housing Guidelines, reformatted 2005) at OMH 37516 (targeting newly-discharged psychiatric hospital patients for supported housing); P-394 at 2 (RFP response seeking to serve individuals who have been "non-compliant with treatment," including medication regimes); P-439 at 3 (RFP response seeking to serve individuals needing assistance "developing or re-developing activities of daily living" and self-care skills); P-442 (RFP response seeking to serve individuals who need service planning regarding "medication compliance and symptom awareness and management").) Indeed, recent OMH RFPs have forbidden providers from screening out applicants because of substance abuse issues. (P-748 (2009 RFP) at 8 ("Agencies cannot reject someone for housing based solely on the past history or current substance use of potential residents"); S-33 (2007 RFP) at OMH 42730 ("no exclusionary admission criteria related to past or current substance use may be imposed"); Tr. 1528:19–21 (Madan).)

56. Defendants also claim, wrongly, that individuals are "normally" visited by a case manager once a month, or perhaps if they have a supportive or intensive case manager, once per week. (Defs.' PFF ¶ 55.) In fact, the evidence demonstrated that the number of visits can vary widely depending on the needs of the resident, up to as often as twice per day. (Tr. 2172:18–2173:8 (Newman); Tr. 2672:8–2673:4 (Lockhart) (testifying that she is aware of individuals who were seen by supported housing case manager twice per day, twice per week, and every other day).) In the Pathways to Housing supported

housing program, the average is about twice per week. (Tr. 228:24 (Tsemberis).) Individuals in supported housing who receive ACT services are *required* to be visited at least six times per month by members of the ACT team. (P-372 (ACT Program Guidelines 2007) at 5.)

57. As defendants acknowledge, supported housing providers fully expect to visit individuals more frequently as they are transitioning into supported housing from institutional settings. (*See* Defs.' PFF ¶ 55.) As new residents acquire the skills they need to live more independently, the frequency of visits can typically be decreased. (Tr. 229:5–10 (Tsemberis); Tr. 2672:23–2673:4 (Lockhart); *see also* DAI's PFF ¶ 112.)

58. While defendants claim that the "supported housing model in New York" does not include services "other than limited case management related primarily to maintaining the housing and resolving housing issues," defendants acknowledge, as they must, that residents are also eligible to obtain supportive or intensive case management services to assist them with other issues. (Defs.' PFF ¶ 55.) Dr. Tsemberis, whom defendants cite for the proposition that supported housing case management relates primarily to housing issues, agreed that it is "common" for supported housing residents to have additional case management services to assist them with issues that are not housing related. (Tr. 237:10–13.)

59. The evidence at trial also demonstrated that those with the highest needs can receive services from Assertive Community Treatment (ACT) teams. (*See* DAI's PFF ¶¶ 45–48, 115.) As demonstrated in DAI's Proposed Findings of Fact, ACT provides intensive, cross-disciplinary treatment to individuals with high needs living in a variety of different settings, including supported housing. (*Id.*) OMH's own guidelines

for ACT are clear that, contrary to defendants' contention (*see* Defs.' PFF ¶ 59), ACT teams can not only provide individuals with mental health treatment, but can also assist them with independent living skills such as medication management, money management, cooking, laundry, and use of public transportation. (P-372 (ACT Program Guidelines 2007) at 3–4; Tr. 818:2–10 (Duckworth); *see also* Tr. 279:2–11, 243:7–246:16 (Tsemberis).) Also contrary to defendants' assertion (*see* Defs.' PFF ¶ 59), ACT teams can and do visit their clients daily or even twice daily when necessary. (Tr. 134:19–135:12 (E. Jones); Tr. 229:2–4 (Tsemberis) ("no prescribed number of contacts; some people seen up to twice a day").) Any individual living in supported housing can apply to receive ACT services. (Tr. 1832:6–12 (Dorfman); Tr. 1414:20–1416:10 (Reilly); Tr. 3170:19–3171:14 (Myers).)

60. In their Proposed Findings of Fact, defendants contend that Adult Home residents are ineligible for ACT services. (Defs.' PFF ¶¶ 59–63.) In essence, defendants argue that Adult Home residents, while too disabled to be served in supported housing without ACT, are not disabled enough to qualify for ACT. In defendants' view, Adult Home residents fall into a sort of public-health "no-man's land," in which they are deemed too psychiatrically stable to be provided with the services defendants themselves contend are necessary to allow them to live independently.

61. According to defendants' Proposed Findings of Fact, ACT services in New York City are only available to individuals who "demonstrate a high use of inpatient hospitalizations or emergency room services," have an inpatient hospitalization during the last year that lasted 90 days or longer, or are under a court's Assisted Outpatient Treatment Order. (Defs.' PFF ¶ 61.)

62. These alleged eligibility requirements for ACT come from a document prepared by the Center for Urban Community Services (CUCS), a third party who is contracted to run the SPOA in New York City. (*See* D-279.) Defendants' witness, Christine Madan, testified at trial that these eligibility requirements do not reflect OMH's statewide ACT policy guidelines, but instead represented "more stringent" guidelines for New York City agreed upon by OMH and the "local government unit," *i.e.*, New York City. (1447:15–1478:4.)

63. The eligibility requirements in OMH's statewide ACT guidelines are broader than those set forth in the CUCS document: they require simply that the applicant have "a severe and persistent mental illness . . . that seriously impairs their functioning in the community," with a "priority" given to individuals with "continuous high service needs that are not being met in more traditional service settings." (P-372 at 4.)

64. Even the alleged more stringent guidelines, if applied, would not preclude large numbers of Adult Home residents from receiving services in supported housing. As DAI's witnesses testified, Adult Home residents have needs and characteristics similar to those of current supported housing residents. (*See* DAI's PFF ¶¶ 99–106.) DAI's expert, Elizabeth Jones, testified that many Adult Home residents could live in supported housing with no additional services at all. (Tr. 83:24–84:9 (E. Jones); *see also* Tr. 856:14–16 (Duckworth) (not all Adult Home residents would require ACT).) Many of those who would need additional services could obtain what they needed through intensive case management or blended case management. (Tr. 1833:10–12 (Dorfman); Tr. 1414:20–1416:10 (Reilly); Tr. 3170:19–3171:14 (Myers).) And those with the very highest needs may well "demonstrate a high use of inpatient hospitalizations or

emergency room services," as defendants claim is required to receive ACT in New York City. (Tr. 1125:17–19 (D. Jones) (some Adult Home residents would meet alleged more stringent New York City ACT guidelines in D-279).)

65. In any event, the alleged "more stringent" eligibility requirements for New York City are the result of an agreement between OMH and New York City; they do not reflect statewide OMH policy. (Tr. 1447:15–1478:4. (Madan).) If it were necessary to apply the statewide ACT guidelines in New York City to ensure that Adult Home residents transitioning into supported housing receive the services necessary for them to succeed, OMH could easily do so.[15] (Tr. 1125:24–1126:1 (D. Jones).)

66. In asserting that ACT is for individuals with higher needs than Adult Home residents, defendants once again take out of context the testimony of Dr. Tsemberis. Defendants cite Dr. Tsemberis as the sole support for their contention that ACT is not frequently used in supported housing because supported housing is for people "who do not require a lot of support." (Defs.' PFF ¶ 62.) But Dr. Tsemberis testified that he thought "most people" receiving ACT services did not live in OMH housing of any kind—rather, they mostly lived either completely independently or with their families. (Tr. 329:18–330:2.) Additionally, Dr. Tsemberis testified that although most individuals participating in his supported housing program receive ACT services when they enter the program, their service needs decrease over time. (Tr. 230:23–25.)

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[15] Requiring the State to permit residents of New York City access to the same services it already provides to other New York State residents would not amount to a fundamental alteration. *See Disability Advocates*, 598 F. Supp. 2d 289, 335 (E.D.N.Y. 2009) (finding that where State already provides services in an integrated setting, "assessing and moving the particular plaintiffs to that setting, in and of itself, is not a fundamental alteration). Defendants have pointed to no important reason for limiting access to ACT services for DAI's constituents.

C. Adult Home Residents Are No More Disabled than Individuals In Supported Housing

67. As set forth in DAI's Proposed Findings of Fact, the evidence at trial established that Adult Home residents with mental illness are no more disabled, and indeed, due to the absence of meaningful supports in Adult Homes, may often be less disabled, than residents of supported housing. (DAI's PFF ¶¶ 99–103.)

68. DAI's evidence that Adult Home residents have generally similar characteristics to supported housing residents included its experts' analyses of the Assessment Project commissioned by DOH, the findings of the Adult Care Facilities Workgroup, and its experts' analyses of the mental health files of numerous Adult Home residents. DAI's evidence also included firsthand observations of numerous Adult Home residents by, among others, its expert Elizabeth Jones, who met with 179 Adult Home residents during the course of her investigation, and Linda Rosenberg, the former Senior Deputy Commissioner of OMH, who, in more than three decades working in Adult Homes and with Adult Home residents, estimates that she has met "probably literally thousands" of Adult Home residents. (S-151 (E. Jones Report) at 1–2; Tr. 773:15–22 (Rosenberg).) Both of these witnesses testified that, in their view, residents of Adult Homes had the same characteristics as individuals in supported housing and could be appropriately served in supported housing. (Tr. 709:8–12 (Rosenberg); Tr. 52:20–53:4 (E. Jones).)

69. In claiming that Adult Home residents are, contrary to the observations of DAI's witnesses, "very disabled," defendants rely heavily on the testimony of Jonas Waizer, the Chief Operating Officer of FEGS, which provides case management services in one Adult Home. (Defs.' PFF ¶ 58; Tr. 2504:15–18.) Mr. Waizer is a senior executive

at FEGS who oversees roughly 3,000 employees. (Tr. 2575:22–25) Mr. Waizer's only firsthand knowledge of Adult Home residents comes from his observations of, in his estimate, between 30 and 40 residents of Riverdale Manor. (Tr. 2577:7–15.) Mr. Waizer did not analyze residents' abilities to live in other settings, rather, he made his observations while visiting Riverdale Manor to negotiate and oversee the implementation of a FEGS case management program at the Adult Home. (Tr. 2558:12–19; 2577:7–15.)

70. Mr. Waizer testified that the Adult Home residents he observed had "pacing behavior," had difficultly "hold[ing] a conversation," and had difficulty "sitting in a group." (Tr. 2559:12–2560:7.) Based on these three characteristics, Mr. Waizer concluded that the residents he observed were "about as bad as the newly-discharged patients from Manhattan Psych." (*Id.*) Neither Mr. Waizer nor defendants in their Proposed Findings of Fact explained how pacing, poor conversational skills, or difficulty sitting in a group would disqualify individuals from supported housing—a service setting that, after all, *requires* one to have a serious mental illness in order to be eligible. (S-101 (Supported Housing Guidelines, reformatted 2005) at OMH 37515; Tr. 1505:2–5 (Madan).) Notably, the newly discharged psychiatric center patients to whom Mr. Waizer compared these Adult Home residents are themselves one of the three original target populations of supported housing and continue to be targeted in OMH's current supported housing RFPs. (S-11 (Supported Housing Guidelines) at OMH 37270; P-749 (2009 RFP); S-67 (2008 RFP); S-17 (2005 RFP).)

71. Defendants also rely on the testimony of Susan Bear of the Jewish Board and Frances Lockhart of Federation of Organizations for the proposition that "adult home residents often require more services than supported housing offers." (Defs.' PFF ¶ 57.)

However, both of these witnesses made clear that their organizations still adhered to the old "linear continuum" approach. (2654:12–17 (Lockhart); 2216:7–13 (Bear).) The fact that these two supported housing programs provide little support to clients reflects limitations in those providers' supported housing programs, not in the supported housing model as espoused by OMH and practiced by numerous other providers.

D. Whether Adult Home Residents Have Been Approved for Supported Housing by HRA Is Irrelevant to Whether They Are Qualified for Supported Housing

72. Defendants wrongly suggest in their Proposed Findings of Fact that Adult Home residents are not "qualified" for supported housing unless they have been approved for supported housing by New York City's Human Resources Administration (HRA). (Defs.' PFF ¶¶ 64–67.) As this Court found on summary judgment, however, completing the HRA form is not an "essential eligibility requirement" to receive community-based services. *Disability Advocates*, 598 F. Supp. 2d at 309. The evidence shows, moreover, that HRA is merely a "clearinghouse" for OMH-funded housing whose determinations are often subject to change and that, in any event, many Adult Home residents lack a meaningful opportunity to submit an application to HRA for the housing of their choice.

73. OMH currently requires individuals seeking to live in any OMH-funded housing in New York City to first submit an application to HRA, a division of the New York City Department of Social Services. Defendants' witness Christine Madan described HRA as a "clearinghouse for receiving applications for housing for persons with mental illness in the city." (Tr. 1461:25–1462:5; *see also Disability Advocates*, 598 F. Supp. 2d at 309, 333 n.44 (describing the HRA process as nothing more than "a bureaucratic avenue to access housing programs").) Based on this application, HRA

decides which types of housing the applicant may apply for. (Tr. 1463:20–25 (Madan); Tr. 1913:2–6 (Kelly).)

74. The evidence at trial made clear that an HRA determination of eligibility for a particular level of housing is not a reliable indication of the type of housing in which an individual could successfully be served.[16] (Tr. 347:4–8.) Kathleen Kelly of HRA also testified that HRA determinations are "not written in stone." To the contrary, it is a "flexible process," in which a service provider can "call the reviewer" or "transmit additional information" if the service provider disagrees with HRA's determination. (Tr. 1908:7–13.) Ms. Kelly further acknowledged the experience level of the reviewer may impact the type of housing an applicant is approved for. (1910:11–19.)

75. Approved HRA applications are also an inappropriate measure of how many Adult Home residents are qualified for supported housing because of the inability of many residents to meaningfully utilize the HRA process. It is undisputed that Adult Home residents must rely on others to complete the application and submit it to HRA. The application is a complicated electronic form that is designed to be completed by a "referring agency," not the individual seeking housing. (Tr. 1462:8–20 (Madan) (HRA application is filed electronically; resident wishing to complete application process would speak with a mental health provider); Tr. 1894:16–21 (Kelly) ("referring agency" is supposed to complete the HRA application).) It requires detailed assessments of the applicant from both a psychiatrist and a social worker. (Tr. 1897:23–1898:9 (Kelly) &

[16] Indeed, the Court has already recognized this fact in denying defendants' summary judgment motion, noting that the HRA process "is unrelated to the characteristics of the individual seeking services that would make him or her suitable for supported housing." *Disability Advocates*, 598 F. Supp. 2d at 333 n.44.

2107:2–7 (Burstein) (HRA application requires psychosocial history signed by a social worker, as well as a psychiatric evaluation signed by a psychiatrist).)

76. The evidence at trial showed that many Adult Home residents may not have anyone to assist them in completing an application. Over half of the Adult Homes do not participate in OMH's case management initiative and, in any event, case managers are not always willing to assist residents in completing the application or in applying for the type of housing that the resident desires. (Tr. 1501:18–1502:7 (Madan) (treatment provider completing the application, not resident, ultimately determines what kind of housing to apply for); Tr. 1834:24–1835:5 (Dorfman) (outside case management in eleven homes and defendants have no plan to expand it), 1835:16–18 (unaware of what information about housing opinions is provided to residents in homes without OMH case management), 1858:6–1859:5; *see also* Tr. 390:19–391:19 (S.K.) (testifying that she spoke with her case manager about moving to more integrated housing about a year ago, but has not heard anything further from the case manager); P-540 (P.B. Dep.) 123:7–20 (case manager not helpful); P-546 (A.M. Dep.) at 169:6–14 (had to "fight" to get HRA application filled out by case manager, who then failed to complete it properly).)

77. Staff or social workers employed by the Adult Home also have a motive to be unhelpful to residents seeking to move: the Adult Homes are for-profit enterprises that lose revenue with each resident who secures alternative housing. DAI's expert Dr. Duckworth testified that the care providers he observed working in the Adult Home seemed to have "lost their professional autonomy" and "basically showed up to work and saw whoever the operator directed them to see." (Tr. 870:11–15.) Linda Rosenberg testified that the operators themselves would threaten to close down whenever OMH

suggested initiatives that would result in residents leaving Adult Homes. (Tr. at 698:9–12.)

78. In addition, several witnesses, including defendants' witnesses, testified at trial that Adult Home residents are simply not aware of other types of housing that may be available to them. (*See, e.g.*, S-151 (E. Jones Report) at 11; Tr. 663:15–18 (Rosenberg) (during her tenure at OMH, residents had only the "vaguest" information about housing alternatives); 2416:15–18 (Geller) (agreeing residents are not adequately informed of housing options); 2083:21–2084:4 (Burstein) ("path wasn't clear" to Adult Home residents seeking alternative housing); 2664:8–11 (Lockhart) (Adult Home residents not participating in case management may not be familiar with alternative housing options).) Residents cannot be expected to take steps to move to more integrated housing if they have not been given the information they would need to make a meaningful choice to do so.

79. In light of the above, it is clear that Adult Home residents need not have obtained a determination from HRA to be qualified to be served in—that is, to meet the essential eligibility requirements for—supported housing.

E. Defendants' Attacks on the Testifying Adult Home Residents Have No Basis

80. DAI called to testify two current Adult Home residents, S.K. and S.P. Each of these witnesses made clear in their testimony they were both willing and able to live in supported housing. Defendants nevertheless ask the Court to find that neither S.K. and S.P. would be qualified for supported housing.

81. Defendants, contrary to all available evidence, describe S.K. as a person who has "been unable to survive in the community" due to her depression. (Defs.' PFF

¶ 71.) In fact, S.K. lived with clinical depression successfully in the community for almost 20 years before being placed in the Adult Home. (Tr. 361:13–14.) S.K. raised a family of four children living in her own home on Long Island, where she cooked, cleaned, shopped, and did the yard work. (Tr. 361:15–364:12.) When her husband died, she moved to an apartment in Astoria and worked for five years as a nurse's aide, where she took care of patients and administered their medications. (Tr. 364:11–366:8.) S.K. then moved to Georgia to live with her daughter, and worked there for 5 years at a supermarket deli. (Tr. 367:7–369:21.) S.K. moved back to New York to live with her sister, but was then voluntarily hospitalized due to an episode of severe depression. (Tr. 370:7–371:11; 397:12–13.)

82. After her hospitalization, S.K.'s sister refused to allow her to move back in with her because the sister "couldn't cope with" S.K.'s depression. (Tr. 371:15–19.) Although S.K. wanted to live in an apartment, the psychiatric hospital instead discharged S.K. to an Adult Home. (Tr. 371:12–372:14.)

83. S.K. testified of her ability to live independently. She testified that she is "well able to take care of a place on [her] own" (Tr. 372:16–18), that she is able to manage her own money (Tr. 380:13–15), and that the only supports she would need would be "somebody to call in on me once in a while just to see how thing are doing." (Tr. 390:12–16.)

84. Defendants contend that S.K. cannot live in supported housing because she was unable on the witness stand to name the medications that the Adult Home administers to her for depression. (Defs.' PFF ¶ 72) But defendants fail to mention that, despite the fact that the Adult Home does not permit S.K. to administer her own

medications (Tr. 377:5–8), S.K. still carried a list of her medications—Klonopin, Effexor XR, Requip, and Remeron (D-349 at 4)—with her in her bag. (Tr. 395:11–14.) S.K. herself said that she would be "well able to manage my own medication," in a supported apartment. (Tr. 378:16.) That assessment that was shared by S.K.'s social worker at the psychiatric hospital from which she was discharged into the Adult Home, who wrote in her psychosocial evaluation that S.K. "has been medication compliant" and "is able to manage her medication independently," and would need only reminders to take her medications. (D-349 at 8.) In any event, as noted above, supported housing residents can be provided assistance with medication management. (*See* Tr. 316:19–317:15 (Tsemberis).)

85. S.K.'s HRA application also reflects that she could easily be served in supported housing. According to S.K.'s application, her only psychiatric disorder is major depressive disorder, with no current "Symptoms/Behaviors" and no substance abuse issues. (D-349 at 5 & 7.) The application indicates that S.K. needed no assistance with personal hygiene, traveling, keeping her room clean, or laundry, and desired only a "low" level of support. (*Id.* at 8.) As noted above, S.K.'s social worker felt that S.K. "is able to manage her medication independently." (*Id.* at 13.) The social worker concluded that that S.K.—"a pleasant, educated and motivated woman" who "has always lived in private residences throughout her life"—needs only "minimal support and would do fine with attending an outpatient mental health program." (*Id.*)

86. Finally, while defendants argue that DAI failed to present evidence that S.K. ever applied for supported housing, they fail to mention that when S.K. has tried to talk to her case worker about moving to an apartment, the case worker "kind of just puts

[her] off," saying that "there's nothing available right now." (Tr. 390:21–25.) Defendants do not explain how S.K. is expected to submit an application to HRA if her case worker will not assist her in doing so.

87. Defendants also question whether Adult Home resident S.P. is qualified for supported housing. (Defs.' PFF ¶¶ 74–75.) S.P. testified that prior to coming to the Adult Home he did his own cooking, cleaning, and laundry, and had his own bank account. (Tr. at 560:12–23 574:6–8; 576:3–12, 22–24.) S.P. further testified that while residing at the Adult Home, he has held a part-time job as a porter at a hospital, and regularly navigates public transportation. (Tr. 567:23–568:10; 592:5–23.) S.P. has been actively searching for alternative housing for over a year, but has so far been unsuccessful. (Tr. 615:24–616:13.) S.P. also testified that his social worker at the Adult Home "started on [the HRA application], but he didn't finish it." (Tr. 615:5.) As with S.K., it is difficult to understand how S.P. is to be expected to complete an HRA application without the assistance of the case management.

88. Defendants also discuss the testimony of G.L., a current resident of supported housing who previously resided in an Adult Home. (Defs.' PFF ¶¶ 76–78.) Defendants do not try to suggest, however, that G.L. is unqualified to live in supported housing. To the contrary, G.L.'s testimony makes clear that he is flourishing in supported housing. (*See, e.g.*, Tr. 463:19–464:21; 485:22–486:4; 495:6–25; 496:16–19; 498:8–9.) While G.L.'s medical records during his time in the Adult Home may reflect some ambivalence about moving to more independent housing, nothing in his medical records impeaches his testimony about the difficulties he experienced trying to get assistance from the care providers at the Adult Home in securing alternative housing.

(*See* Tr. 452:1–456:17.) Further, G.L.'s eventual success in that setting only proves the point that, due to institutionalization, some individuals may need support, encouragement, and education before they are able to make a meaningful choice about whether to live in the community. (*See* DAI's PFF ¶¶ 163–64.)

F. Defendants' Attacks On DAI's Experts Are Without Merit

89. As set forth in DAI's Proposed Findings of Fact, each of DAI's three expert witnesses testified credibly that virtually all Adult Home residents could be appropriately served in defendants' supported housing program. (DAI's PFF ¶¶ 57–72.) Defendants' suggestion in their Proposed Findings of Fact that the testimony of DAI's experts "was not based upon reliable scientific principles or methods" and was not "credible" is without merit. (Defs.' PFF ¶ 79.)

90. Defendants' central critique of all three of DAI's experts—that they did not perform in-person clinical assessments of each of DAI's constituents to determine whether they were qualified for supported housing ignores that such individualized assessments are not necessary to determine whether any individual can be served in supported housing. Rather, as DAI's experts explained, such assessments are only necessary to determine the specific supports that each resident would need once placed in supported housing. (Tr. 53:14–54:12 (E. Jones) (clinical assessment unnecessary "because, at this point, I'm not making individual determinations as to the exact array of supports that people will need when they live in the community setting."); Tr. 811:20–812:15 (Duckworth) (clinical assessment unnecessary because expert could "screen people looking for specific contraindications to why they might not be able to live in the community").)

91. By claiming that DAI's experts' conclusions are unreliable because they did not perform in-person clinical assessments, defendants are holding DAI to a higher standard than they hold their own programs. Kathleen Kelly of HRA testified that HRA does not conduct clinical assessments of individuals before determining whether they are eligible for supported housing. Instead, HRA relies entirely on the electronic application submitted by the referring agency. (Tr. 1908:1–5) (Kelly) (HRA makes determination by reading the application).) As Ms. Kelly explained, "because we're not seeing the client, we're relying very heavily on what the referring agency's telling us about the client." (*Id.*)

92. Finally, defendants' expert Dr. Geller admitted that he did not perform clinical interviews of Adult Home residents to assess them for supported housing either, in part because he felt it would be "unfair" because it would "lead to the expectation by the adult home resident being interviewed that the interview would translate into some action in a timely fashion and that was not going to happen here." (Tr. 2379:24–2380:5.)

93. With regard to defendants' remaining attacks against DAI's expert witnesses, all are without merit and should be rejected:

Kenneth Duckworth

94. As set forth in DAI's Proposed Findings of Fact, Dr. Kenneth Duckworth, a board certified psychiatrist with more than 20 years of experience serving individuals with severe mental illness, including as Medical Director and then Acting Commissioner of the Massachusetts Department of Mental Health, concluded after an extensive investigation that "there are no material clinical differences between adult home residents and supported housing clients" and that "virtually all of the [Adult Home residents] I

looked at I felt would make it in Supported Housing." (DAI's PFF ¶¶ 58–62; S-152 (Duckworth Report) at 5; Tr. 809:17–20.)

95. Defendants first suggest that Dr. Duckworth is somehow biased because he currently works part-time for an organization dedicated to "improving the lives of individuals and families affected by mental illness" (Tr. 880:6–10) and because he expressed support for DAI's decision to bring this lawsuit. (Defs.' PFF ¶ 80.) First, if defendants want to suggest that Dr. Duckworth's current part-time employment with an organization dedicated to helping individuals with mental illness renders his expert opinion somehow suspect, then the testimony of defendants' expert, Dr. Geller, who makes his living in part by testifying around the country as a defense expert in cases brought against state mental health systems, must surely be ignored completely. (*See* Tr. 2374:23–2377:6.) Second, defendants claim that Dr. Duckworth is somehow biased because he wrote in an email, "I wish you the best of luck and will be pulling for you." (Defs.' PFF ¶ 80 (citing D-222).) As Dr. Duckworth's testimony at trial demonstrated, he did so not because he had prejudged the question of whether Adult Home residents are qualified to live in supported housing, but because he was horrified by the "egregious" conditions in Adult Homes described in Clifford Levy's *New York Times* articles. (Tr. 947:21–948:1.)

96. Defendants attempt to criticize Dr. Duckworth's conclusions because he had "only" visited five Adult Homes and spoken to "approximately 38 residents" before drafting his initial report. (Defs.' PFF ¶ 81.) However, defendants do not explain why these numbers are somehow inadequate for Dr. Duckworth to form an opinion on whether Adult Home residents could live in supported housing, particularly given his

extensive clinical experience. Dr. Geller, visited a total of eight Adult Homes before submitting his expert report; Gregory Kaufman visited a total of three. Defendants also fail to mention that Dr. Duckworth, in addition to his visits to Adult Homes, reviewed the medical records of 70 Adult Home residents prior to drafting his initial report, and an additional 203 randomly selected medical records prior to drafting his reply report. (Tr. 813:14–26, 819:4–17, *see also* Tr. 817:2–4 (total volume of the records reviewed occupies one-third of Dr. Duckworth's basement).) Dr. Duckworth also reviewed a number of deposition transcripts of Adult Home residents. (Tr. 813:22–814:2.) In short, Dr. Duckworth's investigation of the qualifications of Adult Home residents was wide-ranging and thorough.

97. Defendants are mistaken that Dr. Duckworth simply "presumed" that nearly all Adult Home residents could live in supported housing. (Defs.' PFF ¶ 82.) Dr. Duckworth in fact based his conclusion on his interviews with residents, his review of resident mental files, his review of resident depositions, and his comparison of Adult Home residents he met with people he had served in supported housing in his work in Massachusetts and the residents he met at Pathways to Housing. (Tr. 813:14–814:2, 854:11–21.) With regard to the last, he found that "[t]hese are the same populations[;] these are individuals living with serious and persistent mental illness who frequently have another associated vulnerability or two." (Tr. 814:8–10.)

98. Dr. Duckworth also identified, as defendants acknowledge (Defs.' PFF ¶ 82), specific "stop signs" such as dementia or nursing needs, that would require further investigation before placing the individual in supported housing. Thus, far from "presuming" that all Adult Home residents could be served in supported housing, he

specifically considered the extent to which these "stop signs" were present in the Adult Home population. (Tr. 812:15–813:13, 907:9–10.) Dr. Duckworth's conclusions that virtually all people could move were thus based not on his presumptions but on his thorough examination of the evidence—including nearly 270 medical records—and his long experience in Massachusetts with serving individuals in supported housing.

99. Defendants also attack Dr. Duckworth's analysis based on his trial testimony regarding a handful of his roughly 270 summaries of resident records, cherry-picked by defendants. (Defs.' PFF ¶¶ 83–84.) Dr. Duckworth testified that, in the case of some of defendants' residents, he would need more information to determine whether the particular individual would be appropriate for supported housing. (*See, e.g.*, Tr. 911:3, 912:15–24.) However, in testifying on direct examination, Dr. Duckworth identified a number of examples of residents whom, based on his review of their records, were well qualified for supported housing. (*See, e.g.*, Tr. at 826:25–827:19 ("This is a man that I could take in Supported Housing in a day."); Tr. 832:10–833:1 ("This person can live in Supported Housing").) Dr. Duckworth also gave detailed testimony about why Dr. Geller, in his review of resident records, greatly overestimated the supports that individuals would need to be served appropriately in supported housing. (*See, e.g.*, 843:3–844:19.) In short, the fact that not every single resident record that Dr. Duckworth reviewed demonstrated beyond a doubt that the resident could be appropriately served in supported housing in no way undermines Dr. Duckworth's conclusion that "virtually" all could be so served. Indeed, Dr. Duckworth's candid assessment of these records in his testimony only bolsters his credibility.

Elizabeth Jones

100. As set forth in DAI's Proposed Findings of Fact, Ms. Jones, an expert in community integration of individuals with mental illness with over 30 years of experience running mental health programs and developing community-based services for individuals with mental illness, reached her conclusion that virtually all Adult Home residents could be served in supported housing after an extensive investigation that included formal and unannounced visits to 23 Adult Homes and in-depth interviews with 179 Adult Home residents. (*See* DAI's PFF ¶¶ 63–69.)

101. Defendants try to discredit Ms. Jones by claiming that she "supported Plaintiff's position in this case before she completed her research." (Defs.' PFF ¶ 86.) Defendants point to a memorandum written by Ms. Jones *some nine months after* she began her investigation, in which she states some of the conclusions that appeared in her final report. (Tr. 190:18–191:4.) By this time, Ms. Jones had already visited 13 Adult Homes—already more than *any* of defendants' witnesses in their entire investigations—and had spoken to "numerous residents." (Tr. 198:3–6.) Ms. Jones explained that, based on those visits and conversations, she had "formed the clear conviction that [Adult Home residents] could live in supported housing with supports." (*Id.*) Ms. Jones explained that the memo simply reflected her then-current thinking on how her report would be structured; she would have revised her conclusions if the remaining 10 Adult Homes she subsequently visited had been different than the first 13. (Tr. 192:14–20.) They were not. (Tr. 192:24–193:1.)

102. Defendants also insinuate that Ms. Jones, in assessing Adult Home residents' qualifications for supported housing, only spoke with residents and not with their care providers. (Defs.' PFF ¶ 89) But this is simply wrong: Ms. Jones testified that

in fact she *did* speak to clinicians, nurses, social workers, and a psychiatrist at some of the homes she visited (Tr. 102:11–103:2) and also had some conversations with social workers about particular residents. (Tr. 103:6–15.)

103. Defendants allege that Ms. Jones "proceeded from the assumption" that Adult Home residents could reside in supported housing. (Defs.' PFF ¶ 88) This is also incorrect. Ms. Jones clearly described in her testimony the factual bases for her judgment that Adult Home residents could live in supported housing: (1) that "adult homes do not provide intensive supervision to people"; in other words, people "have a place to stay and they have their meals and their medicine, but not a whole lot more than that" (Tr. 80:1–11); and (2) that, based on her observations, Adult Home residents in supported housing would not "require more than is available already in the community in New York or that they presented any particular challenge other than what we work with every day in the field of mental health." (Tr. 80:20–81:6.)

104. Defendants assert that Ms. Jones could not name another supported housing provider that uses the Pathways to Housing model. But Ms. Jones testified that, while she was aware of no agency that precisely duplicates the Pathways to Housing program, there were many supported housing providers that utilize a similar model and would be willing to serve Adult Home residents:

> the principles for Pathways to Housing are espoused by other community agencies, and, in fact, that was highlighted in my reading of the proposal[s] submitted to your requests for proposals for new units of housing for adult home residents. So, maybe the agencies have different names or they are not constructed exactly like Pathways to Housing or they didn't start with homeless people, but the idea of housing first, separation of housing from treatment, providing flexible supports that are tapered based on the individual's needs, those are principles that

> are not only consistent with what other agencies have said, but they're consistent with your goals for the mental health system in New York.

(Tr. 199:7–200:4.) Ms. Jones continued that Pathways to Housing is simply "one excellent example of an agency that's worked with very challenging people; but the principles are espoused by other agencies that have applied to apply to provide housing to adult home residents." (Tr. 200:11–17.)

105. Defendants also complain that Ms. Jones was referred by MFY Legal Services to some of the 179 Adult Home residents whom she interviewed. (Defs.' PFF ¶ 87.) But when Ms. Jones was asked whether these residents were different than the other residents she spoke to, she testified: "I don't think so, nothing in a significant way . . . in terms of what their life experiences were or the conditions that they were experiencing in the adult homes or the preferences they had, they were very similar, more similar than different I would say." (Tr. 48:11–22.)

106. Finally, defendants assert that Ms. Jones "assumed" that Adult Home residents with high needs could be served in supported housing with the provision of ACT services. (Defs.' PFF ¶ 90.) Defendants claim that Ms. Jones did not provide evidence that "ACT services are commonly used" in New York in conjunction with supported housing. (*Id.*) Yet, as noted above, the evidence is overwhelming that supported housing residents in New York can and do receive ACT services. (*See*, *e.g.*, *supra* ¶¶ 56, 59, 60.) Defendants' own RFPs describe supported housing as targeted to people who may be receiving ACT services. (*See* S-17 (2005 RFP), S-33 (2007 RFP), S-67 (2008 RFP), P-748 (2009 RFP).) DAI called a witness, Dr. Tsemberis, who runs a supported housing program specifically designed around the provision of ACT services to residents. (Tr. 330:16–331:3.) Linda Rosenberg, the former Senior Deputy

Commissioner of OMH, testified that OMH has issued RFPs specifically aimed at encouraging supported housing providers to create ACT teams, and that the response from supported housing providers showed that they "know how to do [supported housing plus ACT]" (Tr. 655:13–656:23.) Defendants' own witnesses confirmed that individuals in supported housing are eligible to receive ACT services if they otherwise qualify. (Tr. 1833:10–12 (Dorfman); Tr. 1414:20–1416:1 (Reilly); Tr. 3170:19–3171:14 (Myers).) Thus, to the extent Ms. Jones's conclusions are at all based on an "assum[ption]" about the availability of ACT services to residents of supported housing, that assumption was borne out at trial by overwhelming evidence.

Dennis Jones

107. As set forth in DAI's Proposed Findings of Fact, DAI's expert Dennis Jones, who has run the mental health systems of two states and the District of Columbia, concluded after a thorough investigation that "virtually all mentally ill adult home residents are able to live in integrated community settings such as supported housing." (S-150 at 10.) Mr. Jones's conclusions were formed after he visited four Adult Homes, spoke with residents, visited community mental health providers and reviewed numerous documents, including the Adult Care Facilities Workgroup Report and the Assessment Project data. (*See* DAI's PFF ¶¶ 70–72.)

108. Defendants in particular take issue with Mr. Jones's reliance on the Assessment Project data and the Workgroup Report in forming his conclusion that virtually all Adult Home residents could move to supported housing. (Defs.' PFF ¶¶ 82–84.)

109. The Assessment Project, commissioned by DOH and conducted by Dr. Martha Bruce of Columbia University, found, among other things, that Adult Home

residents were not a seriously impaired population, and relatively few had serious difficulties with activities of daily living. (See DAI's PFF ¶¶ 86–98.)

110. Defendants assert that the Assessment Project "was never intended to be used as an assessment tool for determining what type of housing individuals were qualified for and able to reside in." (Defs.' PFF ¶ 94) But this is misleading at best. Dr. Bruce testified at her deposition that one of the intended uses for the Assessment Project data was to "screen for residents who might benefit from a changing housing to more supportive or more independent" (P-583 (Bruce Dep.) 66:21–67:7) and that, to the best of her understanding, OMH officials such as Glenn Liebman and Lisa Wickens understood this purpose (*id.* 67:24–68:13). Dr. Bruce testified that she participated in conference calls with OMH and advocacy groups in which the housing-related questions were devised and refined. (*Id.* 202:15–203:7.) OMH official Glenn Liebman testified that "[t]here were obviously questions in the assessment geared to individuals' desire to live more independently. There were questions about cognition and executive functioning and how symptomatic they were. That would all be part of any determination if people wanted to move forward . . . ." (P-555 (Liebman Dep.) 54:12–23.) Lisa Wickens testified that she was actually concerned about the survey used by the Assessment Project because the questions might lead residents to believe that they would be offered alternative housing if they participated in the survey. (P-566 (Wickens Dep.) 74:19–22.) Adult home administrator Hinda Burstein testified that residents were specifically told by the assessors that the surveys would be used to assess them for alternative housing. (Tr. 2107:17–2108:10.)

111. In any event, regardless of the *purpose* of the Assessment Project, it is indisputable that the information collected about residents' cognitive levels, ability levels, and housing preferences are directly relevant to the question of whether Adult Home residents could be served in more integrated housing. (*See* P-555 (Liebman Dep.) 54:12–23.) Mr. Jones testified that the data collected by the Assessment Project showed a "huge mismatch" between the abilities of Adult Home residents and the custodial setting in which they lived, and represented "a big problem" requiring "a very serious multi-year initiative." (Tr. 1037:18–1038:4.)

112. Mr. Jones, working with Dr. Ivor Groves, an expert in data analysis, devised an algorithm that allowed them to assess whether the Adult Home residents in 15 Adult Homes at issue in this case in which the Assessment was conducted were not opposed to moving, and also whether those residents would need a high or low level of support. That algorithm determined that of the 2,080 residents in the sample, 1,769 would be able to live in supported housing with less support, and 311 would need greater support. The algorithm also determined that 1,536 would not be opposed to moving to supported housing and 544 would be resistant. Of those who were non-resistant, only 199 would need a high level of support. (Tr. 1048:9–1050:12.)

113. In his testimony as a witness for defendants, Dr. Groves stated his bottom-line conclusion from the Assessment Project data: Adult Home residents "are not a seriously impaired population in the vast majority; meaning, they don't have severe cognitive deficits and they don't have real significant problems in daily living skills." (Tr. 3072:7–17.) Thus, "the vast majority of [Adult Home residents] could live in supported housing with appropriate supports." (Tr. 3074:19–20.)

114. Mr. Jones reached the same conclusion from the Assessment data. He testified that the analysis showed "a large majority of people who, given the right situation, would chose to [move to supported housing]" and "the amount of supports that people are going to need out there are within what I would consider the range of what the New York system can accommodate." (Tr. 1051:6–13.)

115. Strikingly, defendants' Proposed Findings of Fact contain not a word criticizing Dr. Groves's methodology or the accuracy of his conclusions. Defendants do not suggest, for example, that Dr. Groves's algorithm was flawed or his interpretation of the data incorrect. The only criticism defendants' can muster is that Dr. Groves's conclusions were derived from "aggregate data" and were not the result of in-person clinical interviews with each of the 2,080 residents in the 15 Adult Homes who participated in the Assessment. (Defs.' PFF ¶ 95.) But, as argued above, in-person clinical assessments are simply not necessary to determine whether DAI's constituents are qualified for supported housing.

116. Defendants' only other criticism of Dr. Groves's analysis is that he revised his algorithm based on concerns that the original algorithm he designed was undercounting individuals that were both qualified and unopposed to living in supported housing. Defendants point to the fact that the algorithm was revised, but never explain why the Court should not credit the legitimate concern underlying the change. (*See* Defs.' PFF ¶ 96.) As Dr. Groves explained, after running the original analysis, DAI's experts determined that the results were "under-representative" of the persons in the homes who could live in supported housing. (Tr. 3091:1–17.) Dr. Groves explained that he revised the algorithm so that it filtered out individuals with "severe cognitive

impairments or real problems in adaptive living," as well as those who had expressed that they "definitely don't want to leave" the Adult Home, as opposed to all residents who did not express an affirmative desire to leave. (*Id.*) In short, the new algorithm reflects an entirely reasonable approach to determining the numbers of Adult Home residents qualified for and not opposed to moving to supported housing.

117. Defendants also attack Mr. Jones's alleged reliance on the Workgroup Report for his conclusion that virtually all Adult Home residents could live in supported housing. (Defs.' PFF ¶ 92.)

118. As DAI set forth in its Proposed Findings of Fact, the Adult Care Facilities Workgroup was a blue ribbon commission created by defendants to make policy recommendations regarding Adult Homes in response to the "crisis atmosphere" created by the Levy articles. Defendants themselves were intimately involved in shaping the recommendations that were included in the Workgroup's final Report. That Report recommended, among other things, that the state move roughly 6,000 adult home residents into more integrated settings, including supported housing. Because the state had never systematically collected data on adult home residents, a key basis for the Workgroup's recommendation that 6,000 should move was its finding, after extensive research and investigation, that adult home residents had the same characteristics as other populations with mental illness who were living more independently. (*See* DAI's PFF ¶¶ 78–85.)

119. The Workgroup Report's recommendation that 6,000 people should be moved to more integrated service settings is significant in that it is, in effect, an admission by defendants that very large numbers of adult home residents are

inappropriately housed in adult homes. Defendants' assertion, however, that the Workgroup Report was somehow integral to Mr. Jones's conclusions that virtually all Adult Home residents could be served in supported housing ignores Mr. Jones's own testimony regarding the Report. Mr. Jones explained that while he found it significant and worth considering in his report that a "very serious and diligent group of many high-level people across the departments" concluded that 6,000 people could be served in more integrated settings than adult homes, "I didn't conclude that 6,000 people could be moved." (Tr. 1127:9–18; *see also* 1128:20–21 ("I feel like I'm repeating myself. I did not conclude that 6,000 people could move. I had no basis around which to make that determination. I was simply citing a work group that had met very diligently over a period of time, made a number of recommendations; and that was one.").)

G. Dr. Geller's Conclusions Are Not Credible

120. DAI has set forth at length in its Proposed Findings of Fact why Dr. Geller's conclusion that most Adult Home residents could not be served in supported housing is based on a deeply flawed analysis that is not credible. (*See* DAI's PFF ¶¶ 135–141.) Among other things, Dr. Geller determined the capacity of supported housing providers to serve Adult Home residents without reviewing the RFP responses of supported housing providers who actually propose to serve Adult Home residents, without considering the admission criteria of Adult Homes, which prohibit admission of individuals with many of the conditions that Dr. Geller said would bar Adult Home residents from supported housing, and without considering the limited nature of the supports that are available to residents of Adult Homes. Nothing in defendants' Proposed Findings of Fact addresses these glaring flaws in Dr. Geller's analysis. (*Id.*)

121. A particularly glaring problem with Dr. Geller's testimony is his failure to consider a single response to one of defendants' supported housing RFPs that actually target Adult Home residents. While each of DAI's experts considered such RFP responses in assessing whether New York's supported housing providers could serve Adult Home residents (*see* Tr. 1064:17–1065:12 (D. Jones); Tr. 83:9–14 (E. Jones); Tr. 857:23–862:3 (Duckworth)), Dr. Geller testified that the only RFP responses he reviewed were two responses from providers seeking to exclusively serve homeless individuals, a different population that is less likely to need support with issues of institutionalization. (Tr. 2412:5–17, 2414:17–25.)

122. Defendants also fail to grapple in their Proposed Findings of Fact with Dr. Geller's testimony on the stand that every single current resident of an Adult Home could be served in supported housing with varying degrees of support. (Tr. 2370:17–19.) Dr. Geller further conceded that 50% of Adult Home residents whose records he reviewed could eventually be appropriately served in supported housing with or without ACT services. (Tr. 2409:13–17.) Thus, even Dr. Geller analysis shows that many, many Adult Home residents are currently housed inappropriately in Adult Homes.

123. Finally, defendants point to Dr. Geller's testimony that placing virtually all Adult Home residents in supported housing would be "inhumane" and "possibly dangerous" because, for example, individuals may "set[] a fire while learning to cook," and that individuals should therefore be taught independent living skills in the Adult Homes first, and then moved to more independent settings. (Defs.' PFF ¶ 102.)

124. But Dr. Geller's testimony on this point was contradicted by numerous other witnesses. Several witnesses, including Dr. Geller himself, testified that

independent living skills cannot be taught effectively in institutional settings, because the individuals are unable to practice the skills that are taught. (Tr. 1140:10–14 (D. Jones) (teaching independent living skills in congregate settings is a "waste of good public time and money" because "[p]eople don't transfer skills from one setting another"); Tr. 67:20–69:6 (E. Jones); Tr. 2360:9–2361:1 (Geller).) In contrast, ACT teams can assist individuals with learning these independent living skills in their own homes. (*See* Tr. 938:12–14 (Duckworth) (ACT teams expect to teach people medication management); P-372 (2007 ACT Program Guidelines) at 3–4 (listing independent living skills taught by ACT team).) OMH's own commissioner has rejected the notion that individuals must progress through "transitional" housing before they may be served in a permanent, independent setting. (P-590 (2008–2009 Executive Budget Recommendation Highlights Testimony) at 4.) Finally, Dr. Tsemberis's Pathways to Housing program, which specifically seeks out and successfully serves some of the hardest-to-serve individuals in the mental health system, is proof that supported housing providers can safely serve individuals with a very wide range of support needs. (Tr. 247:8–11 (Tsemberis) ("Q. So, would it be fair to say you wouldn't shy away from difficult-to-serve clients? A. I think we seek them out and sometimes you actually have to fight the system to get them.").)

125. In short, defendants' contentions in their Proposed Findings of Fact that Adult Home residents could not be appropriately served in supported housing is contradicted by the overwhelming evidence and should be rejected.

III. DAI's Constituents Are Systematically Excluded From Defendants' Supported Housing Program

126. Defendants assert that Adult Home residents who are able to live in supported housing have access to supported housing. (Defs.' PFF ¶¶ 2, 103.) The

evidence conclusively established that the exact opposite is true. DAI's constituents have historically and systematically been excluded from supported housing, and the recent initiatives have done nothing to accommodate them. As a result, people with mental illness remain "stuck" in Adult Homes, and Adult Homes remain "overuse[d]" settings in which to provide services to people with mental illness. (P-59 (OMH Guiding Principles) at 1; S-71 (Statewide Comprehensive Plan, 2006–1010) at OMH 43287; D-182 (2009–2010 Mental Health Update & Executive Budget Testimony of OMH Commissioner M. Hogan) at OMH 43466; Tr. 2424:13–2427:15 (Geller).)

127. The numbers defendants include in their Proposed Findings of Fact show that their assertion is false that all who can and want to live in supported housing have access. Defendants acknowledge that while Adult Home residents submitted more than 800 applications for OMH-sponsored housing from January 2000 through January 2006 (Defs.' PFF ¶ 108), *only twenty-one Adult Home residents moved* to supported housing in New York City from January 2002 through January 2006 (Defs.' PFF ¶ 111), and only sixty-five Adult Home residents moved to other forms of OMH community housing in that same time period (Defs.' PFF ¶ 112). Thus, based on the most recent census data (P-774 (2008 Census Report)), only 0.5% of people with mental illness living in impacted Adult Homes, and only 2.6% of individuals submitting HRA applications, were able to access supported housing in a five-year period. If other forms of OMH housing are included, only 2% of people with mental illness living in impacted Adult Homes, and only 10% of people who submitted HRA applications, were able to access any form of OMH community housing. By no measure do these statistics evidence an effective

Olmstead plan, and by all measures they show that defendants' assertion that all who can live in supported housing have access to the program is false.

128. Given that Adult Home residents have virtually no access to supported housing, defendants' assertions—that Adult Home residents are a target population and that mental health providers and others are expected to assist residents who want to move by filling out applications or educating them about their options—are simply beside the point. Even with respect to the relatively few supported beds for which Adult Home residents have been designated as a target population, Adult Home residents are still largely denied access because the current vacancy rate is less than 2% (Tr. 1503:9–1504:2 (Madan)), residential mental health service providers have "exorbitant waiting lists" (Tr. 1874:11–20 (Dorfman); (Tr. 2983:19–2084:4 (Burstein)), and members of other priority populations receive higher priority (Tr. 660:12–20, 662:6–18 (Rosenberg); Tr. 1089:15–1091:4 (D. Jones); Tr. 2165:11–2166:17, 2198:9–2199:2 (Newman)).

129. The negligible rate at which Adult Home residents have accessed supported housing beds and the success of the recent legislative mandate to fill 60 supported housing beds set aside by the New York State legislature exclusively for Adult Home residents (*see* Tr. 1461:3–9 (Madan)), demonstrate that without a specific allocation of beds for DAI's constituents, no amount of case management or assistance will enable Adult Home residents to have access to supported housing.

130. Once the 60 supported housing beds are filled, the pipeline of supported housing beds for Adult Home residents will be closed. OMH did not propose or advance this initiative (Tr. 1460:25–1461:9, 1510:8–10 (Madan); Tr. 2141:17–2142:9 (Newman); Tr. 3354:10–17 (Schaefer-Hayes)), and defendants have made it clear that they are

opposed to set-asides for this population (*see* Defs.' Mem. of Law in Support of Motion for Summ. Judg. at 71 (arguing that "requiring the State to earmark its resources to conduct housing assessments of, and to develop and set aside Supported Housing beds . . . for New York City adult home residents" would constitute a fundamental alteration of the state's services and programs)).

131. Even if there were more supported housing beds available to Adult Home residents, the evidence shows that defendants' assertion that Adult Home residents are assisted in efforts to move out of the Adult Homes has little support. Defendants maintain that OMH-funded case managers "educate residents about housing options available to them," and "assist residents who are interested in moving" by filing the necessary applications and interfacing with housing providers. (Defs.' PFF ¶¶ 104–105.) Yet Frances Lockhart testified that, in her eight years working for Federation of Organizations, which provided case management services in four Adult Homes, she recalled *two residents* who moved to supported housing, whom Federation assisted to fill out the HRA form and go on interviews. (Tr. 2630:25–2632:4.) Jonas Waizer, the chief operating officer FEGS, a case management and housing provider, testified that he is "really not aware" of any residents of Riverdale Manor, where FEGS operates, who have been placed into FEGS's supported housing program. (Tr. 2551:19–2552:16 (Waizer).) Adult Home administrator Hinda Burstein testified that since the OMH Case Management Initiative began in Park Inn Adult Home three years ago, not one resident has been discharged to supported housing. (Tr. 2079:17–2080:16 ("I don't think we discharged any to supported [housing].").)

132. Moreover, the Case Management Initiative is in only a minority of the Adult Homes at issue in this litigation, and defendants concede that residents who live in one of the Homes that does not participate in the Initiative are unlikely ever to be informed about, or receive assistance with, securing alternative housing. (Tr. 2917:3–2918:4 (Kaufman) (testifying about his observations that Adult Home staff and on-site treatment providers were not "up-to-date" and "could benefit from education as to what is going on in the field," what expectations are possible, and "what services could be provided . . ."); Tr. 2663:15–2664:16 (Lockhart) (stating that residents who have not participated in a case management program would not likely be familiar with alternative housing opportunities).) While defendants' witnesses repeatedly testified that they "expected" Adult Home case managers and social workers and other mental health professionals to follow up on residents' expressed desires to move to more integrated housing (Tr. 1500:13–1502:3 (Madan); Tr. 1365:16–1366:17 (Reilly)), they conceded that they have no idea whether residents receive any information from those case managers about alternatives (Tr. 1835:15–18 (Dorfman)). Given that some Adult Homes have been cited for a failure to follow up on residents' expressed desire to move (Joint Stipulations of Fact ¶ 22), the assumption that those case managers are effective at assisting residents is unwarranted.

133. The record is replete with testimony from residents explaining that they received no help—and often outright discouragement—from case managers, social workers and Adult Home staff, in exploring and securing alternative housing options. (*See*, *e.g.*, Tr. 614:20–615:13 (S.P.) (his case managers started filling out an HRA 2000 application for him but "didn't finish it," and did not, to his knowledge, ever submit it);

Tr. 390:21–25 (S.K.) (case managers "put [her] off," telling her "there's nothing available right now"); Tr. 452:1–454:22 (G.L.) (conversations with his social worker about housing were "very discouraging." She provided "very, very little" information about what might be available and what the process would be, and "never talked about doing any paperwork." "She would throw a phone number at me and say, why don't you give them a call," following up with "don't be disappointed if they can't help you"); P-536 (D.N. Dep.) 150:17–153:2, 154:10–22 (when she asked for help obtaining an application for New York City housing, one social worker told her it would be "better if you stay here," and another refused to assist her); *see also id.* Tr. 155:7–156:22 (when she asked for assistance in moving to independent housing, the case manager responded "we don't do that here"); P-540 (P.B. Dep.) 185:17–19, 186:5–14[17] (she "tried to move out once and they tell me no, they want me to stay. . . . I have to stay"); P-542 (L.G. Dep.) 105:25–106:24 (testifying that although her therapist encouraged her to move out of the Adult Home, she never mentioned supported or any other type of OMH housing, and never discussed the application process; resident testified she "[does] everything on [her] own").)

IV. Defendants Have No Comprehensive or Effective Plan to Enable Adult Home Residents to Receive Services in the Most Integrated Setting

134. Defendants have no comprehensive or effective plan to enable DAI's constituents to move to more integrated settings. Instead, defendants have maintained throughout this litigation that no plan is needed for people with mental illness residing in Adult Homes. (S-133 (Defs.' Obj. & Resp. to Pl.'s 1st Set of Reqs. for Admissions) at 9

[17] Defendants object to the admissibility of this testimony pursuant to Fed. R. Civ. P. 802.

("there is no need for an *Olmstead* plan for adult home residents"); S-87 (Defs.' Am. Obj. & Resp. to Pl.'s 1st Set of Reqs. for Admissions) at 2 (same); *see also* Defs.' PFF ¶ 238 ("Assuming arguendo . . . that *Olmstead* were to be expanded to require a "plan" for adult home residents . . ."); Defs.' PFF ¶ 122 (arguing that New York's *Olmstead* plan is designed with the intention of providing services outside of a hospital).) Thus, defendants do not believe *Olmstead* requires a plan for Adult Home residents; they do not believe a plan is needed; and they have therefore declined to develop a plan to enable Adult Home residents to move to more integrated settings. In other words, they *admit* there is no *Olmstead* plan to enable people with mental illness in Adult Homes to receive services in an integrated setting. Indeed, the evidence presented at trial—including evidence of significant expenditures to Adult Homes for infrastructure and other improvements and of the facilitation of referrals of patients from state psychiatric hospitals to Adult Homes—established that defendants are committed to maintaining the status quo.

135. Despite their admission that they have not developed a plan, defendants describe in their Proposed Findings of Fact a number of activities which, according to them, comprise a "comprehensive, effective *Olmstead* plan." (*See* Defs.' PFF ¶¶ 116–143.) Defendants have assembled this purported *Olmstead* plan entirely post hoc for their post-trial submission. Not one State official or other witness at trial identified or described a comprehensive plan to enable Adult Home residents to receive services in more integrated settings. Not one State official or other witness at trial identified any of the activities now listed in defendants' brief as part of a plan to enable Adult Home residents to move to more integrated settings.

136. The activities listed by defendants' attorneys in their post-trial submission do not—either alone or together—comprise a comprehensive, effective plan to enable DAI's constituents to receive services in more integrated settings. Indeed, several activities described in defendants' Proposed Findings of Fact have nothing to do with people with mental illness who reside in Adult Homes. (*See, e.g.*, Defs.' PFF ¶¶ 118–20, 125 (describing activities relating to the children's division, the forensic division, research and the deinstitutionalization of people from state psychiatric hospitals).) Defendants have also characterized as part of their *Olmstead* plan for Adult Home residents certain services for which they have claimed DAI's constituents are not eligible. For example, defendants assert that ACT team slots are part of their purported *Olmstead* plan for Adult Home residents (Defs.' PFF ¶¶ 126–27) but elsewhere in their brief they assert (albeit wrongly) that ACT teams "are not appropriate for" Adult Home residents. (Defs.' PFF at 31 (Heading III.C).)

137. Defendants claim that "[m]uch of [their] Olmstead planning is reflected in OMH's Statewide Comprehensive Plans for Mental Health Services, referred to as 5.07 plans." (Defs.' PFF ¶ 123 (citing various 5.07 plans: S-5, S-6, S-8, S-38, S-39).) None of defendants' witnesses at trial, however, testified about the 5.07 plans or their connection to any purported *Olmstead* plan for Adult Home residents, and indeed the documents contain no reference to any plan to enable Adult Home residents to move to more integrated settings. Defendants cite to an appendix in the January 2004 5.07 plan, titled "Interagency Adult Home Initiative." (Defs.' PFF ¶ 123 (citing S-5 at OMH 6136–38).) The appendix does not appear in any of the other 5.07 plans cited by defendants. (*See* S-6 (2005 Plan), S-8 (2006 Plan), S-38 (2002 Plan), S-30 (2001 Plan).) The

activities enumerated in the appendix focus on improving the quality of life and care for residents *in* Adult Homes, rather than taking steps to enable residents of Adult Homes to move to more integrated settings. To the extent the document mentions housing, it describes "assisting residents in homes that are closing." (S-5 at OMH 6138.) While the document references "[i]ncreas[ing] access to 31,000 community residential beds," it does not describe how such access was to be improved. (*Id.*) Indeed, the evidence demonstrated that Adult Home residents have been categorically excluded from most OMH community residential beds and do not receive priority for others, such that they are effectively excluded. (*See* DAI's PFF ¶¶ 177–79; *see also supra* ¶¶ 126-28.) Finally, defendants' most recent 5.07 plan update, dated October 2008, acknowledges that adult homes are "overuse[d]." (S-71 at OMH 43287) and identifies no plan to solve the problem.

138. Surprisingly, defendants assert that the Most Integrated Settings Coordinating Council ("MISCC") and the Coalition to Promote Community Based Care are aspects of "the State's more formal efforts to ensure compliance with the *Olmstead* decision." (Defs.' PFF ¶ 133.) As in other sections of their Proposed Findings of Fact, defendants cite to no record evidence in support of their assertion.[18] Indeed, with respect to the so-called Coalition to Promote Community Based Care in particular, there was no mention of it at trial in either testimony or exhibits. Thus, it cannot be considered by the Court. With respect to MISCC, it is undisputed that MISCC did not develop a plan to

[18] Similarly, in paragraph 132 of their Proposed Findings, defendants describe various "[a]dditional components of defendants' *Olmstead* plan," without citing to a single piece of documentary or testimonial evidence. Because defendants cite no support for their assertions in paragraph 132, there is no basis for a finding of fact as to those assertions and they should be rejected.

enable Adult Home residents to receive services in more integrated settings. (Defs.' PFF ¶ 133; *see also* DAI's PFF ¶¶ 171–72.) Defendants assert without evidentiary support that MISCC addressed "the adequacy of and access to community services for all individuals with disabilities, including adult home residents," but their designated Rule 30(b)(6) witness, Kathryn Kuhmerker, testified that other than "occasional discussions" regarding Adult Home residents:

> I don't believe there's been anything specific that the MISCC has done to specifically address in any way, shape, or form individuals who happen to reside in adult homes.

(P-553 (Kuhmerker Dep.) 31:4–7; *see also id.* 33:12–24 (explaining that the MISCC has no plan for placing Adult Home residents who otherwise meet the criteria for living in supported housing or OMH community housing into any of those types of residential programs).)

139. The majority of the activities listed by defendants as part of their purported *Olmstead* plan entail efforts to improve safety and quality of services *in the Adult Homes*, as opposed to enabling Adult Home residents to move from the Adult Homes to more integrated settings. (*See* Defs.' PFF ¶¶ 129–131, 134–138, 142.) Defendants assert that DOH's licensure and enforcement of regulations governing Adult Homes are part of their *Olmstead* plan (Defs.' PFF ¶ 131) but they cite no evidentiary support for this assertion nor do they explain how these activities enable Adult Home residents to move to more integrated settings. Defendants also claim that the Inter-Agency Committee on Adult Homes and the OMH Adult Home Team have "addressed issues of quality of care in adult homes," "developed a mechanism for joint inspections," "took steps to strengthen the Do Not Refer list," "enhanced the oversight of mental health programs providing services to residents on-site in adult homes and off-site," and

"investigated complaints." (Defs.' PFF ¶¶ 135–36.) All of these activities, even if successful, relate to improving conditions for Adult Home residents *in* Adult Homes, and therefore cannot seriously be considered part of a plan or commitment to enable individuals in Adult Homes to move to more integrated service settings.[19] Indeed, one of the witnesses whose testimony defendants cite for the proposition that the Adult Home Team is part of their *Olmstead* plan testified that OMH does not do anything to investigate whether there are residents of Adult Homes who would be more appropriately placed in supported housing and that, to her knowledge, no one is assessing whether residents of Adult Homes would be more appropriately situated in supported housing. (P-564 (Tacoronti Dep.) 202:12–203:6.) If anything, the activities enumerated by defendants evidence a commitment to maintaining the status quo.

140. Despite attempting elsewhere to disown the work of the Adult Care Facilities Workgroup and the New York Presbyterian Hospital Assessment Project (*see, e.g.*, Defs.' PFF ¶¶ 92–94) defendants claim that those initiatives are part of their *Olmstead* plan for Adult Home residents (*see* Defs.' PFF ¶¶ 137–138). With respect to the Adult Care Facilities Workgroup, defendants rejected the Workgroup's recommendation that proposed a timeline for moving 6,000 people with mental illness from adult homes into supported housing. (Tr. 1640:23–1645:12 (Wollner).) Most of the

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[19] Defendants cite no evidence suggesting that any of these efforts have been successful in improving the lives of Adult Home residents, as they allege. In support of their assertion, they cite an excerpt from the deposition of one Adult Home resident, R.H., but the excerpt they cite has not been admitted into evidence. (Defs.' PFF ¶ 134.) In any event, it has nothing to do with any "acknowledgment that these steps have improved conditions and the quality of life for residents." (P-543 (R.H. Dep.) 130:9-131:15 (testifying that while he was pleased that there was a $14 increase in PNA allowance, it needed to be more because he and other residents have to rely on donations for clothing).)

recommendations that were implemented by defendants had to do with curbing the abuses that had been occurring in the Adult Homes, as opposed to taking steps to enable Adult Home residents to move to more integrated settings. (Tr. 1623:18–1639:19 (Wollner) (describing (1) medication training for adult home staff (not adult home residents); (2) changes in the ability of DOH to fine homes that were endangering residents; (3) expanding the Do Not Refer list to include prohibiting the Department of Corrections and Parole from referring individuals to homes with serious deficiencies).) Defendants implemented the Workgroup's recommendations relating to assessments and case management, but as discussed further below and in DAI's Proposed Findings of Fact, those activities have not had any meaningful effect on the ability of Adult Home residents to access supported housing or OMH community housing.

141. In December 2002, DOH contracted with New York Presbyterian Hospital to conduct an assessment of residents in 19 adult homes in New York City, resulting in the New York State Adult Home Assessment Project. (P-591 (Joint Stipulations of Fact) ¶¶ 7–8; Tr. 1678:10–13 (Wollner).)

142. One of the original purposes of the Assessment Project was to assess adult home residents' needs and desires regarding the settings in which they received services. (P-583 (Bruce Dep.) 66:21–68:13; P-555 (Liebman Dep.) 25:19–23 (testifying that "part of the assessment process was to review to see if there were people who wanted to live in other settings"), 134:20–135:8 (testifying that one of the aims of the assessments was to contribute to housing decisions for adult home residents); Tr. 1676:22–1678:9 (Wollner); Tr. 2108:6–10 (Burstein).)

143. The data collected in the Assessment Project could have been useful to assist the State in identifying and assisting Adult Home residents to move to more integrated settings. (P-583 (Bruce Dep.) 52:20–53:9, 55:21–25.) As DAI's expert Dennis Jones explained:

> [T]his was a very rich set of data, frankly better than you get in most decision-making projects, where you really knew something about the psychiatric history, you knew something about the level of impairment and you knew something about the physical history, the degree of cooperation, all those sorts of things.
>
> So when I looked at this, I guess several things jumped out at me. One is that, yes, we do have a group of people who are in the main, have an identifiable diagnosable mental illness. No question about that we're dealing with. And—but, secondly, that when you get down to the question of, is that psychiatric impairment or the concomitant physical impairment such that people need to be in a 24-hour setting? I would say the answer was a very clear no, they do not. That our technology allows us to care for people in integrated settings and provide both the mental health supports that they need, the life supports that they need and whatever physical supports that they need in an integrated setting.

(Tr. 1036:7–1037:11 (D. Jones).) When asked whether he would have considered the Assessment Project data to be relevant and important when he was a state mental health commissioner, Mr. Jones explained:

> Absolutely. I mean this is just a what I'd call an in-your-face sort of report. And I mean what it says, which, you know, certainly anecdotally and in terms of part reports, you know, I came in understanding or believing might be the case was that we had this huge mismatch between people who ended up in these settings and the settings themselves and what they can and should be able to do. So you've got a huge, a huge mismatch.
>
> And so if I were commissioner looking at this, I would say, wow, we've got a big problem here and we're going to

> have to put together a very serious multi-year initiative to deal with this.

(Tr. 1037:18–1038:4.)

144. Despite the validity of the Assessment Project data, the State embargoed the results because of this litigation. (P-583 (Bruce Dep.) 43:2–9.) The State also prohibited Dr. Bruce from performing analyses for use in her own research. (P-583 (Bruce Dep.) 54:8–21; *see also* P-566 (Wickens Dep.) 90:1–15 (stating that Columbia-Presbyterian had not analyzed Assessment data to determine how many Adult Home residents could live in integrated settings).)

145. In the end, the State used the data collected in the Assessment Project in a very limited manner. (Tr. 1348:3–12 (Reilly).) The data was disseminated to OMH-funded case managers in a minority of impacted Adult Homes several years after it was collected. (*Id.*) Defendants presented no evidence that the data has been used to enable Adult Home residents to move to more integrated settings, or in connection with their strategic planning. (Tr. 1623:2–17 (Wollner).) Nor have defendants shared the data with the MISCC or the Adult Care Facilities Workgroup so that it might be used in their planning. (P-566 (Wickens Dep.) 93:10–13, 94:8–95:2.) Indeed, while the evidence showed that one of the initial purposes of the Assessment Project was to assess Adult Home residents' needs and desires relating to the settings in which they receive services, *see supra* ¶ 110, the defendants argued at trial and in their Proposed Findings of Fact that "the [Assessment Project] was never intended to be used as an assessment tool for determining what type of housing individuals were qualified for and able to reside in." (Defs.' PFF ¶ 94.) Thus, they admit the Assessment Project is not part of any plan to enable Adult Home residents to move to more integrated settings.

146. The Assessment Project, which at its inception had the potential to aid Adult Home residents, instead turned out to be window dressing. Indeed, a former high-ranking OMH official, Linda Rosenberg, testified that, in her view, the assessments were done to "deflect[] . . . what had become a crisis for the Governor's office." (Tr. 740:2–3 (Rosenberg); *see also* P-543 (R.H. Dep.) 28:16–29:3 (Adult Home resident explaining that after the assessments were done, they never heard anything back).)

147. Defendants also claim that the EnAble, case management and peer support program that have been implemented in a minority of the impacted Adult Homes in New York City also constitute part of their *Olmstead* plan for Adult Home residents. (Defs.' PFF ¶ 141.) As discussed in DAI's Proposed Findings of Fact, however, these initiatives have had and will continue to have very little, if any, effect on enabling Adult Home residents to receive services in more integrated settings. (*See* DAI's PFF ¶¶ 186–195.) As both sides' experts testified, the provision of independent skills training is effective only if coupled with the opportunity to apply such skills in real life. (DAI's PFF ¶ 193.) As long as Adult Home residents are excluded from supported housing and remain in dependency-based settings where they are not permitted to conduct their own activities of daily living, they will not have the opportunity to enhance their independent living skills. (*Id.*) As DAI's expert Dennis Jones explained:

> [I]f case management—primarily what it does is to arrange services within the existing setting and not really deal—not deal frontally with the issue of where people live, then it is not accomplishing very much. . . . [U]nless you have a systemic initiative here that moves to create significant numbers of supported housing slots into which people can go and there is a clear organizational commitment to make that happen up and down the line, no individual case manager is going to do anything more than what I think they have been doing, which is doing the best they can,

> without any commitment. And that translates into the status quo.

(Tr. 1172:1–1173:2.)

148. Finally, defendants claim as part of their *Olmstead* plan the fact that Adult Home residents were added as a target population for housing licensed or funded by OMH. (Defs.' PFF ¶ 143.) As discussed above, however, *supra* ¶ 128, and in DAI's Proposed Findings of Fact, even after being designated as a target population for the first time in 2005, Adult Home residents have continued, for the most part, to be denied access to supported housing because other target populations continue to receive priority to the exclusion of Adult Home residents. (DAI's PFF ¶ 179.)

149. Moreover, Adult Home residents appear no longer to be a priority population for supported housing beds. (*See* P-748 (2009 RFP).) While defendants claim that some Adult Home residents have in fact moved from Adult Homes (Defs.' PFF ¶ 143), the data regarding the small number of residents who have moved to OMH community housing show that any efforts defendants have taken are a far cry from an effective or comprehensive plan.

V. Defendants Have Not Shown that the Requested Relief Would Increase Costs

150. The State has the burden of proving its fundamental alteration defense by a preponderance of the evidence. Although the State argues that the proposed relief would increase the cost to the State if current Adult Home residents were instead served in supported housing (Defs.' PFF ¶¶ 144–61, 221–27; *see also* D-398 (chart prepared by Gregory Kipper); D-441 (chart prepared by Martha Schaefer-Hayes); Tr. 2774:20–2775:1 (Kipper); Tr. 3341:6–3342:9 (Schaefer-Hayes)), it has not done any analysis to determine

the financial impact of the requested relief (Tr. 3368:7–3369:8 (Schaefer-Hayes)). Its fundamental alteration defense fails for that reason alone.

151. Recognizing that its failure to conduct an adequate analysis is fatal to its fundamental alteration defense, the State claims that it "could not put on more specific evidence of the costs in support of its fundamental alteration defense" because it needed information about the precise number of residents DAI believes could be served in supported housing and the exact mix of supports each individual would need for that to occur. (Defs.' PFF ¶ 223.) Defendants' cost expert, Mr. Kipper, however, conceded that there are any number of ways that an estimate could have been done to arrive at approximate figures. (Tr. 2834:21–2835:24; *see also* Tr. 3464:19–21 (D. Jones Rebuttal) (explaining that "there are probably multiple ways that one could slice and dice" the data).)

152. For example, the State identifies its programs by unique "program codes" (Tr. 3241:7–11 (Schaefer-Hayes).) The State could have used its own Medicaid database to compare services for former Adult Home residents before and after they moved to supported housing using those codes. (Tr. 2834:21–2835:24 (Kipper); Tr. 3464:22–25 (D. Jones).) As Mr. Jones testified, because the Medicaid data is categorized by codes for various programs, the State could have looked at what it was "spending for those people while they were in adult homes and what [] it [is] now spending for them subsequently in supported housing." (Tr. 3465:1–6.)

A. Defendants' Analysis is Fatally Flawed Because They Failed to Consider All the Costs of Serving Adult Home Residents in Adult Homes

153. Both residents of Adult Homes and residents of supported housing receive services funded by Medicaid, which is paid for jointly by the State and the federal

government. (S-55 (Kipper Report) at 7–8 & n.4.) As discussed in DAI's Proposed Findings of Fact ¶¶ 202–14, defendants' comparison of the cost of serving a person with mental illness in an Adult Home versus the cost of serving that person in supported housing ignores significant savings that could be achieved in Medicaid costs by serving such persons in supported housing.

154. The State's own analyses show (a) that Medicaid costs are, on average, $15,000 higher per person for Adult Home residents than they are for residents of supported housing (P-63 (State's Analysis) at DOH 0131663–64; *see also* P-773 (D. Jones Summary of Cost Evidence) at 1; Tr. 3424:2–14 (D. Jones Rebuttal); S-55 (Kipper Report) at 8), and (b) that there has historically been a pattern of "over-utilization"—if not outright fraud—with regard to Medicaid expenditures in Adult Homes (P-94 (Commission on Quality of Care and Advocacy for Persons with Disabilities, *A Review of Assisted Living Programs in "Impacted" Adult Homes*, June 2007 ("2007 ALP Report")); P-228 (New York State Commission on Quality of Care, *Adult Homes Serving Residents with Mental Illness: A Study on Layering of Services*, August 2002 ("Layering Report"))).

155. Rather than delve into their own data, the State glosses over these facts by assuming that the over-utilization problem has been remedied (*see* Defs.' PFF ¶¶ 225–26 (stating that there is no "evidence of current Medicaid abuse"); Tr. 2833:7–25 (Kipper) (testifying that he "thought the problem would have been addressed")), or alternatively, asserting that the difference in cost can be attributed to the characteristics of the persons living in the Adult Homes rather than the nature of the Adult Homes themselves (*see* Defs.' PFF ¶¶ 155, 227; *see also* S-144 (Kipper Report) (opining that there is no "causal link between Medicaid spending and residential setting")). The State undertook no

analysis to prove either assertion, however, and neither is supported by the evidence in the record.

156. The Layering Report, released by the New York State Commission on Quality of Care in 2002, was only one of several studies that were highly critical of the Adult Home system of care. (*See generally* P-228.) The Layering Report did not report a mild concern with a temporary situation. Instead, the Report called the entire Adult Home system of care "fundamentally flawed" and in need of "reform." (*Id.* at CQC 114–15.) The Report documented ingrained "structural problems" that had been ongoing for "more than 25 years" (*id.* at CQC 97), describing a system

> in which services are often not sought by the recipient, but initiated by the practitioner; in which providers fail to communicate with one another on treatments and medications, even on such matters as the need for surgery; and, in which the primary care physician plays no role in assuring that services are coordinated effectively.

(*Id.* at CQC 96.)

157. The findings in the Layering Report are entirely consistent with findings reached in other reviews and reports. (*See* D-385 (Commission on Quality of Care, *Health Care in Impacted Adult Homes: A Survey*, May 2006 ("Health Care Report") (finding that because primary care physicians and specialists provided services on-site at Adult Homes, "this sometimes meant that individuals were seen monthly by their primary care physician even when they had no complaints and had made no request to see him/her" and that "individuals were screened by specialists [such as dermatologists and gynecologists] when they had no documented need for such"); P-94 (2007 ALP Report) at i (finding that assisted living services provided to Adult Home residents "were not commensurate with the increased charges to Medicaid"); S-103 (Workgroup Report) at

DOH 86205–209 (discussing potential Medicaid savings from reforming services to Adult Home residents).)

158. Several witnesses also identified the same problems as the Layering Report. (*E.g.*, Tr. 709:22–710:4 (Rosenberg) (testifying that Adult Home residents had home health aides that worked for agencies owned by the Adult Home operators and billed their services to Medicaid, but that residents were unaware they even had home health aides); Tr. 3431:12–3432:19 (D. Jones Rebuttal) (explaining Workgroup's Payment Subworkgroup's finding that there was over-utilization of nursing services and home health aides in Adult Homes).) Given the magnitude of the problems found with Adult Home Medicaid services, and the fact that they had been going on for decades, the State's professed belief that the problems had been resolved is difficult to swallow.

159. In fact, defendants' assertion that the problems identified in the Layering Report had been resolved before Mr. Kipper's analysis in this case is flatly contradicted by the numbers themselves. The Layering Report found that the average Medicaid costs in Homes it analyzed exceeded $27,000 per resident, a figure that it called "expensive" and indicative of "uncoordinated" and "unnecessary" services. (P-228 at CQC 96.) When the State analyzed the Medicaid data for this litigation for the fiscal year 2004–2005, two years after the Layering Report was issued, the average cost in all the Homes analyzed totaled $31,830 per resident—nearly $5,000 more per resident on average than the $27,000 figure found in only the eleven largest Homes in 2002. (P-63 (State's Analysis) at DOH 131637.) The State's Analysis found that twenty Homes still had expenditures in excess of $27,000 per resident, and seven Homes had costs exceeding $35,000 per resident—a *30% increase* in costs since the release of the Layering Report.

(P-63 at DOH 131637.) The State's assumption that these cost problems have somehow been fixed is thus impossible to reconcile with the facts.

160. Nor were the problems identified in the Layering Report limited to a few isolated Homes, as defendants suggest. Rather, the Layering Report found that financial abuses existed in at least "the 11 largest adult homes in the greater New York City area," Homes that together "cared for about one-fifth of the total population of 'impacted adult homes.'" (P-228 at CQC 99.) Most of those Homes continue to serve Adult Home residents to this day. (*See* P-774 (2008 Census Report).)

161. The State continues to blame Adult Home residents for the higher Medicaid costs in Adult Homes, asserting that their "needs are greater than those of the average supported housing resident." (*See* Defs.' PFF ¶¶ 155, 226–27.) There is no evidence in the record to support that proposition. The Layering Report, for example, showed that the problem is with *the system of care*, not with the residents subject to the system. There is no discussion in the Report about characteristics of the *residents* leading to high costs. Instead, the Report details at length the "multiple layers of services from different providers that [are] costly, fragmented, sometimes unnecessary, and often appear[] to be revenue-driven, rather than based on medical necessity." (P-228 at CQC 100.) Far from being driven by the needs of Adult Home residents, the Report found that services were "characterized by their lack of individualization," and that the "breadth" and "volume" of services is instead "attributed to easy accessibility and the absence of a gatekeeper or service coordinator." (*Id.*)

162. The State's Analysis of the comparative Medicaid data for 2004–2005—an apples to apples comparison of Adult Home residents with similarly-diagnosed

residents of supported housing—also demonstrates that the problem is with the system of care and not with the residents. (*See generally* P-63 (State's Analysis).) Defendants' expert, Mr. Kipper, agreed that the State's Analysis of the comparative Medicaid data "divide[d] [the two] populations into subgroups that had similar characteristics" "based on diagnosis codes in the Medicaid database." (Tr. 2827:6–2828:16.) Mr. Kipper also agreed that "no matter how you cut the data you get the same kind of result, it's considerably higher in the adult home than in supported housing." (Tr. 2830:19–24.) In fact, the data showed plainly that for every category, the savings in supported housing were staggering, ranging from $10,000 to $18,700 per person. (P-63 (State's Analysis) at DOH 131663–64.) That is, for persons with a given diagnosis, the State was likely to pay many thousands of dollars more per year for that person if he or she lived in an Adult Home than if he or she lived in supported housing. (*See id.*)

163. Similarly, at trial Mr. Kipper pointed to D-385, the Health Care Report, as one source of his view that Adult Home residents had higher needs than residents of supported housing. (Tr. 2789:11–2792:6.) The reference to that report, however, is misleading. That report compared the medical needs of Adult Home residents with the medical needs of *the general population*, not with the medical needs of residents of supported housing. (*See* D-385 at 2–3 (describing the fact that Adult Home residents had higher incidences of certain disorders than "the general American population").) In fact, the report explained that its findings were not surprising because people with serious psychiatric disorders "may [be] predispose[d] . . . to certain health risks" because of lifestyle choices, the psychotropic medications they take, and their limited incomes. (*Id.* at 2–3.) None of those factors are unique to Adult Home residents, but instead are

generally applicable to persons with mental illness whether they are served in an Adult Home or in supported housing. There is nothing in this report that supports defendants' argument that Adult Home residents are a needier population than residents of supported housing.

164. Finally, the State argues that residents of Adult Homes must be needier than residents of supported housing because supported housing "is the most independent type of mental health housing." (Defs.' PFF ¶ 155.) The record is replete, however, with evidence showing that many Adult Home residents are very independent and that very few receive meaningful supervision from Adult Homes. (Tr. 122:11–17 (E. Jones); D-394 (Schimke Dep.) 54:13–54:22 (explaining her frustration when Adult Home residents are called "low-functioning"); *see also generally* Tr. 359:11–420:3 (testimony of S.K.); Tr. 438:7–547:9 (testimony of G.L.); Tr. 548:16–620:10 (testimony of S.P.); 2679:18–2708:10, 2714:6–2753:18 (testimony of I.K.) (fact that these current and former Adult Home residents were able to appear in court and withstand the stress of testifying indicates a high level of independence); DAI's PFF ¶¶ 86–98; *supra*, ¶¶ 67-71.) The evidence is also clear that whether or not a person with mental illness is placed in an Adult Home rather than in supported housing is the "luck of the draw." (*See* Tr. 709:8–12 (Rosenberg); *see also* Tr. 646:14–18; D-394 (Schimke Dep.) 10:10–11:10; P-68 (Stone Memo).) For these reasons, too, defendants' argument that Adult Home residents are somehow needier than residents of supported housing should be rejected.

B. There Is No Evidence that Many Adult Home Residents Would Require the Services of an ACT Team if they Were Served in Supported Housing

165. Defendants wrongly assert that DAI's experts "conceded that many, if not all, of plaintiff's constituents will need additional services to live in scatter site supported

housing" (Defs.' PFF ¶ 160) despite clear testimony to the contrary (*e.g.*, Tr. 83:24–84:8 (E. Jones) (concluding that "many people" in Adult Homes could move to supported housing with "little or no support"); Tr. 3072:7–17 (Groves) (testifying that Adult Home residents are "not a seriously impaired population in the vast majority"); *see also* DAI's PFF ¶¶ 86–98). Based solely on that assertion, defendants argue that "it is likely that many [Adult Home residents] would need the services of an ACT team." (Defs.' PFF ¶ 160.) Alternatively, they hypothesize that some Adult Home residents might require an "Intensive Case Manager" or "additional services that cannot be provided by an ACT team or a case manager, such as a home health aide." (*Id.*)

166. As a threshold matter, defendants' argument ignores the fact that current supported housing residents receive these services already (Tr. 223:3–16, 224:9–14, 237:10–18 (Tsemberis); Tr. 2413:9–2414:1 (Geller); P-286 (TSI proposal in response to RFP) as OMH 42968), and the cost of these services is *already* included in the Medicaid comparison between Adult Home residents and supported housing residents (*see* D-441 (chart prepared by Schaefer Hayes) (showing the Medicaid percentages the State pays)).

167. Moreover, showing that it is *possible* that Adult Home residents might need additional services is a far cry from proving it is so by a preponderance of the evidence. As with the other figures necessary for their fundamental alteration defense, the State has made no showing that many Adult Home residents would require ACT (*see* Tr. 3464:19:20–21 (D. Jones Rebuttal)); neither have defendants presented the Court with any analysis comparing the cost of ACT with the cost of the various mental health services those residents currently receive.

168. To the contrary, there is evidence that a great number of residents would require very little support to live in supported housing. (*See* Tr. 83:24–84:8 (E. Jones); Tr. 856:12–14 (Duckworth).) Dr. Tsemberis testified, for example, that "there is nothing about [Adult Home residents] that make[s] them a different class [of] people with mental illness than any other people with severe mental illness that are getting services in all kinds of other settings . . . ." (Tr. 287:4–22.) Plaintiff's expert, Dr. Duckworth, also found that the population of Adult Home residents and the population of persons in supported housing was "identical." (Tr. 854:11–855:1, 856:12–14.) S.K., a current Adult Home resident, was asked what she would need in order to live in more independent housing. Her response was simply that she "would like to have somebody to call in on me once in a while just to see how things are doing. I'd like to have somebody there that I could call." (Tr. 390:12–16.) Similarly, G.L., a former Adult Home resident that now lives in a Pathways to Housing home, testified that he does not use ACT services. (Tr. 459:5–16 (G.L.).) Even defendants' expert Dr. Geller conceded that 29% of current Adult Home residents in his sample could go to supported housing "without ancillary services." (Tr. 2406:6–16.) Clearly, there is no basis to assume that Adult Home residents will require ACT services more than anyone else in supported housing.

169. Nor have the defendants presented any evidence comparing the cost of supported housing with ACT services to the cost of supported plus the other Medicaid Services that supported housing residents receive when they do not utilize an ACT team. As Mr. Jones testified, "ACT is a bundled set of services, so that if you're in an ACT team, that . . . ACT team really provides the full gamut of what you're going to need in terms of mental health services." (Tr. 3462:23–3463:1.) Thus, residents with an ACT

team will not be incurring the expense of other programs offered by the State. As OMH's website explains, ACT services are carried out "at the locations where problems occur and support is needed rather than in hospital and clinic settings." (S-97 (OMH website describing ACT) at 1.) That shift in the locus of services means that costs formerly borne by the State are avoided: "Studies have shown that recipients who receive ACT services experience greater reductions in psychiatric hospitalization rates and a higher level of housing stability. Research has also shown that ACT . . . is no more expensive than other types of community-based care." (*Id.*; *see also* Tr. 3428:11–3429:8 (D. Jones); P-725 (SAMSHA Report) at 5–6 (federal agency's study found that supported housing with ACT services cost less than supported housing coupled with traditional community services, and that residents who received ACT spent less time in psychiatric hospitals than persons receiving traditional community services).) Thus, even if many of DAI's constituents would need ACT services, the defendants have not proven it would be more costly.

170. The State also argues that the cost of assessments of Adult Home residents should be included in the cost of DAI's requested relief, and argues that that cost will "undoubtedly" be more than the $1.3 million it spent on the Assessment Project. (Defs.' PFF ¶ 222.) That argument is without support in the record. Defendants' bald assertions ignore that supported housing providers, as part of their work, routinely do assessments to identify supports and services. (*See* P-748 at 4 (2009 RFP) (requiring supported housing providers to "provide in-reach, develop coordinated discharge/admission plans with PC staff, and identify/provide services and supports to ensure successful transition to the community").) It also ignores that case managers are already expected to assist

Adult Home residents to move to more integrated settings. (Tr. 1500:13–1502:3 (Madan); Tr. 1365:16–1366:17 (Reilly).) There is thus no evidence in the record that the State would need to expend money hiring an outside contractor to conduct assessments.

171. Finally, the State argues that "increased administrative and staff costs for OMH of overseeing additional supported housing should also be considered." (*Id.*) There is no evidence in the record, however, demonstrating whether such costs would reasonably be incurred or how much they might be—another failure of proof that further dooms defendants' fundamental alteration defense. Moreover, if an expansion of the State's supported housing program would require additional oversight and costs, surely the concommitant reduction in Adult Home beds would save the State oversight expense.

C. The State Also Fails to Consider Other Savings

172. Medicaid costs are not the only expenses that the State fails to include in its analysis. The State also incurs additional expenses for Adult Home residents that it does not incur for residents of supported housing, such as costs for the QUIP program, the EnAble program, and the Case Management Initiative. (*See* DAI's PFF ¶¶ 215–226; *see also* Tr. 3439:17–3440:3, 3459:20–3460:23 (D. Jones Rebuttal); P-773 (D. Jones Summary of Cost Evidence) at 3–12.) Defendants argue, however, that "it is . . . not appropriate to consider [those] costs" for two reasons. (Defs.' PFF ¶ 227.) First, they argue that it is inappropriate to consider those costs because "adult homes are likely to remain full." (*Id.*) Second, they argue that these programs should not be included in a cost analysis because they are "not entitlements like SSI, issued to each resident separately." (*Id.*)

173. The first point is discussed extensively *infra*, ¶¶ 175-82. As discussed there, because backfilling vacated Adult Home beds would be inappropriate and unnecessary, that is not a reason to discount the possible savings in those programs.

174. Defendants' second point—that Adult Home programs "are not entitlements" is nonsensical. All told, the State has expended at least $68.7 million dollars—and possibly quite a bit more—on various initiatives and programs targeted at Adult Home residents that are routinely funded year after year. (Tr. 3460:5-23 (D. Jones).) That the State would intentionally omit significant sums clearly directed at Adult Homes renders their analysis meaningless. The State has expended more than $28 million on the QuIP program. It has also expended at least $10.5 million on EnAble in the past five years, and perhaps significantly more. It has allocated $23.5 million towards the Case Management Initiative for Adult Homes. The State has also appropriated $1.5 million for an Infrastructure Capital Program; $2.8 million for air conditioning for Adult Homes; $2 million to Adult Home initiatives in 2003–2004; and, in 2005–2006, $350,000 "for services and expenses to promote programs to improve the quality of care for residents in adult homes." (*See* DAI's PFF ¶¶ 215-226.)

D. The State Need Not, and Should Not, "Backfill" Beds Vacated by Adult Home Residents

175. The State also argues that its costs would increase even further if beds vacated by Adult Home residents were "backfilled" by other individuals with mental illness. (Defs.' PFF ¶¶ 224–225.) Once again they have done no analysis of the issue. Defendants' own cost expert flatly stated that he undertook no such inquiry. (Tr. 2784:21–2785:14 (Kipper) ("Q. [D]o you have an opinion whether backfill would occur

if adult home residents moved to alternative settings? A. No."); *see also* Tr. 2786:12–15 (stating that he did not include the potential for backfill in his analysis).)

176. The State has seized on the backfill issue because some courts have recognized that states are not always able to take advantage of savings associated with moving institutionalized individuals to more integrated settings because the need for the institution may remain. *See Olmstead*, 527 U.S. at 605 (explaining that "some individuals . . . 'may need institutional care from time to time to stabilize acute psychiatric symptoms") (internal quotation marks omitted); *see also Williams* v. *Wasserman*, 164 F. Supp. 2d 591, 636 (D. Md. 2001) (same). Here, however, Adult Homes do not serve the purpose of providing the care and treatment of acute or other psychiatric symptoms.[20] They were not designed to be treatment settings for people with serious mental illness; instead they filled a void caused by the unavailability of community-based housing. (*See*, *e.g.*, P-68 (Stone Memo).) Accordingly, defendants' argument that the State has a need to keep Adult Home beds filled has limited, if any, relevance here where the institutions do not serve a necessary mental health treatment purpose.

177. Moreover, the evidence shows that virtually all of the people with mental illness currently served in Adult Homes could be served instead in supported housing. (*See supra* ¶¶ 89-119; DAI's PFF ¶¶ 52–141.) For this reason, it is unlikely that the State could refill the Adult Homes at issue here without recreating the very legal violation that is the subject of this suit—the unlawful segregation of individuals with mental illness in Adult Homes. (*See* Tr. 2954:17–21 (Zucker) (testifying that if New York does not take

[20] Indeed, state regulations prohibit Adult Homes from admitting or retaining anyone with acute psychiatric symptoms. (S-141 (18 N.Y.C.R.R. 487.4) at (b)(2).)

the money it is currently spending on Adult Homes and use it to create sufficient supported housing beds, there is a danger that more people will end up in Adult Homes).)

178. Defendants also did not put on any evidence demonstrating that backfill would result in increased costs to the State. Instead, the evidence is to the contrary. The evidence indicates that the persons most likely to fill vacant Adult Home beds are homeless persons and persons being discharged from State psychiatric hospitals. (*See*, *e.g.*, Tr. 2156:5–2157:7 (Newman); Tr. 3198:13–3200:4 (Myers); Tr. 1311:3–1312:10 (Reilly); Tr. 2905:7–25 (Kaufman).) The evidence also shows that if Adult Home beds were backfilled with persons in those populations, those individuals would likely be served less expensively in an Adult Home than in the settings from which they were coming. For example, a person with mental illness who is homeless costs, on average, $40,000 a year in Medicaid expenses alone, and can cost as much as $100,000 per year. (Tr. 292:1–17 (Tsemberis).) That is more than the average $31,530 in Medicaid expenditures for Adult Home residents. (See P-773 at 1–2.) Similarly, a person that has come from an inpatient psychiatric setting, such as a State hospital, will have come from a much higher cost setting than an Adult Home. (Tr. 3372:8–12 (Schaefer-Hayes (estimating that in 2007, the State saved $73,000 for each psychiatric center bed it closed); Tr. 3428:14–3429:8 (D. Jones) (stating that "when you darken the door of an inpatient psychiatric unit, that is not only the most intensive part of treatment, but it's also the most expensive and so, to the degree to which you can maintain people avoiding that is a major factor in keeping costs down").)

179. Whether backfilling occurs is a matter within the State's control. New York State has no obligation to insure that vacated Adult Home beds are backfilled.

To the contrary, the law permits the State to regulate admissions to Adult Homes, and also permits the State to downsize or close Adult Homes for which there is no public need.

180. New York has the authority to limit or prohibit the admission of persons with serious and persistent mental illness into impacted Adult Homes if it finds that the Adult Homes are not suitable places to provide care and treatment. New York Social Services Law § 461(1) gives DOH the authority to make and amend regulations "effectuating the provisions of this title, including but not limited to establishing fiscal, administrative, architectural, safety, nutritional and program standards which apply to all adult care facilities subject to its inspection and supervision." New York Social Services Law § 461(2) further gives the State the ability to promulgate new regulations governing "the necessity for and content of programs designed to protect the health and well-being" of persons with mental illness. DOH has already exercised this authority to prohibit the admission of some persons with mental and physical illnesses into Adult Homes because they are inappropriate for Adult Homes. (*See generally* S-141 (18 N.Y.C.R.R. § 487.4) (listing descriptions of persons who may not be served in Adult Homes).) Thus, New York could certainly prevent admission when the Adult Home is not the most integrated setting appropriate to the person's needs and the person prefers to live in supported housing instead.

181. New York also could reduce the number of Adult Home beds in New York City by downsizing or closing Adult Homes. DOH is the State entity that issues operating certificates for Adult Homes. (P-591 (Joint Stipulations of Fact) ¶¶ 3, 4.) DOH may "suspend, limit, modify or revoke an operating certificate of . . . [an] adult

home upon determining that such action would be in the public interest in order to conserve resources by restricting the number of beds, or the level of services, or both, to those which are 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 whole or any part of a facility. . . ." N.Y. Soc. Serv. Law § 461-b; 18 N.Y.C.R.R. § 485.5(m)(1)(i); *see also* P-591 (Joint Stipulations of Fact) ¶ 5 ("Operating certificates must be reissued at least every four years and may be revoked or suspended if the DOH determines that if [sic] the facility does not comply with State regulations."); Tr. 3047:25–3048:4 (Hart). In fact, Linda Rosenberg testified that if Adult Home beds are not backfilled, Adult Homes might even voluntarily close their doors. (*See* Tr. 698:7–13 (Rosenberg) (testifying that Adult Homes threatened to close if beds were not backfilled).)

182. It is clear, then, that New York can extricate itself from reliance on Adult Homes to serve persons with mental illness if it chooses to do so. What it needs is a plan and the will to follow through with that plan. (*See* S-150 (D. Jones Report); Tr. 3477:19–3478:9 (D. Jones Rebuttal); Tr. 772:23–773:9 (Rosenberg) (stating that sufficient supported housing could be created for all the needy populations "because if there was the will to close Adult Homes, and I think it will take political will, that money could be shifted and used for the services people in supported apartments would need").)

183. The State avows that the economic crisis has "required OMH to make significant budget cuts" (Defs.' PFF ¶ 158), suggesting that the cuts would make it difficult to execute the proposed relief in this matter. The State also points to the fact that

capital expenditures have been frozen in the current budget cycle. (Defs.' PFF ¶¶ 219–20.) However, the requested relief here is the provision of supported housing beds, and it is undisputed that creation of new supported housing beds does not require an outlay of capital (*e.g.*, Tr. 2159:5–2160:4 (Newman)); those are not the beds whose creation has been frozen. The record is devoid of any evidence showing that the current fiscal difficulties have had any impact on OMH's ability to develop supported housing. In fact, while this trial was ongoing, the State issued an RFP for 230 beds of new supported housing. (*See* P-748 (2009 RFP) at 2.) Moreover, DAI's proposed relief would result in overall savings to the State (*see supra*, ¶¶ 153-64) and that the savings earned could be redirected to pay for supported housing (Tr. 3261:2–3263:4 (Schaefer-Hayes); S-150 (D. Jones Report) at 22–23; Tr. 1947:14–20 (Newman); Tr. 1613:15–24 (Wollner).) Because the proposed relief here would not only remedy an untenable situation for DAI's constituents, but also ultimately lead to savings to the State, the State's arguments should be rejected.

RESPONSE TO DEFENDANTS' PROPOSED CONCLUSIONS OF LAW

I. Basic Principles of the ADA and the Integration Mandate

184. Defendants' contentions that the ADA requires neither "equal results" from public programs nor a "standard of care" for medical services are beside the point. (*See* Defs.' PFF ¶ 164.) DAI seeks neither equal results from public programs nor a particular standard of care. Rather, DAI seeks to have defendants administer services to DAI's constituents in the most integrated setting appropriate to their needs. *Olmstead* explicitly states that its holding does not "impose[] on the States a 'standard of care' for

whatever medical services they render, or . . . require[] States to 'provide a certain level of benefits to individuals with disabilities," but *does* require states to adhere to the ADA's nondiscrimination mandate and administer their services to these individuals in the most integrated setting appropriate to their needs. *Olmstead* v. *L.C.*, 527 U.S. 581, 603 n.14 (1999).

185. Defendants misstate the holding of *Olmstead* in arguing that the Court "must consider the cost of providing community-based care to everyone eligible for and desirous of it." (Defs.' PFF ¶ 166.) Rather, *Olmstead* requires the Court to consider whether the state has shown "that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." 527 U.S. at 604. Defendants have failed to show that the relief sought by DAI's constituents would be inequitable to other individuals with mental disabilities. To the contrary, the relief sought would be no more costly to the State than serving DAI's constituents in Adult Homes, and thus would not interfere with defendants' ability to serve other individuals with mental disabilities.

II. DAI's Constituents Are Not in the Most Integrated Setting

186. Defendants maintain that Adult Homes are integrated settings and that they "enable individuals with disabilities to interact with nondisabled persons to the fullest extent possible." (Defs.' PFF ¶ 167.) In support of this assertion, defendants make several arguments. First, they claim that Adult Homes enable interaction with nondisabled persons to the fullest extent possible because they are located in "residential areas" close to "stores, restaurants, religious institutions, libraries, parks and/or beaches and boardwalks." (Defs.' PFF ¶ 168.) Second, they argue that Adult Home residents

come and go from the facilities and "take full advantage of the benefits afforded by living in New York City." (Defs.' PFF ¶ 169.) Third, they argue that the OMH-funded case managers and other mental health providers available to Adult Home residents "facilitate integration." (Defs.' PFF ¶¶ 170, 172.) And finally, they argue that Adult Homes organize outings and on-site entertainment and activities. (Defs.' PFF ¶ 171.) None of these factors, however, even if they were accurately characterized by defendants (which they are not), render Adult Homes integrated settings or settings that enable interaction with nondisabled persons to the fullest extent possible, either on their own or as compared to supported housing. Adult Homes are institutions. They house dozens and, in some cases, hundreds, of people with mental illness in one setting controlled by rigid rules and regimented routines that restrict residents' daily lives and impede opportunities for interaction with non-disabled persons.

187. Defendants' argument that Adult Homes are the most integrated setting because they are close to stores and other establishments is without merit. Given that the Adult Homes at issue in this case are by definition large, impacted Adult Homes in New York City, they are of course located in urban settings nearby to the kinds of establishments and services one usually finds in an urban setting such as New York City. But that does not render them integrated settings. By that measure, any large psychiatric facility located in an urban setting would be a setting that is integrated in the community, no matter how institutional. As described by the Assistant Executive Director of the Jewish Board of Family and Children's Services, rather than being integrated settings, Adult Homes are "community-based psychiatric ghettos in which smaller groups of individuals were located in a community, but never helped to become part of it." (P-673

(Bear letter to J. Reilly) at JBFCS 354; Tr. 2236:12–2238:24 (Bear).) Contrary to defendants' assertion, the fact that Adult Homes are physically located in New York City does not make them part of the community, does not make residents feel any less segregated, and does not make them any less institutional. (*See also* P-535 (T.M. Dep.) 89:21–90:18, 110:3–112:2); P-544 (C.H. Dep.) 75:16–24).)

188. Defendants' characterization that "residents frequently avail themselves of these opportunities and take full advantage of the other benefits afforded by living in New York City" is a gross distortion of the record evidence. (Defs.' PFF ¶ 169.) Indeed, defendants fail to cite to one item of record evidence to support their assertion. (*See* Defs.' PFF ¶ 169.) Instead, they cobble together isolated and unsupported examples of activities in order to suggest that many residents engage in a variety of activities outside the Homes. (*Id.*) For example, defendants state that "[r]esidents explore educational and vocational opportunities including GED classes for GEDs at local schools . . . ." (Defs.' PFF ¶ 169.) But in defendants' Proposed Findings of Fact, defendants cite only one circumstance in which a resident obtained her GED and, based on the testimony cited, it is not even clear that she pursued her GED while living in the Adult Home. (*See* Defs.' PFF ¶ 21 (citing P-538 (B.J. Dep.) 19:10–21:20).) Viewed in its entirety, the record evidence established that Adult Homes impede the ability of Adult Home residents to participate in their communities outside the Homes. Among other factors, because of inflexible schedules for medication, meals and other activities, there are significant restrictions on when residents can be absent from the Homes. (*See supra* ¶¶ 12–18; DAI's PFF ¶¶ 18–23.) Because of the large numbers of people, the lack of privacy, and

restrictions on visitors, residents are limited from developing relationships with people inside or outside the Homes. (*See id.*; DAI's PFF ¶14, 19–20, 29.)

189. Defendants' argument that OMH-funded case managers and other mental health providers "facilitate integration" is similarly without merit. The evidence established that the programs offered by mental health providers on-site or off-site at day programs contribute further to the isolation and segregation of residents and, as defendants' own expert acknowledged, have virtually no effect on the enhancement of independent living skills. (*See supra* ¶¶ 29-30; DAI's PFF ¶¶ 23–27, 193.) While Adult Home residents sometimes leave the facility to attend continuing day treatment or other mental health programs, they are generally transported together in a bus or van, (*e.g.*, S-151 (E. Jones Report) at 3), and spend their time there with other persons with mental illness (*id.*; Tr. 601:25–602:9 (S.P.)). Moreover, the mental health programs that residents attend—both in and outside the Adult Homes—are at odds with current practices and principles in the field of mental health. These programs often have little focus on skill development (Tr. 897:25–898:11 (Duckworth); *see generally* P-93 (Commission on Quality of Care, *Continuing Day Treatment Review*, Dec. 2006)), and to the extent that these programs aim to teach residents independent living skills, such as cooking, budgeting, and grocery shopping, residents have little or no opportunity to practice those skills in their present living situation (S-152 (Duckworth Report) at 6–7 & n.5; Tr. 67:22–69:6, 170:7–171:1 (E. Jones) (explaining that the most effective way for people with mental illness to recover and retain skills is to practice them in the environment in which they actually live)). While residents of supported housing can learn and practice these skills in their own homes, residents of the Adult Homes derive

little benefit from this type of training. (S-152 (Duckworth Report) at 7–8; Tr. 870:7–10 (Duckworth) (residents unlikely to learn to cook in Adult Home environment simply because a kitchen is installed); Tr. 412:14–413:5 (S.K.) (describing day treatment program in which residents learned to make cakes by being told what ingredients to put in a pan and having staff "do the rest")). Indeed, the evidence established that OMH is now trying to close some of these "old fashioned" programs. (Tr. 720:10–15, 749:24–750:8 (Rosenberg); *see also* Tr. 3317:1–3318:7 (Schaefer-Hayes).)

190. With respect to the OMH-funded case managers that have been recently placed in Adult Homes, defendants acknowledge that they are present in only eleven facilities. (Defs.' PFF ¶ 172.) And even as to those eleven Adult Homes, the presence of case managers does not alter the segregated nature of the setting in which DAI's constituents receive services. It simply arranges services within the existing institutional setting. (Tr. 171:8–22 (E. Jones); Tr. 1172:1–1173:2 (D. Jones).)

191. Finally, defendants' assertion that Adult Homes enable integration because residents are taken on trips outside the Homes or provided with recreational activities and entertainment inside the Homes is equally baseless. The evidence at trial showed that outings outside the Homes contribute little to residents' integration into the community. The residents generally travel as a group, in a bus or van, and interact mainly with each other. (P-542 (L.G. Dep.) 37:20–38:5; P-543 (R.H. Dep.) 48:12–50:18; Tr. 2061:4–10, 2104:19–2105:16 (Burstein); S-151 (E. Jones Report) at 3.) At Park Inn Home for Adults, for example, residents are taken on shopping excursions in the Home's van with as many residents as can fit. (Tr. 2061:4–10 (Burstein).) The Home also organizes monthly restaurant and movie outings for groups of residents transported in

ambulettes. (Tr. 2104:19–2105:16 (Burstein).) Residents of Riverdale Manor Home for Adults are taken by a mental health provider, the Federation of Employment and Guidance Services ("FEGS"), on "field trips" to museums and libraries, but the visits are after hours when the facilities are closed the general public. (Tr. 2561:9–16 (Waizer).) Accordingly, the outings cited by defendants do nothing to facilitate interaction with nondisabled persons.

192. Defendants claim that DAI presented evidence of "characteristics of Adult Homes that defendants allege are "irrelevant to an analysis of integration." (Defs.' PFF ¶ 173.) For instance, defendants claim—perhaps because they cannot seriously dispute that Adult Homes are institutions—that the fact that Adult Homes have institutional qualities does "not render Adult Homes non-integrated." (Defs.' PFF at 75, (Heading 1).) The institutional nature, however, renders them segregated in the exact way the institution in which L.C. received services in *Olmstead* was segregated. As the Supreme Court in *Olmstead* stated, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life" and institutional confinement "severely diminishes" individuals' everyday activities. 527 U.S. at 600–601. The discriminatory effects of institutional placement recognized by the Supreme Court are inherent in the Adult Home model. As the former Senior Deputy Commissioner of OMH explained, people with mental illness do not "have to be defined by their illness; yet when you're in an adult home, that's completely what you're defined by." (Tr. 645:6–8 (Rosenberg).)

193. Defendants attempt to distinguish the setting in *Olmstead* on the basis that Adult Home residents are not locked in the facilities.[21] (Defs.' ¶¶ 175–76.) But in *Olmstead*, the plaintiff L.C., left the institution on a regular basis and:

> Receive[d] a wide variety of community-care services … leaving 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.

Pet. Reply Br., *Olmstead* v. *L.C.*, No. 98-536, 1999 WL 220130, at *17–18 (S. Ct. Apr. 14, 1999). Thus, that residents have opportunities to come and go from the facilities is not dispositive and does not lead to the inference that Adult Home residents are in the *most* integrated setting.

194. Defendants claim that DAI presented evidence of other "considerations [that] are irrelevant to an analysis of integration" (Defs.' PFF ¶¶ 173–182); namely, the population of the Homes, the lack of autonomy and independence, the actual number of contacts with disabled persons, and the quality of mental health programs. But these are all relevant characteristics that contribute to create a setting that is institutional and does not enable interaction with non-disabled persons to the fullest extent possible.

195. The population of Adult Homes is relevant to the issue of integration. That dozens of people with mental illness live in one setting without any nondisabled persons renders the Adult Homes institutions and also contributes to the segregation of DAI's constituents. (Tr. 2162:9–21 (Newman) (agreeing that a housing setting shared by 120 people, all of whom have serious mental illness, is a "segregated" setting).)

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[21] As discussed above, *supra* ¶¶ 18-22, defendants create a misleading portrayal of the extent to which residents come and go from the facilities and interact with others in their communities.

Additionally, because they are designed to manage large numbers of people, Adult Homes establish inflexible routines for the convenience of staff, impose rules and regulations, and implement measures to maximize efficiency. (*See, e.g,* Tr. 2065:4–5 (Burstein) ("[T]here are assigned seats because we are required to take attendance. It would be impossible to do so with 180 clients.").) Because Adult Home residents live under these rules and routines, they are limited in their ability to interact with nondisabled persons. (*See supra* ¶¶ 12-18; DAI's PFF ¶¶ 18–24.) Additionally, the large number of people residing in one setting and sharing relatively few living areas also contributes to the lack of privacy that impedes residents' ability to develop relationships with others. (*See supra* ¶¶ 20-21, 197; DAI's PFF ¶¶ 14, 18–24, 29.)

196. Similarly, the lack of autonomy and isolation of residents are also relevant. Rehashing the arguments made by their expert witness Dr. Geller, who disagrees with the *Olmstead* decision, defendants assert that autonomy and isolation are not functions of where DAI's constituents live; they are a matter of "whether a resident takes advantage of opportunities for contact with nondisabled persons." (Defs.' PFF ¶¶ 180, 182.) But it is the very *opportunity* itself that is impeded by virtue of receiving services in an Adult Home. (P-535 (T.M. Dep.) 111:3–112:1 ("You're in program, you're in a home. All your energy is surrounded with the home, so it's hard to meet different people.").) As Dr. Geller himself conceded, living in a place where the phone is answered "Brooklyn Adult Care Center" diminishes work options and social contacts, and being subject to visiting hours diminishes opportunities to cultivate social or family relationships. (Tr. 2374:15–22 (Geller); *see also* S-54 (Kaufman Report) at 10–11 ("Understandably, 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."); Tr. 2899:10–13 (Kaufman).)

197. With respect to defendants' assertion that DAI is taking issue with the quality of services provided to its constituents, it was primarily defendants, not DAI, who raised arguments concerning the quality of services in mental health programs available to Adult Home residents, arguing that the programs "facilitate" integration and are part of the State's *Olmstead* Plan. (The evidence conclusively established that the programs neither facilitate integration nor comprise any part of a purported plan.) Contrary to defendants' assertions, DAI seeks neither equal results from public programs nor a particular standard of care. Rather, DAI seeks to have defendants administer services to DAI's constituents in integrated settings.

198. Perhaps most baseless of defendants' arguments is the assertion that DAI failed to show "that supported housing is any more integrated than Adult Homes." (Defs.' PFF ¶ 186.) To the contrary, the testimony of I.K. and G.L.—two former Adult Home residents who now live in supported housing—establishes that supported housing is a setting that enables interaction with nondisabled persons to the fullest extent possible and that it is far more integrated than an Adult Home. I.K. testified that the Adult Home "discourage[d] independence" and "foster[ed] complete dependency upon them to do everything for [her]." (Tr. 2734:21–2735:2.) She explained that now that she lives in supported housing she feels "free;" she is "able actually to live like a human being again." (Tr. 2751:24–25.) G.L. testified that guests visit him more frequently now that he is in supported housing because in the Adult Home there was nowhere to have a private conversation, the visiting areas were small, guests could not join in meals, guests

had to sign in, guests were not allowed to stay overnight, and visiting hours ended at 8 p.m. (Tr. 477:20–480:3, 483:13–16 (G.L.).) G.L. described the holiday dinners and barbeques he has hosted since living in supported housing and testified that he would never opt to go back to an Adult Home because he can now have visitors any time. (Tr. 501:22–502:13 (G.L.) ("I can have people stay overnight. I can entertain. I couldn't do that in the adult home. Q. Anything else? A. Visitors can come any time. Q. And that means something to you? A. Yes.").)

199. The testimony of I.K. and G.L. is fully consistent with OMH documents describing supported housing and the testimony of State officials and many others concerning supported housing. As Sam Tsemberis, Executive Director of the Pathways to Housing supported housing program, explained, it is the very ordinariness of supported housing, the ability to choose when you wake up and what you eat, that residents appreciate:

> You sort of say that like it's taken for granted. When people first move into an apartment that is so much the thing they appreciate the most, because many of the people that we're housing out of shelters and hospitals, especially, have been for years told when to wake up, what to eat, when to eat, what TV channels to watch, which are selected for them, what they watch, and when they watch it, when they can make phone calls. Every tiny aspect of their life is decided by someone else and what people appreciate immediately are the ordinary day to day freedoms of things, like when you can choose to wake up or go to sleep or watch a TV channel or eat when you are hungry as opposed to when it's time to eat. They seem ordinary and mundane and are profoundly important to build a sense of well being for the person.

(Tr. 290:22–291:11.)

200. In supported housing, people with mental illness live much like their non-disabled peers. Scattered site supported housing is a "normalized" residential setting.

(Tr. 654:5–655:6 (Rosenberg).) In other words, it is a setting much like those in which non-disabled persons live. (*Id.*) It is the individual's home. (S-150 (D. Jones Report) at 25–27; Tr. 252:8–21 (Tsemberis); Tr. 851:10–25 (Duckworth).)

201. Residents of supported housing have the same freedoms that other apartment tenants do. (Tr. 501:22–502:13 (G.L.); Tr. 2751:18–25 (I.K.); P-546 (A.M. Dep.) 204:23–205:18.) They can control their own schedules and daily lives. (Tr. 475:21–477:7, 483:18–487:4 (G.L.); Tr. 290:21–291:11 (Tsemberis).) They are free to come and go when they like. They can live with a significant other, marry and live with a spouse, live with their children, invite whomever they would like for dinner, decorate their own apartment and have overnight guests. (Tr. 251:11–18 (Tsemberis).) They have the same privacy rights and freedoms as any other tenant in a landlord-tenant relationship (Tr. 2160:1–4 (Newman)), including the keys to their own apartment (Tr. 251:19–21 (Tsemberis)).

202. Residents of supported housing live and receive services in integrated settings. (Tr. 654:22–655:9 (Rosenberg); Tr. 2915:10–2916:4 (Kaufman) ("As a whole, I believe that people in supported housing are participating or feel more integrated in the community than those that are in group homes.").) Compared to Adult Home residents, residents of supported housing have far greater opportunities to interact with non-disabled persons and be integrated into the larger community. (Tr. 653:21–655:8 (Rosenberg); Tr. 482:12–487:4 (G.L.) (supported housing resident describing the guests and family members who have visited, as well as the barbecues and holiday dinners he has prepared for guests in his own home).) As Michael Newman, Director of OMH's

Bureau of Housing Development and Support, acknowledged, supported housing provides "maximum opportunities" for community integration. (Tr. 2162:17–21.)

III. DAI Has Demonstrated That Virtually All Adult Home Residents Meet the Essential Eligibility Requirements of Supported Housing

203. The ADA and RA provide that individuals with disabilities are entitled to receive services in the most integrated setting that is "appropriate" to their needs. 28 C.F.R. § 35.130(d); 28 C.F.R. § 41.51(a). In *Olmstead*, the Supreme Court held that a setting is "appropriate" for individuals if those individuals meet the "essential eligibility requirements for habilitation in a community based program." 527 U.S. at 603; *see also Disability Advocates, Inc.* v. *Paterson*, 598 F. Supp. 2d 289, 331 (E.D.N.Y. 2009). As the Court noted in its Memorandum & Order denying summary judgment, "[n]ot every eligibility requirement is an '*essential* eligibility requirement.'" *Disability Advocates*, 598 F. Supp. 2d at 333 (citing *PGA Tour, Inc.* v. *Martin*, 532 U.S. 661, 688 (2001).

204. DAI's constituents meet the essential eligibility requirements of supported housing. The evidence at trial demonstrated that defendants expect New York's supported housing programs to serve individuals with serious mental illness who have a wide range of support needs—including individuals transitioning directly from institutional settings. (*See supra* ¶¶ 40, 43, 48-49, 52-58, 62.) The evidence at trial further demonstrated that the supports that Adult Home residents would need to live independently are well within the capabilities of New York's supported housing providers to accommodate; indeed, many of DAI's constituents would need minimal supports or none at all. (*See supra* ¶¶ 42, 67, 80-84, 87.)

205. DAI's evidence on this issue included:

- The conclusions of DAI's three experts, after extensive investigations that included interviews with hundreds of

residents and the review of hundreds of mental health records, that virtually all Adult Home residents could be served in supported housing (*see supra* ¶¶ 7, 88, 93, 99, 106);

- The testimony of OMH's own former Senior Deputy Commissioner agreeing with the conclusions of DAI's experts that virtually all Adult Home residents could be appropriately served in supported housing (*see supra* ¶¶ 42, 163);

- OMH's own supported housing RFPs targeting the very institutionalized individuals—including Adult Home residents themselves—that defendants claim cannot be served in supported housing (*see supra* ¶¶ 35, 46, 53);

- Numerous responses to these RFPs by supported housing providers indicating that these providers are willing and able to serve individuals needing a wide variety of supports relating to managing their illness and learning independent living skills (*see supra* ¶¶ 36, 45, 46, 120, 121; *see infra* ¶¶ 208, 227);

- The successful transition of 60 Adult Home residents into supported housing by OMH (when required to do so by the legislature) (*see supra* ¶¶ 46, 129);

- Testimony to the legislature by the Commissioner of OMH and testimony at trial by OMH's former Senior Deputy Commissioner that OMH has abandoned the "linear continuum" model that requires institutionalized individuals to transition through gradually less restrictive forms of housing before moving to supported housing (*see supra* ¶¶ 33-39.);

- The findings of the Assessment Project—a study commissioned by defendants—that Adult Home residents are not a particularly disabled population and that few residents would be opposed to moving to more integrated settings (*see* DAI's PFF ¶¶ 91–98);

- The recommendation of the Adult Care Facilities Workgroup Report, in a 2002 report significantly shaped by defendants, that 6,000 Adult Home residents be moved to more integrated settings (*see supra* ¶ 225);

- Dr. Tsemberis's testimony that his Pathways to Housing program routinely and successfully serves individuals needing all manner of supports, and, that Pathways does not regard many of the independent living issues cited by defendants as absolute barriers to independent living to be "difficult issues" to resolve (*see supra* ¶¶ 37, 47, 49, 53, 55, 58, 66, 124).

206. This evidence demonstrates overwhelmingly that DAI's constituents meet the essential eligibility requirements to be served in supported housing.

A. Providing DAI's Constituents With Meaningful Access to Supported Housing Will Not "Change the Nature of Supported Housing"

207. In response to this overwhelming evidence that virtually everyone in an Adult Home could be served appropriately in supported housing, defendants nevertheless maintain that DAI is somehow seeking to "change the nature of supported housing." (Defs.' PFF ¶¶ 191–92.) In support of that contention, defendants rely on the testimony of (a) a handful of mental health providers that apparently still employ the "linear continuum" housing model despite its abandonment by OMH, (b) the self-serving testimony of their own employees, and (c) a written description of supported housing by a third party, CUCS. (*Id.* ¶¶ 53, 54, 57, 58.)

208. None of defendants' evidence comes close to demonstrating that the relief requested by DAI would somehow change the nature of supported housing. The numerous RFP responses in evidence demonstrate that the "linear continuum" approach apparently employed by the three mental health providers called by defendants is not shared by other supported housing providers. The testimony of defendants' OMH witnesses that supported housing cannot serve individuals from institutions was contradicted by OMH's own documents, particularly the various RFPs, which all acknowledge that individuals served in supported housing need "varying" levels of

support (including, for some, ACT or intensive case management). (*See supra* ¶ 45.) The testimony of the OMH witnesses was also premised on their assumption that Adult Home residents would need extremely intensive supports, when in fact most would not. Finally, with regard to the CUCS documents purporting to describe supported housing, not only are those documents inconsistent with OMH's own descriptions of supported housing, defendants' own witness, Kathleen Kelly of HRA, testified that HRA does not rely on CUCS eligibility criteria in reviewing applications for supported housing. (Tr. 1892:21–1893:23.)

B. DAI's Experts Used A Rigorous and Reliable Methodology to Determine That Virtually All Adult Home Residents Could Move

209. Defendants also argue that DAI has not established that its constituents are qualified for supported housing because DAI's experts did not conduct in-person clinical examinations of each of DAI's constituents to determine whether each is eligible for supported housing. (Defs.' PFF ¶¶ 69, 85, 89, 91, 92, 95, 196–200.)

210. This Court has already rejected defendants' argument that DAI's experts were required to conduct in-person clinical assessments of each Adult Home resident. In its Memorandum & Order denying defendants' motion to exclude DAI's experts, the Court held that a clinical assessment was not a necessary requisite for any experts' opinion and found that each of DAI's experts' opinions was "based on substantial experience, sufficient facts and data, and reliable methodologies." *See Disability Advocates, Inc.* v. *Paterson*, No. 03-cv-3209 (NGG) (MDG), 2008 WL 5378365, *3 (E.D.N.Y. Dec. 22, 2008); *id.* at *5 ("That [Dr. Duckworth] did not conduct a clinical examination of each patient does not render his methodology unreliable or his opinion inadmissible."); *id.* at *6 ("Mr. Jones's failure to conduct or order a clinical assessment of

each adult home resident does not render his testimony inadmissible"); *id.* at *9 (Ms. Jones' analysis was reliable without having performed clinical assessments because an assessment does not address "whether or not an adult home resident is capable of living in alternative housing; rather, it addresses what individualized planning and support an individual would need upon moving to alternative housing").)

211. The evidence at trial demonstrated that not only were DAI's experts' methodologies on this issue reliable, they in fact produced credible and persuasive results. In-person clinical assessments are unnecessary to determine whether an individual could be served in supported housing. As DAI's expert Dr. Duckworth explained, because supported housing is capable of serving people with a wide range of support needs, the applicable analysis for determining whether someone qualifies for supported housing is to screen individuals for specific "stop signs," such as dementia or nursing needs, that would require further investigation before placing the individual in a supported apartment. (Tr. 812:3–813:15, 907:9–10 (Duckworth).) Clinical assessments would then be used *after* the individual was admitted to supported housing to determine the precise mix of supports that would be necessary for that individual. (Tr. 944:24–945:1.) DAI's other experts confirmed that this was the correct approach to assessing residents for supported housing.

212. Dr. Duckworth in fact performed this analysis on the roughly 270 records that he reviewed as part of his investigation, and found that very few Adult Home residents' records contained such "stop signs." (Tr. 813:14–814:2.) Defendants attempt to attack Dr. Duckworth's analysis by arguing that the first 70 records that Dr. Duckworth reviewed were records from the Adult Homes and not records of the

individual's mental health provider. (*See* Tr. 888:2–889:5.) Dr. Duckworth explained, however, that those Adult Home records included sufficient information to determine whether any "stop signs" were present. (Tr. 889:15–24.) Defendants also fail to mention that, in addition to those 70 records, Dr. Duckworth also reviewed all of the allegedly superior mental health records that Dr. Geller reviewed and concluded that each of those individuals could also be served in supported housing as well. (S-149 (Duckworth R. Report) at 3.)

213. Defendants' assertion that DAI cannot determine whether its constituents are qualified for supported housing without doing clinical assessments also seeks to hold DAI to a higher standard than that to which defendants hold themselves. The evidence at trial established that OMH does not perform clinical assessments of individuals to determine their eligibility for supported housing. HRA relies entirely on written information provided to them by the referring agency to determine whether an individual is eligible for supported housing; no in-person clinical assessment is conducted. (*See* Tr. 1902:16–25 (Kelly).) OMH's most recent RFP for supported housing describes an "in-reach" process in which individuals are assessed to determine the necessary supports *after* they are accepted into the program (P-748 (2009 RFP at 2.) Even defendants' own expert, Dr. Geller, did not perform such assessments before opining on whether DAI's constituents could live in supported housing. (Tr. 2379:20–2380:5.)

214. Finally, although defendants assert that "it is impossible to know whether an individual can live safely in a particular type of housing without knowing what supports the person would need," they make no effort to explain why this is so. (*See* Defs.' PFF ¶ 196.) DAI's experts determined, after rigorous investigation, that the

supports needed by Adult Home residents are well within the range of what is currently offered by New York's supported housing providers. DAI has thus demonstrated that all residents could live "safely" in supported housing. It is not DAI's burden to go further and assess the specific supports that each resident would need in order to be served in supported housing; that is a job for the supported housing provider once the resident is placed.

215. In short, the methods employed by DAI's experts in assessing Adult Home residents—which included reviewing hundreds of medical records, interviewing hundreds Adult Home residents, and analyzing data regarding over 2,000 residents' cognitive abilities and needs for support—formed a reliable basis for their conclusions that virtually all Adult Home residents could be served in supported housing.

C. DAI Is Not Required To Show That Each of its Constituents Has Been Deemed Eligible for Supported Housing by A Treatment Provider

216. Defendants next claim that, no matter how persuasive DAI's evidence that virtually all Adult Home residents could be served in supported housing, the Court must disregard it because *Olmstead* requires DAI to show that each of its constituents have been determined to be eligible for supported housing by a "treatment provider." (Defs.' PFF ¶¶ 195, 201–202.)

217. That is not the law. *Olmstead* holds that a state "generally may rely on the reasonable assessments of its own professionals" in determining whether an individual is qualified. *Olmstead*, 527 U.S. at 602. *Olmstead* contains no requirement, however, that a plaintiff alleging discrimination under the ADA present evidence that he or she has been assessed by a "treatment provider" and found eligible to be served in a more integrated setting. *See Joseph S.* v. *Hogan*, 561 F. Supp. 2d 280, 291 (E.D.N.Y. 2008)

(holding that no eligibility determination from "state's mental health professionals" is required and that "it is not clear whether *Olmstead* even requires a specific determination by *any* medical professional that an individual with mental illness may receive services in a less restrictive setting"); *see also Frederick L.* v. *Dep't of Pub. Welfare*, 157 F. Supp. 2d 509, 540 (E.D. Pa. 2001) (finding that *Olmstead* does not require a formal recommendation from a treatment provider for community placement); *Long* v. *Benson*, No. 4:08v26-RH/WCS, 2008 WL 4571904, at *2 (N.D. Fla. Oct. 14, 2008) (rejecting State's argument that state professional should determine who in the plaintiff class is qualified to be served in integrated settings).

218. "*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." *Frederick L.*, 157 F. Supp. 2d at 540; *see also Long*, 2008 WL 4571904, at *2 ("[The State] cannot deny the right [to an integrated setting] simply by refusing to acknowledge that the individual could receive appropriate care in the community. Otherwise the right would, or at least could, become wholly illusory.").

219. Yet here, defendants' position that the ADA applies to an Adult Home resident only if that resident's "treatment provider" determines that the individual is qualified to receive services in a more integrated setting would render the ADA effectively inapplicable to Adult Homes. The evidence at trial established that OMH considers Adult Homes to be permanent placements and is focused almost exclusively on improving services *in* the Adult Homes rather than helping residents leave. The evidence further established that the for-profit Adult Homes (and the treatment providers employed

by them) have no incentive—and in fact make little effort—to assist people in moving to alternative housing. To hold under these circumstances that the ADA does not apply to Adult Home residents who are concededly qualified for supported housing simply because those residents have not obtained an eligibility determination from their "treatment provider" would essentially reward defendants for the very failures that necessitated this lawsuit in the first place. Simply put, if the ADA's integration mandate is to have any meaning at all in this context, defendants' proposed "treatment provider" requirement must be rejected.

D. DAI's Experts Gave Credible and Persuasive Testimony Based on Reliable Data and Methodologies

220. Finally, defendants claim that DAI's experts should not have relied upon the Assessment Project data or the Workgroup Report, and in general did not give credible testimony. Defendants' arguments should be rejected.

221. Defendants first attack DAI's reliance on the Assessment Project, which found that Adult Home residents were not a seriously impaired population and had relatively few difficulties with activities of daily living. In claiming that the Assessment Project "was never intended to be used to assess housing and support needs for adult home residents," defendants mischaracterize the testimony of Dr. Bruce as well as their own employees. Dr. Bruce specifically testified in her deposition that one of the purposes of the Assessment Project was to "screen for residents who might benefit from" a change in housing and that this view was shared by DOH officials. (P-583 (Bruce Dep.) 66:21–67:10.) Dr. Bruce's liaison at DOH, Glenn Liebman, agreed that much of the data collected by the Assessment Project was directly relevant to the question of

whether the individual could live in an a more integrated setting. (*E.g.*, P-555 (Liebman Dep.) 25:19–26:9.)

222. Defendants next claim that there were "serious flaws and limitations" to the Assessment Project (*see* Defs.' PFF ¶ 203), despite the fact that defendants themselves helped design the housing portion of the survey instrument (*see* DAI's PFF ¶ 88). Indeed, Dennis Jones described the Assessment Project data as "a very rich set of data, frankly better than you get in most decision-making projects, where you really knew something about the psychiatric history." (Tr. 1172:1–1173:2.)

223. Defendants point to some "limitations" of the Assessment Project data identified by Dr. Groves in his testimony, such as the fact that the surveyors were strangers to the residents and that some residents may have underreported substance abuse issues. But Dr. Groves in fact confirmed that overall he felt that the survey data was reliable:

> At one point, I sat down and said: What are all of the possible issues around the Columbia Presbyterian data? And I made a list. And those, those were the items that I thought about. In terms of the analysis we did and the data we used, *do I think that that, those limitations significantly affected that analysis in the data? The answer is no.*

(Tr. 3095:25–3096:6 (emphasis added).)

224. Defendants also point to Dr. Geller's argument that the Assessment Project did not provide an accurate cross-section of Adult Home residents. (Defs.' PFF ¶ 203.) Dr. Geller is mistaken. The Assessment Project surveyed over 2,000 Adult Home residents and had a response rate of 74%. (P-583 (Bruce Dep.) 73:3–16.) The large number of residents surveyed and very high response rate make it highly unlikely that the data is skewed. Even if, as Dr. Geller posits, the non-responding residents were,

on average, more disabled than the responding residents, the effect on the overall percentages would be small. But in fact, Dr. Geller acknowledged that some of those whom the assessment missed were probably "on their own going places" and would therefore likely be *less* disabled that the individuals who participated in the Assessment. (Tr. 2333:2–11.)

225. Next, defendants try to disown their own Workgroup Report, arguing that the Report's proposal that 6,000 individuals be moved to more independent housing is "not based on sufficient data" to be reliable. DAI's experts, however, have never endorsed the Workgroup's "6,000" figure, which no one disputes was not based on quantitative data (as defendants had never collected any). Rather, the Workgroup Report is probative because it is shows that a group of accomplished New York experts on mental health chosen by defendants and working diligently over a year-long period with a large staff provided by defendants, unanimously concluded that there were large numbers of Adult Home residents that could be more appropriately served in more integrated settings. This is precisely the light in which DAI's experts considered it. (*See supra* ¶ 119.)

226. Finally, defendants allege that DAI's experts are not credible because they started with the "assumption" that virtually anyone can live in supported housing and because "[DAI's] counsel . . . influenced their conclusions." (Defs.' PFF ¶ 205.) Both of these assertions are untrue.

227. DAI's experts "assumed" nothing about the nature of supported housing in New York. Rather the evidence shows that they carefully considered the range of supports available in New York's supported housing programs to reach the conclusion

that the range of available supports was adequate to address the needs of the Adult Home population. DAI's experts visited supported housing programs, met with ACT teams and supported housing residents, and—in stark contrast to Dr. Geller—reviewed the RFP responses of supported housing providers actually proposing to serve Adult Home residents and other institutionalized populations. (*See supra*, ¶ 121.)

228. Nor did DAI's experts "assume" anything about the needs of Adult Home residents. Ms. Jones interviewed 179 residents in 23 different Adult Homes; Dr. Duckworth reviewed roughly 270 mental health records of Adult Home residents, including all of the records reviewed by Dr. Geller; Mr. Jones and Dr. Groves performed an analysis of data concerning the cognitive abilities, skills, and desires of over 2,000 Adult Home residents. (*See generally supra*, ¶¶ 94–118.) In short, the record reflects an exceedingly thorough and unbiased investigation by each of DAI's experts.

229. Defendants' allegation that DAI's counsel somehow "influenced" the conclusions of DAI's experts is categorically false. Ms. Jones's outline in which she is alleged to have prejudged the issues in the case was written after Ms. Jones had already visited thirteen Adult Homes—five more than Dr. Geller would ever visit. (Tr. 192:9–22 (E. Jones).) Dr. Duckworth's expression of support for DAI's lawsuits was prompted solely by his revulsion at the conditions in adult homes reported by Clifford Levy in the *New York Times* and had nothing to do with his opinion on whether Adult Home residents are qualified for supported housing. (Tr. 947:19–948:1.) Moreover, the "changes" that Dr. Duckworth made to his report "after he discussed it with plaintiffs' counsel," were nothing more than an effort to "tighten up" the draft. (Tr. 944:10–13.) Finally, while Dr. Groves revised his algorithm for analyzing the Assessment Project

data, he did so on the basis of a well-founded concern that the first algorithm was under-representing individuals who were willing and able to be served in supported housing. (Tr. 3093:10–3094:4.)

230. In short, DAI has met its burden to establish that its constituents meet the essential eligibility requirements for supported housing.

IV. Defendants Have Not Reasonably Accommodated DAI's Constituents

231. Defendants misread *Olmstead* to the extent they are suggesting that it recognizes a "reasonable accommodation" defense that is separate and distinct from the fundamental alteration defense. *Olmstead* states that a "reasonable accommodation" analysis requires "taking into account the resources available to the State and the needs of others with mental disabilities." 527 U.S. at 607. *Olmstead* makes clear, then, that in order to demonstrate "reasonable accommodation," defendants must show either compliance with the integration mandate of *Olmstead* or that the relief requested would require *un*reasonable modifications to the State's programs, *i.e.* a fundamental alteration. Defendants cannot simply assert, as they try to do here, that they are making a good-faith effort to comply with *Olmstead* and call it a reasonable accommodation. *See Frederick L.* v. *Dep't of Pub. Welfare*, 422 F.3d 151, 158 (3d Cir. 2005) ("good faith intentions" insufficient).

232. Defendants nevertheless contend that they have "taken a number of steps that constitute a reasonable accommodation of any right the [Adult Home] residents may have to access supported housing." (Def's. PFF ¶ 207.) They point to the designation of residents as a target population for OMH housing, programs that teach "independent living skills," and case managers who "discuss housing alternatives with residents." (*Id.* ¶ 208.) These alleged efforts, however, cannot obscure the fact that defendants operate

their mental health system in a manner that effectively excludes Adult Home residents from the vast majority of supported housing beds.

233. When OMH issues a Request For Proposals ("RFP") for the development of new housing, it designates specific target populations to receive priority access to those beds. (Tr. 1927:16–1929:8 (Newman) (explaining the RFP process); *see e.g.*, S-17 (2005 RFP).) Defendants' policies ensure that any individual who is not a member of one of these target populations is highly unlikely to ever secure a bed. (*See* DAI's PFF ¶ 176.)

234. The state did not designate Adult Home residents as a target population for supported housing until 2005. (Tr. 1534:16–22 (Madan); S-17 (2005 RFP).) Residents were therefore effectively excluded from all supported housing beds prior to 2005. (Tr. 1532:10–1534:22 (Madan).) Moreover, the priority designation of Adult Home residents in 2005 applied only to *new* beds being developed pursuant to that particular RFP; residents have continued to be excluded from all previously-developed beds, even as vacancies occur. Those beds remain exclusively accessible to members of priority populations enumerated in the RFPs under which the beds were created. (Tr. 2193:15–2195:9 (Newman); Tr. 1534:18–22 (Madan).)

235. Even the designation of Adult Home residents as a priority population in 2005 has made very little difference in residents' ability to access supported housing beds. The current supported housing vacancy rate is less than 2 percent (Tr. 1503:13–23 (Madan)), and applicants languish for years on housing providers' "exorbitant waiting lists." (Tr. 1874:11–20 (Dorfman).) When vacancies do occur, other target populations

are routinely given higher priority that Adult Home residents. (Tr. 660:12–18, 662:6–18 (Rosenberg).)

236. The numbers place this reality in stark relief: It is undisputed that only twenty-one individuals with mental illness living in impacted Adult Homes were able to access supported housing from January 2002 through January 2006, and only 65 such individuals have secured any other type of OMH community housing. (Defs.' PFF ¶¶ 111–12.) This rate of movement is strikingly low, particularly in light of the fact that more than 800 residents submitted HRA applications from January 2000 through January 2006. (Defs.' PFF ¶ 108.)

237. While defendants seek to claim credit for "facilitat[ing] access" to the 60 supported housing beds allocated to Adult Home residents by the legislature (Def's. PFF ¶ 208), this allocation was *imposed* on defendants, who have no intention of pursuing similar set-asides in the future. (*See supra* ¶ 130.) The fact that 45 residents have moved to supported housing since the 60-bed initiative began less than two years ago, with an additional 15 residents in the process of moving (*see* DAI's PFF ¶ 120), demonstrates that without a specific allocation of beds to DAI's constituents, none of defendants' other "reasonable accommodations" will make a difference.

238. As DAI's expert, Dennis Jones, explained with respect to the OMH-funded case management program that exists in 11 Adult Homes,

> [U]nless you have a systemic initiative here that moves to create significant numbers of supported housing slots into which people can go and there is a clear organizational commitment to make that happen up and down the line, no individual case manager is going to do anything more than what I think they have been doing, which is doing the best they can, without any commitment. And that translates into the status quo.

(Tr. 1172:1–1173:2 (D. Jones).)

239. Similarly, defendants' attempt to claim credit for programs that "teach independent living skills" to DAI's constituents is also belied by the evidence. The programs that Adult Home residents attend often have little focus on skill development, and to the extent that these programs do aim to teach independent living skills, residents have little or no opportunity to practice those skills in their present living situation. (*See supra* ¶¶ 29-31.)

240. Perhaps more importantly, teaching residents independent living skills does little to ensure that they can receive services in more integrated settings if such settings are not available to them. Defendants ignore the plain meaning of *Olmstead*: public entities are required to make reasonable modifications to their service systems to enable individuals with disabilities to receive services in integrated, community-based settings. In other words, the type of reasonable modification required by *Olmstead* is the opportunity to live and receive services in the most integrated setting appropriate, not merely to learn independent living skills or discuss housing alternatives.

V. DAI's Proposed Relief Would Not Fundamentally Alter the State's Programs

241. Defendants have failed to meet their burden to demonstrate that the relief proposed by DAI would be a fundamental alteration of the State's programs.

A. Defendants' Fundamental Alteration Defense Fails Because They Have Made No Genuine Attempt to Comply with the Integration Mandate

242. As this Court previously held, a state must make efforts to comply with the integration mandate in order to show that the specific relief requested would be too costly. *Disability Advocates,* 598 F. Supp. 2d at 339. Defendants argue that the Court should not order the relief sought by DAI because their "'Olmstead plan' is sufficient"

(Defs.' PFF ¶ 235), and cite cases following *Olmstead* that hold that, when a state has developed a comprehensive, effective plan to provide services in integrated settings, a court should not interfere with the state's administration of its service system and allocation of resources (Defs.' PFF ¶¶ 212–215 (citing *Sanchez* v. *Johnson*, 416 F.3d 1051, 1067–68 (9th Cir. 2005) ("[W]hen there is evidence that a State has in place a comprehensive deinstitutionalization scheme, which, in light of existing budgetary restraints and the competing demands of other services that the State provides, including the maintenance of institutional care facilities, . . . is 'effectively working,' . . . the courts will not tinker with that scheme."); *ARC of Wash. State, Inc.* v. *Braddock*, 427 F.3d 615, 620 (9th Cir. 2005) ("So long as states are genuinely and effectively in the process of deinstitutionalizing disabled persons 'with an even hand,' we will not interfere."))).

243. Contrary to *Sanchez* and *ARC of Washington*, however, the defendants here have not developed—and indeed deny that they are required to develop—a genuine or effective plan or commitment to enable DAI's constituents to move to less restrictive settings. In *Sanchez* and *ARC of Washington*, the defendants had demonstrated a genuine commitment to a plan that actually included the plaintiffs in those cases. In *Sanchez*, the plaintiffs were individuals with disabilities residing in institutional facilities called developmental centers. *Sanchez*, 416 F.3d at 1066. Defendants in *Sanchez* had developed individualized community placement plans to move individuals residing in developmental centers to community residential settings. *Id*. at 1064–1066. The plans included the identification of supports required by residents to live in the community. *Id*. at 1065. Additionally, the defendants had reduced the percentage of developmentally

disabled persons living in developmental centers from 6% of the developmentally disabled population to 2% of the developmentally disabled population. *Id*. at 1066.

244. In stark contrast to *Sanchez*, the defendants here have not developed a plan to move DAI's constituents from Adult Homes to community-based settings, and there has been no reduction in the percentage of mentally ill people receiving services in Adult Homes. Moreover, in *Sanchez*, the State developed individualized community placement plans that, among other things, identified supports necessary to enable the residents to live successfully in the community. *See id.* at 1064–65. Here, the State concedes that no one is doing any such assessments and argues that it would be a fundamental alteration to implement them.

245. Similarly, in *ARC of Washington*, defendants had implemented a plan to enable persons in the plaintiff class of developmentally disabled persons to move to the community, including maintaining a waiting list and ensuring that vacancies in community based programs were available to all eligible disabled persons based solely on their mental health needs and position on the waiting list. 427 F.3d at 617, 622. The defendants had also reduced the census of the institutions in which plaintiffs were receiving services. *Id*. Here, defendants have failed to implement a waiting list, and continue to facilitate the referrals of people with mental illness to Adult Homes.

246. Unlike here, the actions taken by defendants in *Sanchez* and *ARC of Washington* actually applied to the plaintiffs at issue in those cases. In this case, the State has disavowed any obligation to develop a plan to enable Adult Home residents to move to more integrated settings and has evidenced a commitment to the continued use of Adult Homes as a service setting for persons with mental illness. (*See supra* ¶¶ 134; *see*

also DAI's PFF ¶ 169; *see also* Defs.' PFF ¶ 238 (arguing that if "*Olmstead* were to be expanded to require a 'plan' for adult home residents, the fundamental alteration defense would logically need to be modified . . . .) Accordingly, there can be no serious dispute that defendants have *no* plan for Adult Home residents, much less a plan that is sufficient. *See Pa. Prot. & Advocacy, Inc.*, 402 F.3d at 383 (finding that admissions made by defendant during litigation that it did not require planning for community-based services for the residents of the facility at issue "foreclose[d] the genuine contention that it ha[d] made a commitment to . . . compliance with the ADA and RA).

247. Defendants also argue that this Court should reject the Third Circuit's definition of an integration plan under *Olmstead*. The Third Circuit, however, appropriately applied the standard set forth by the Supreme Court in *Olmstead*. In *Olmstead*, the Supreme Court held that an integration plan must be "comprehensive," "effectively working" and contain "a waiting list that move[s] at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated." *Olmstead*, 527 U.S. at 605–606. In other words, as the Third Circuit held, "general assurances" and expression of "good faith intentions" are not enough. *Frederick L.*, 422 F.3d at 158. 2005). There must be "a plan that adequately demonstrates a reasonably specific and measurable commitment to deinstitutionalization" for which defendants "may be held accountable." *Id.* at 157. Any less specific standard would render the requirement of a plan meaningless. Defendants' activities fall short of the standards set forth in *Olmstead* and all of the circuit courts interpreting *Olmstead*. Far from articulating even a "general assurance," the defendants have rejected the notion that an integration plan of any kind is required for DAI's constituents and have evidenced a continued commitment to

maintaining the status quo reliance on Adult Homes as service settings. Because defendants have not developed a plan to enable Adult Home residents to move to less restricted settings, they cannot establish that compliance with the integration mandate would be a fundamental alteration of their mental health service system.

B. Defendants Failed to Prove That the Cost of the Relief Would Amount to a Fundamental Alteration

248. The State has the burden of proof to show by a preponderance of the evidence that the increase in cost of the proposed relief, if any, would amount to a fundamental alteration. Here again, defendants fail to meet their burden of proof. The relevant budget for purposes of analyzing the cost of DAI's proposed relief is the "mental health budget," which "includes the budgets of OMH, DOH (which includes the Medicaid program), and other State expenditures on individuals with mental illness"—essentially, "any money the State receives, allots for spending, and/or spends on mental health services and programs." *Disability Advocates*, 598 F. Supp. 2d at 349. Defendants concede that the relevant budget for purposes of evaluating their fundamental alteration defense is the State's mental health budget. (Defs.' PFF ¶ 97 (citing *Bryson* v. *Stephen*, 2006 U.S. Dist. LEXIS 71775, at *22 (D.N.H. Sept. 29, 2006); *Frederick L.* v. *Dep't of Pub. Welfare*, 364 F.3d 487, 493 n.6 (3d Cir. 2004); *Bruggeman* v. *Blagojevich*, 219 F.R.D. 430, 435 (N.D. Ill. 2004)).)

249. When the State's entire mental health budget is considered, it is clear that serving persons with mental illness in Adult Homes is more expensive than serving them in supported housing. *See supra*, Section V. The cost analysis is simple and straightforward. The evidence also shows that if the State were to serve current Adult Home residents in supported housing rather than in Adult Homes, some of the money that

is currently being expended in Adult Homes could be redirected to serve those residents in supported housing (*see* DAI's PFF ¶¶ 215–26); the remaining money could be put to use on other community services.

250. The State cites a number of cases that attempt to muddy the waters on this issue. For example, defendants cite *Frederick L.*, 364 F.3d at 497, for the proposition that the State's budget process is "beyond judicial scrutiny," implying that this Court is somehow hamstrung from effecting relief out of deference to the State budgetary process. (Defs.' PFF ¶ 97.) In *Frederick L.*, however, plaintiff/appellants sought an order requiring the state agency to request money in its budget for "the full amount necessary to fund all of the community placements requested." *Id.* The state agency successfully proved, however, that it would not have been able to do so because of requirements in the budget process. *Id.* The Third Circuit reasonably found that it could not "require the agency to request[] additional funding beyond that which it was permitted under the Governor's guidelines." *Id.* DAI has not requested that remedy, so this holding is not on point. Moreover, the state budgetary process may not trump the court-ordered measures necessary to remedy defendants' violations of the ADA. *See Ass'n of Surrogates* v. *New York*, 966 F. 2d 75, 79 (2d. Cir. 1992) (holding that "state budgetary processes may not trump court-ordered measures necessary to undo a federal constitutional violation").

251. Defendants also cite *Frederick L.* for the proposition that a court may not order a state to "shift[] funds from other programs to fund additional community placements." (Defs.' PFF ¶ 97.) Here again, defendants mischaracterize that case. *Frederick L.* does not bar the shifting of funds from one area of the budget to another. As the portion of the case quoted by defendants makes clear, what *Frederick L.* proscribes is

"fund-shifting that would disadvantage *other segments* of the mentally disabled population." 364 F.3d at 497 (emphasis added). Because the relief sought here could be accomplished by redirecting funds currently being spent on Adult Home residents in Adult Homes to serve those same persons in supported housing, it neither affects "other segments of the mentally disabled population" nor causes any "disadvantage."

252. The State makes much of the fact that it, "along with the rest of the country, has [lately] experienced a significant economic crisis not seen since the Depression." (*Id.*) The State avows that the economic crisis has "required OMH to make significant budget cuts" (*id.*), suggesting that the cuts would make it difficult to execute the proposed relief in this matter. In *Frederick L.*, the Third Circuit, vacating the decision and remanding, agreed with plaintiffs "that states cannot sustain a fundamental-alteration defense based solely upon the conclusory invocation of vaguely defined fiscal constraints." 364 F.3d at 496. Similarly, the Tenth Circuit held in *Fisher* v. *Oklahoma Health Care Auth.*, 335 F.3d 1175, 1182–83 (10th Cir. 2003), that "the fact that [a state] has a fiscal problem, by itself, does not lead to an automatic conclusion" that providing the community services that plaintiffs sought would be a fundamental alteration. *Id.* (citing *Townsend v. Quasim*, 328 F.3d 511, 520 (9th Cir. 2003)). As the Fisher Court observed, 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.'. . . If every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed." *Fisher*, 335 F.3d at 1183.

253. Defendants did not present any evidence showing a nexus between the current state of the economy and the specific relief DAI seeks.[22] Indeed, because the evidence showed that the State's cost would actually *decrease* if the DAI's proposed relief were effected, defendants cannot prove their fundamental alteration defense on that ground.

C. DAI's Constituents Can Be Served In Supported Housing Without Altering the Nature of the State's Programs

254. In denying summary judgment to defendants, the Court held that "where individuals with disabilities seek to receive services in a more integrated setting—and the state already provides services to others with disabilities in that setting—assessing and moving the particular plaintiffs to that setting, in and of itself, is not a 'fundamental alteration.'" *Disability Advocates*, 598 F. Supp. 2d at 335. Here, the evidence at trial established that defendants already fund supported housing programs that successfully serve individuals with the same support needs as DAI's constituents. (*See supra* ¶¶ 36, 41-71.)

255. Defendants nevertheless assert that they cannot serve DAI's constituents in supported housing without "altering the nature" of their programs. Defendants list five ways in which the relief sought by DAI would supposedly alter their current programs: (1) it would force defendants to create "a new program" to "assess and place" Adult Home residents in supported housing; (2) it would alter the purported "minimal needs" requirement of supported housing; (3) it would require the State to abandon its alleged

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[22] For example, Defendants state that 1673 "pipeline beds" have been "frozen" due to the economy (Defs." PFF ¶ 128), but none of those beds are supported housing beds. (Tr. 1966.) Indeed, defendants issued an RFP to develop 230 supported housing beds shortly before this trial. (P-748.)

"linear continuum" approach; (4) it would somehow prevent the State from considering the needs of other populations in need of mental health services; and (5) it would alter the nature of the ACT program. (Defs.' PFF ¶¶ 230–34.)

256. Defendants apocalyptic predictions are simply not supported by the evidence. To the contrary, the evidence shows that DAI's constituents could be appropriately served by the State's existing supported housing program and require no more than meaningful access to programs defendants already have in place.

257. *First*, as noted above, the Court has already squarely rejected the proposition that the relief requested in this action could fundamentally alter the State's programs merely because it would require defendants to "assess and place" Adult Home residents in a more integrated setting. *Disability Advocates*, 598 F. Supp. 2d at 335 ("assessing and moving" plaintiffs to integrated setting in which the state already provides services to others not a fundamental alteration). Indeed, the ADA *requires* defendants to conduct such assessments;[23] defendants' claim that assessments would fundamentally alter the State's current programs is tantamount to an admission that it has no functioning *Olmstead* plan for Adult Home residents. *See Frederick L.*, 157 F. Supp. 2d at 540 ("*Olmstead* does not allow the state 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' contention that they would have to "staff and fund" a "new program" to assess and place DAI's constituents in supported housing does not even make sense: the evidence at trial showed that it is the supported housing providers, not the State, that assess which

[23] *See Olmstead*, 527 U.S. at 605–06.

supports individuals will need. (*See, e.g.*, D-749 (2009 RFP) at 4 (supported housing provider must "identify/provide supports"); Tr. 1486:23–1487:10 (Madan) (applicants for supported housing must interview with the supported housing provider).)

258. *Second*, DAI has conclusively shown—most notably through OMH's own RFPs—that OMH does not recognize a "minimal needs" requirement for supported housing, and to the contrary, often targets populations, such as long-term residents of psychiatric hospitals (*see, e.g.*, P-749 (2009 RFP)), that are far more likely to have high support needs than Adult Home residents. (*See supra* ¶¶ 36.) Thus, the small number of DAI's constituents who have significant support needs could be served in supported housing without any change to OMH's current policies and practices.

259. *Third,* DAI has also conclusively shown that OMH has abandoned the obsolete "linear continuum" approach to serving individuals with serious mental illness. (*See supra* ¶¶ 34–40.) Rather than forcing individuals to transition through a series of gradually less restrictive transitional service settings, OMH has moved to a model of "long term" housing "linked to flexible services that can be increased or decreased as needed." (*See*, *e.g.*, P-590 (OMH 2008–2009 Executive Budget Recommendation Highlights Testimony) at 4.) Placing residents of Adult Homes directly into supported housing, rather than forcing them to transition through a "continuum of care" would not fundamentally alter current State policy and practice.

260. *Fourth*, defendants' argument that, if relief is granted in this matter, it will prevent defendants from "consider[ing] the needs of *all* State residents with mental illness" is premised on a false dilemma. Defendants have failed to prove that serving Adult Home residents in supported housing would divert one penny from services

currently provided to other needy populations. (*See supra* ¶¶ 150–174.) Moreover, the dismal numbers of Adult Home residents who have actually been able to move to supported housing (other than through the 60-bed initiative) under the current system shows that the system does not "consider" the needs of Adult Home residents at all; rather, it systematically excludes them from supported housing. (*See supra* ¶¶ 126–130.)

261. *Finally*, defendants assert that the relief sought by DAI would alter the "nature and eligibility requirements" of the ACT program. But the evidence showed that OMH's statewide ACT guidelines contain broad eligibility criteria that would plainly cover any high-needs Adult Home residents (*See supra* ¶¶ 60–64.) Although OMH contended at trial that it uses "more stringent" eligibility criteria in New York City, OMH would hardly be fundamentally altering its programs merely by applying its own statewide guidelines in New York City. In any event, there is no evidence that large numbers of Adult Home residents would require ACT in order to be served in supported housing. In fact, the evidence is to the contrary. (*See supra* ¶¶ 165–168.) Moreover, there may well be Adult Home residents who would be qualified for ACT under the allegedly more stringent New York City guidelines. (*See supra* ¶ 64.)

262. In short, the evidence at trial demonstrated that New York's supported housing providers successfully serve individuals just like DAI's constituents every day. Defendants have failed to demonstrate that serving DAI's constituents in supported housing would require significant changes to any of the State's programs and services.

VI. DOH and Commissioner Daines are Proper Defendants

263. Defendants DOH and DOH Commissioner Richard Daines should not be dismissed as parties. These defendants are necessary to afford DAI full relief with respect to its *Olmstead* claims. While defendants correctly note that DAI, in its summary

judgment briefing, withdrew claims based on defendants' failure to take adequate measures to redress poor conditions in impacted Adult Homes, DOH and Daines remain proper defendants for purposes of DAI's *Olmstead* claims. DOH participates in the administration of the State's service system for individuals with mental illness and controls the number of Adult Home beds certified by the State.

264. DOH is responsible for promoting the "development of sufficient and appropriate residential care programs for dependent adults." 18 N.Y.C.R.R. §§ 485.3(a)(1), 487.1(b). As part of those activities, DOH issues operating certificates to establish and operate adult homes. 18 N.Y.C.R.R. § 485.3(a)(3). These operating certificates must be reissued at least every four years and may be revoked or suspended if the DOH determines that such an action is in the public interest because it would conserve resources. *Id.* § 485.5(m)(1)(i). DOH can use this authority to restrict the number of Adult Home 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." *Id.* § 485.5(m)(1)(i). To support the reallocation of resources from Adult Homes to supported housing, DOH may need to certify fewer Adult Home beds.

265. Additionally, a number of the activities required to effect relief in this case will occur in or require coordination with the Adult Homes, including, importantly, the in-reach and education of DAI's constituents concerning supported housing. As DOH regulates the Homes, its participation in the relief is necessary to ensure these activities can be conducted appropriately. DOH's participation may also be necessary in order to

reallocate certain funds, such as QUIP money, from the Adult Homes in order to finance the relief.

VII. The Court Has The Authority To Order The Injunctive Relief Requested

266. Appropriate consideration must be given to principles of federalism in framing equitable relief, and "remedies that intrude unnecessarily on a state's governance of its own affairs should be avoided." *Schwartz* v. *Dolan*, 86 F.3d 315, 319 (2d Cir. 1996). This is so because unnecessarily detailed remedial orders may inject federal courts into the business of "regulating a state's administration of its own facilities," and courts are ill-equipped "for formulation and day-to-day administration of detailed plans designed to assure [compliance with the law]." *Dean* v. *Coughlin*, 804 F.2d 207, 213–14 (2d Cir. 1986).

267. Nevertheless, when discrimination has been shown, the Court has a duty to act and "the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies." *Milliken* v. *Bradley*, 433 U.S. 267, 281 (1977) (quoting *Swann* v. *Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 15 (1971), *see also Ass' of Surrogates,* 966 F.2d at 9. The remedy "must be designed as nearly as possible to restore victims of discrimination to the position they would have occupied" absent the discrimination. *Milliken*, 433 U.S. at 280 (citing Swann, 402 U.S. at 746); *see also Todaro* v. *Ward*, 565 F.2d 48, 54 n.7 (2d Cir. 1977) (stating that courts have broad discretion to fashion equitable relief that is commensurate with the scope of the violation).

268. A remedial order must therefore "strike a balance between the court's obligation to identify and take steps toward the elimination of constitutional [or statutory] violations" and the state's right to administer its own facilities or systems; the state

should be given responsibility to devise and carry out a plan to come into compliance in the manner directed by the court." *Dean*, 804 F.2d at 214.[24]

269. The relief in this case strikes the appropriate balance. It identifies the essential elements necessary to afford relief to DAI's constituents: (1) a timeframe for ensuring that all of DAI's constituents are afforded supported housing if they are qualified for it and desire it; (2) a minimum number of supported housing beds to be developed for DAI's constituents; (3) a requirement that DAI's constituents be treated as qualified for supported housing unless they have certain characteristics; and (4) identification of several issues to be addressed by the plan, including selection of supported housing providers to develop housing and conduct in-reach to Adult Home residents, education of DAI's constituents concerning supported housing, regular review of the housing preferences of DAI's constituents, a description of each defendant's responsibilities, and timelines for accomplishing tasks. (*See* DAI's PFF ¶¶ 297–98.) Under DAI's requested relief, defendants are required to report certain basic information on a regular basis to a Special Master, who will monitor defendants' compliance. (*Id.* ¶¶ 299–302.) These elements of the relief are necessary to remedy defendants' past discrimination as well as its present effects, such as the "learned helplessness" and lack of confidence experienced by many of DAI's constituents as a result of prolonged institutionalization.

270. The relief is needed—and appropriately tailored—to ensure that DAI's constituents have a meaningful opportunity to receive services in the most integrated

[24] *Dean* v. *Coughlin* involved preliminary injunctive relief, and the court noted that it would expect a remedial order "issued after a full-scale lengthy trial to be more detailed than a preliminary injunction." 804 F.2d at 214.

setting appropriate to their needs. DAI's requested relief leaves it up to the defendants, however, to determine how best to accomplish these goals in light of their expertise. Under DAI's requested relief, defendants will propose the measures that they believe are most appropriate to implement in light of their expertise—for example, the process for selecting providers to develop supported housing and to conduct in-reach to DAI's constituents, the process for working with Adult Home operators to conduct in-reach, the process of selecting residents for supported housing targeted to DAI's constituents, and the process of reviewing the housing preferences of DAI's constituents.

Conclusion

271. For the forgoing reasons, DAI respectfully requests that the Court adopt in their entirety the Proposed Findings of Fact and Conclusions of Law of Plaintiff Disability Advocates, Inc.

Dated: July 22, 2009

Respectfully submitted,

By: /s/ Anne S. Raish

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