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 PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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Plaintiff Disability Advocates, Inc. ("DAI") respectfully submits the following proposed findings of fact and conclusions of law.

Proposed Findings of Fact

Background

1. In this action, plaintiff Disability Advocates, Inc. seeks relief under the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101, et seq., and the Rehabilitation Act ("RA"), 29 U.S.C. § 791, et seq., claiming that the defendants, the Governor of the State of New York, the Commissioners of Health and Mental Health, the Department of Health, and the Office of Mental Health (collectively, "defendants" or "the State") have violated the ADA and the RA by consigning thousands of persons with mental illness to live and receive services in large "adult homes."

2. Both Title II of the ADA and Section 504 of the RA require that, when a state provides services to individuals with disabilities, it must do so "in the most integrated setting appropriate to their needs." 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d); 29 U.S.C. § 794(a); 28 C.F.R. §41.51(d). The Supreme Court in *Olmstead* v. *L.C.*, 527 U.S. 581, 597 (1999) explicitly recognized that "[u]njustified isolation . . . is properly regarded as discrimination based on disability," observing that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that the persons so isolated are incapable of or unworthy of participating in community life." Based on the evidence presented at trial, as set forth below, this Court finds that defendants have unnecessarily segregated individuals with mental illness in adult homes, violating federal law and entitling DAI to relief.

3. DAI is a protection and advocacy organization authorized by statute to bring suit on behalf of individuals with disabilities. Its constituents are people with mental illness residing in, or at risk of entry into, adult homes in New York City with more than 120 beds and in which 25 residents or 25% of the resident population (whichever is fewer) have a mental illness, collectively, the "Adult Homes." DAI alleges that the State plans and administers its mental health service system in a manner that unnecessarily segregates people with mental illness in institutional Adult Homes and systematically excludes them from far more integrated mental health service settings funded and developed by the State.

4. On June 30, 2003, DAI filed this action for declaratory and injunctive relief to enable Adult Home residents to receive services in integrated settings. Specifically, DAI asks the Court to require defendants to offer supported housing to all DAI constituents who qualify.

5. Defendants are the New York State Department of Health ("DOH") and the New York Office of Mental Health ("OMH"), as well as Governor David A. Paterson and the Commissioners of DOH and OMH. The individual defendants are sued in their official capacities only.

6. DOH and OMH are defendants for purposes of DAI's RA claim only. DOH and OMH are recipients of federal financial assistance, (P-591 (Joint Stipulations of Fact) ¶¶ 36-37)), and are therefore subject to liability under the RA. Defendants, as required by New York law, administer the State's mental health service system, plan the settings in which mental health services are provided, and allocate resources within the mental health service system. *See, e.g.*, N.Y. Mental Hyg. L. §§ 5.07, 7.07, 41.03, 41.42,

41.39; 18 N.Y.C.R.R. §§ 485.1(a), 487.1(b). Carrying out these duties, defendants have denied DAI's constituents the opportunity to receive services in the most integrated setting appropriate to their needs.

7. Discovery in this case concluded on November 14, 2006. On February 19, 2009, the Court denied the parties' motions for summary judgment. In its Memorandum & Order, the Court concluded that (1) DAI has statutory and Article III standing, rejecting defendants' argument that DAI lacks standing to seek system-wide relief on behalf of its constituents; (2) Title II of the ADA applies to the claims in this case; and (3) the Governor is a proper party. *Disability Advocates, Inc.* v. *Paterson, et al.*, 598 F. Supp. 2d 289, 307-311, 313-319, 356-57 (E.D.N.Y. 2009). In addition, the Court discussed at length the elements of the fundamental alteration defense. *Id.* at 333-39. The Court's ruling identified three issues for trial: (1) whether adult homes are the most integrated setting appropriate to the needs of DAI's constituents; (2) whether DAI's constituents are "qualified" for supported housing; and (3) whether the relief DAI seeks would work a "fundamental alteration" of New York's mental health service system. *Id.* at 319-56.

8. The trial of the matter commenced on May 11, 2009, and concluded on June 16, 2009. The Court heard testimony from State officials, mental health and other experts, lay witnesses with extensive experience in New York's care system for persons with mental illness, and current and former Adult Home residents. Twenty-nine witnesses testified at trial, over 300 exhibits were admitted into evidence, and excerpts from the deposition transcripts of 23 additional witnesses were entered into the record.

I. Adult Homes Are Not the Most Integrated Setting for DAI's Constituents

9. Adult Homes are not integrated settings. Nor are they the "most integrated setting" for DAI's constituents.

10. Adult Homes are a type of adult care facility licensed by the State of New York and authorized to provide long-term residential care, room, board, housekeeping, personal care, and supervision to five or more adults unrelated to the operator. (P-591 (Joint Stipulations of Fact) ¶ 2.) Adult homes in which at least 25% of the residents or 25 residents, whichever is fewer, have mental disabilities are referred to as "impacted" adult homes. (Tr. 2996:20-2997:3 (Hart); *see also* Mental Hygiene Law §§ 45.09(a), 45.10(a).) Defendants identify which homes are impacted based on information reported by the Adult Homes themselves. (Tr. 2996:23-2997:10 (Hart).)

11. According to a DOH Adult Care Facility Census Report for 2008, which was produced by defendants only after the trial concluded, there were 28 impacted Adult Homes in New York City with more than 120 beds as of December 31, 2008. (P-774 (NYSDOH Adult Care Facility Annual Census Report 2008 ("2008 Census Report").)[1]

[1] P-774 is not in evidence. DAI's counsel requested the census data underlying the testimony of DOH employee Mary Hart during trial. In response, counsel for defendants stated that she thought "it would be possible for [defendants] to stipulate on the final '08 figures for those homes." (Tr. 3043:17-3044:4). The Court directed defendants to produce the census reports to DAI in order to work out a stipulation. (Tr. 3044:5-9.) After trial, defendants produced P-774, which is a DOH report reflecting the 2008 census data relating to impacted Adult Homes in New York City, but defendants have refused to stipulate to either (a) facts concerning the identity of currently impacted Adult Homes, or (b) the admissibility of the census report – even though the same type of census reports, for prior periods, were admitted into evidence without objection. (*See* P-283 (2004, 2005, and 2006 Census Reports).) Accordingly, DAI has also submitted to the Court today a motion to admit P-774 into evidence.

The DOH report that was admitted into evidence as P-283 reflects that, as of December 31, 2006, the following Adult Homes were impacted: Anna Erika Assisted

These Adult Homes are Anna Erika Assisted Living, Bayview Manor Home for Adults, Belle Harbor Manor, Bronxwood, Brooklyn Adult Care Center, Central Assisted Living, LLC (formerly known as New Central Manor), Castle Senior Living at Forest Hills, Elm-York LLC, Garden of Eden Home, Lakeside Manor Home for Adults, Long Island Hebrew Living Center, Mermaid Manor Home for Adults, New Broadview Manor Home for Adults, New Gloria's Manor Home for Adults, New Haven Manor, Oceanview Manor Home for Adults, Park Inn Home, Parkview Home for Adults, Queens Adult Care Center, Riverdale Manor Home for Adults, Rockaway Manor HFA, Sanford Home, Scharome Manor, Seaview Manor, LLC, S.S. Cosmas and Damian Adult Home, Surf Manor Home for Adults, Surfside Manor Home for Adults, and Wavecrest Home for Adults. (*Id.*)

12. According to the 2008 census data, 4,242 people with mental illness lived in the Adult Homes on December 31, 2008. (P-774 (2008 Census Report).)

13. The findings set forth herein apply to all impacted homes in New York City with more than 120 beds. There are no material differences among the Adult Homes with respect to the issues in this case. (Tr. 70:7-25 (E. Jones) (testifying that there were

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Living, Bayview Manor Home for Adults, Belle Harbor Manor, Bronxwood, Brooklyn Adult Care Center, Elm-York LLC, Garden of Eden Home, Lakeside Manor Home for Adults, Long Island Hebrew Living Center, Madison-York Home for Adults, Mermaid Manor Home for Adults, New Broadview Manor Home for Adults, New Central Manor, New Gloria's Manor Home for Adults, New Haven Manor, Ocean House Center, Oceanview Manor Home for Adults, Park Inn Home, Parkview Home for Adults, Queens Adult Care Center, Riverdale Manor Home for Adults, Rockaway Manor HFA, Sanford Home, Seaview Manor, LLC, S.S. Cosmas and Damian Adult Home, Surf Manor Home for Adults, Surfside Manor Home for Adults, and Wavecrest Home for Adults. (P-283 (Census data for 2004, 2005, and 2006).)

no significant differences between the environments and characteristics of the 23 adult homes she visited); Tr. 2916:9-23 (Kaufman) (acknowledging that Seaview Manor, Garden of Eden and Surfside Manor Home for Adult Homes were a representative sample of adult homes).) While certain details of the homes' operations and resident population may vary, the homes share a common history and purpose and have common characteristics. (Tr. 648:6-9 (Rosenberg) (New York did not create adequate community supports for deinstitutionalization and "adult homes kind of filled the gap"); *see also* P-68 (Letter from OMH Commissioner James Stone to Members of Mental Health Services Council ("Stone Memo")) (adult homes developed because "community resources weren't up to speed with state operated bed reductions" caused by deinstitutionalization).) Despite certain variations from home to home, none is an integrated setting. None of these homes is the most integrated setting for DAI's constituents.

14. The Adult Homes are large, for-profit facilities in which residents live in close quarters entirely with other persons with disabilities. (Tr. 644:19-645:23 (Rosenberg).) Each serves more than 100 people with disabilities, and many house well over 200 people. (P-774 (2008 Census Report); P-283 (2004-2006 Census Report).) The great majority of the residents in the Adult Homes have a mental illness. (*Id.*) In most of the Adult Homes, more than 90% of the residents have mental illness, and in eight of the Adult Homes, 100% of the residents have mental illness. (*Id.*) In only four of the homes do fewer than 50% of the residents have mental illness. (*Id.*)

15. Adult Homes were not developed with people with mental illness in mind. (D-394 (Schimke Dep.) 289:4-15 (adult homes were designed to house the "frail elderly,"

not persons with serious mental illness).) They became settings in which people with mental illness lived and received services, however, when New York began to deinstitutionalize its State hospitals in the early 1970s. As the former Senior Deputy Commissioner for OMH, Linda Rosenberg, explained, because New York lacked other service settings for individuals coming out of its psychiatric hospitals, the State began to rely on Adult Homes as service settings for individuals with mental illness. As a result, individuals discharged from the State's psychiatric hospitals were placed directly into Adult Homes. (Tr. 640:10-25, 641:21-642:23, 647:18-648:14 (Rosenberg); P-68 (Stone Memo).)

16. Despite OMH's recognition that Adult Homes are neither desirable service settings for people with mental illness nor settings that promote integration and full social inclusion (Tr. 648:6-9 (Rosenberg); P-59 (OMH Guiding Principles)), Adult Homes continue to be used as a discharge option for individuals leaving psychiatric hospitals (Tr. 658:3-17 (Rosenberg); Tr. 448:8-12 (G.L.); Tr. 2085:19-20 (Burstein); Tr. 2684:13-2687:7 (I.K.); S-151 (E. Jones Report at 3, 9); P-534 (L.H. Dep.) 45:18-46:10; P-540 (P.B. Dep.) 30:16-31:10; P-537 (P.C. Dep.) 46:12-47:9). OMH recently made an effort to facilitate discharges from state hospitals in the New York City area to New York City adult homes, including many of the Adult Homes at issue in this litigation. (P-363, P-364, P-365 (Emails from Mitchell Dorfman to state psychiatric center directors and discharge managers regarding referrals to adult homes); Tr. 1808:10-16, 1810:18-21, 1812:23-1813:3, 1814:21-22, 1824:10-16, 1824:25-1826:1 (Dorfman).) This was not a singular effort by one official; to the contrary, OMH central office officials—up to the deputy commissioner level—were appraised of these efforts to facilitate discharges from

state psychiatric hospitals to impacted Adult Homes, and did not halt them. (*See* Tr. 1808:5-9 (Dorfman).) This effort was likely undertaken to allay the concerns of Adult Home operators that recent State initiatives might reduce the number of people with mental illness who lived in the homes. (*See* Tr. 1836:3-18 (Dorfman).)

17. Adult Homes are institutions. (*E.g.* S-151 (E. Jones Report) at 2; Tr. 642:25-643:4 (Rosenberg); Tr. 75:5-76:19 (E. Jones).) Although they are in some ways less restrictive than psychiatric hospitals, and they do not serve persons who are dangerous to themselves or others as hospitals may, Adult Homes share many of the features of state psychiatric hospitals. Indeed, witnesses commented that Adult Homes had the look and feel of the "back wards" of State hospitals. (Tr. 1006:24-1007:15 (D. Jones); Tr. 865:1-5 (Duckworth) ("The adult homes are large and there's a congregation of a tremendous number of people with psychiatric disabilities in them. This is reminiscent of a state psychiatric hospital and its culture."); Tr. 2241:21-2242:20 (Bear); P-674 (Siskind letter to OMH Commissioner) (stating that "the adult homes are much like the psychiatric centers where our customers lived for so long").) Like state hospitals, Adult Homes house dozens, and oftentimes hundreds of people with mental illness in a setting that can only be described as "institutional."

18. Life in Adult Homes is highly regimented. There are inflexible schedules for meals, taking medication, receiving public benefits and other daily activities. (S-54 (Kaufman Report) at 8-9; Tr. 644:16-645:24 (Rosenberg); Tr. 809:21-810:6, 865:1-868:20 (Duckworth); Tr. 2895:11-2897:13, Tr. 2911:10-2912:13 (Kaufman); Tr. 2356:21-2357:11 (Geller); Tr. 289:21-290:9 (Tsemberis); P-674 (Siskind letter to OMH Commissioner); Tr. 54:16-55:4, 75:5-76:17 (E. Jones); P-546 (A.M. Dep.) 154:25-

155:23, 157:22-159:24; D-391 (D.W. Dep.) 76:14-23; Tr. 54:18-57:17 (E. Jones); Tr. 374:12-375:1, 376:18-377:4 (S.K.).) Residents are assigned roommates and assigned to sit at a specific seat at a specific table in the cafeteria, a practice which is atypical even in a state psychiatric center. (Tr. 2065:2-2066:1 (Burstein); Tr. 375:7-25, (S.K.), 558:16-559:4 (S.P.); P-542 (L.G. Dep.) 98:6-24; P-543 (R.H. Dep.) 99:23-25; P-534 (L.H. Dep.) 74:9-21; P-544 (C.H. Dep.) 95:14-20; P-536 (D.N. Dep.) 91:10-12; D-391 (D.W. Dep. 71:25-72.10.) Most Adult Home residents line up to receive their medications and personal needs allowance at scheduled times. (Tr. 54:18-55:4, 67:10-19 (E. Jones); S-151 (E. Jones Report) at 5; Tr. 360:25-361:6, 376:18-378:16 (S.K.); Tr. 2103:4-19 (Burstein); Tr. 464:21-466:16 (G.L.); P-540 (P.B. Dep.) 131:16-132:17; P-542 (L.G. Dep.) 122:15-21; P-543 (R.H. Dep.) 200:12-202:8; P-534 (L.H. Dep.) 103:7-11; P-535 (T.M. Dep.) 76:14-20; P-545 (J.M. Dep.) 76:18-80:3; P-546 (A.M. Dep.) 95:2-12.)

19. The Adult Homes bear little resemblance to the homes in which people without disabilities normally live. (Tr. 289:22-290:10 (Tsemberis).) Meals, medication, phone calls and mail deliveries are announced over a public address system, and medical and mental health staff are a constant presence. (P-543 (R.H. Dep.) 97:10-99:17; P-545 (J.M Dep.) 100:3-12; P-536 (D.N. Dep.) 236:1-238:20; S-151 (E. Jones Report) at 4-5; S-54 (Kaufman Report) at 8-9; Tr. 644:18-645:24 (Rosenberg); Tr. 809:23-810:4, 865:1-868:20 (Duckworth); Tr. 2895:11-2897:13, 2911:10-2912:13 (Kaufman); Tr. 2356:21-2357:11 (Geller); Tr. 2241:8-2242: 14 (Bear); Tr. 289:21-290:9 (Tsemberis); P-674 (Siskind letter to OMH Commissioner); Tr. 809:23-810:6 (Duckworth); Tr. 54:18-55:4, Tr. 75:5-76:19 (E. Jones); P-546 (A.M. Dep.) 154:25-155:23, 157:22-159:24.) Privacy is limited. The Adult Homes have large numbers of residents and staff, and there are few or

no private spaces. It is difficult to receive visitors or talk on the phone in private. (Tr. 489:12-490:23 (G.L.); Tr. 360:21-361:6 (S.K.); Tr. 57:18-58:17, 150:9-14 (E. Jones); Tr. 863:23-864:5, 865:6-14 (Duckworth); D-394 (Schimke Dep.) 288:7-15; P-545 (J.M. Dep.) 53:22-54:24, 80:25-81:19, 95:23-96:8; P-546 (A.M. Dep.) 207:12-208:5); Tr. 360:25-361:6 (S.K.); Tr. 464:21-467:19, 477:20-478:10 (G.L.); Tr. 563:11-565:3, 574:12-575:5 (S.P.); P-540 (P.B. Dep.) 61:10-62:13; P-541 (S.B. Dep.) 70:10-74:17; P-542 (L.G. Dep.) 116:13-117:7; P-536 (D.N. Dep.) 110:15-111:12, 128:21-129:7, 241:24-244:11.)

20. Residents of Adult Homes are subject to an extensive and significant set of rules. (Tr. 62:7-64:5 (E. Jones); S-151 (E. Jones Report) at 4); Tr. 2299:18-2300:10, 2356:21-2357:11 (Geller); S-52 (Geller Report) at 11-12; S-158 (Brooklyn Manor Facility Rules and Conditions), S-159 (Garden of Eden Facility Rules and Policies), S-160 (Rules for Residents of Lakeside Manor Home for Adults), S-161 (New Central Manor Facility Rules and Conditions), S-165 (Queens Adult Care Center Facility Rules).) Homes restrict when and where residents may receive visitors; restrict when residents may be absent; and require visitors to sign in and state the purpose of their visit. (Tr. 64:6-65:18 (E. Jones) (describing the procedures for gaining entry to Adult Homes, such as signing the register and producing a driver's license for photocopying, and recounting an episode in which Surfside Manor refused entry and threatened to call the police, despite the fact that Ms. Jones was invited by residents to visit); Tr. 2103:20-21, 2104:10-17 (Burstein) (Park Inn does not allow overnight visitors and residents are not provided keys to the facility); P-541 (S.B. Dep.) 84:7-85:17; P-542 (L.G. Dep.) 164:23-165:15, 166:9-20; P-534 (L.H. Dep.) 78:2-22; P-546 (A.M. Dep.) 100:15-101:10; P-536 (D.N

Dep.) 96:13-97:14, 170:22-24 (residents must inform staff where they are going each time they leave the facility); P-744 (complaint in action by a coalition of Adult Home operators against advocacy groups to enforce restrictive guidelines for visitor access); P-545 (J.M. Dep.) 159:5-7; P-537 (P.C. Dep.) 98:19-99:5 (residents at times have trouble getting back into their facility).)

21. Residents fear retaliation, and some have been arbitrarily penalized. (P-534 (L.H. Dep.) 12:11-13:25 (Adult Home resident expressing fear at the beginning of her deposition that the Adult Home administrator would find out about her testimony and kick her out of the Home); Tr. 467:20-468:5 (G.L.); Tr. 563:3-7 (S.P.); P-544 (C.H. Dep.) 113:17-114:10; P-546 (A.M. Dep.) 43:14-44:19, 118:17-119:23; P-536 (D.N. Dep.) 123:12-124:22, 135:9-136:1;[2] Tr. 1683:3-1684:17 (Wollner) (acknowledging that Adult Home residents expressed fear of repercussions from Adult Home staff for participating in the Adult Home assessment project).) DAI's expert Elizabeth Jones, who spent a significant amount of time in 23 Adult Homes, wrote in her report that "Residents fear retaliation, especially psychiatric hospitalization, if they complain or do not follow the rules in the adult home. This fear is "grounded in their experiences of being sent to the hospital themselves or of witnessing the police remove other residents from the home." (S-151 (E. Jones Report) at 7).)

22. Much of residents' daily lives takes place inside the Adult Homes. (Tr. 148:2-3 (E. Jones) ("[T]here is a large number of people who seem to stay in the homes and don't really go out a whole lot at all").) Residents are assigned doctors and

[2] Defendants have objected pursuant to Fed. R. Civ. P. 802 to lines 123:12-124:5, 124:12-18, and 135:9-136:1. The Court has not yet ruled on that objection.

psychiatrists, usually on-site in the Adult Homes, and are told when to see the treatment provider. (Tr. 462:19-463:6 (G.L.); Tr. 566:9 -567:1 (S.P.); P-546 (A.M. Dep.) 109:18-110:6; P-536 (D.N. Dep.) 125:6-17).) For instance, the Park Inn Home for Adults contracts with local medical facilities and psychiatric centers that provide on-site doctors, psychiatrists and social workers, and the majority of the residents of Park Inn attend on-site mental health clinics and are treated by on-site doctors and mental health professionals. (Tr. 462:19-463:6 (G.L.); Tr. 2046:18-2049:8, 2096:7-2097:18 (Burstein).) Park Inn and other Adult Homes also provide religious services at the home. (Tr. 2045:12-17 (Burstein); Tr. 150:23-151-2 (E. Jones); Tr. 2692:3-9 (I.K.)

23. Residents spend most of the day in activities organized for them by the Adult Homes and/or providers associated with the Homes. These activities typically include games, puzzles, and other child-appropriate leisure activities, and do little to help residents to regain skills. (Tr. 69:12-70:19 (E. Jones); Tr. 2560:12-2562:9 (Waizer) (describing recreational activities provided on-site for residents of Riverdale Manor, such as computer games suitable "for a three- or four-year-old"); S-166 (calendar of recreational activities at Surfside Manor, such as beads, nail painting and bingo).)

24. Unless residents are involved in a continuing day treatment program, they do not have much interaction with individuals outside of the Adult Home setting. (Tr. 2663:2-9 (Lockhart).) While Adult Home residents do 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. (S-151 (E. Jones Report) at 3; Tr. 601:25-602:9 (S.P.).)

25. 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. 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")). 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).)

26. 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,[3] 94:12-95:9; Tr. 54:19-55:1 (E. Jones); Tr. 376:10-377:8 (S.K.); Tr. 862:4-863:1 (Duckworth); Tr. 2917:3-2918:4 (Kaufman) (testifying about his observations that Adult Home staff 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, 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-

[3] Defendants have objected to lines 89:20-23 pursuant to Fed. R. Civ. P. 602. The Court has not yet ruled on that objection.

259:21 (Tsemberis); D-182 at OMH 0043462; Tr. 2734:21-2735:2 (I.K.); P-546 (A.M. Dep.) 153:17-154:14, 211:13-213:5.)[4]

27. 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 after hours when the facilities are closed the general public. (Tr. 2560:9-16 (Waizer).)

28. Overall, the Adult Homes provide little support or encouragement for residents to interact with non-disabled peers or become integrated into the community. (Tr. 71:15-73:2 (E. Jones); S-150 (D. Jones Report) at 9). Many residents have testified that they feel isolated living in the Adult Homes. (P-569 (G.H. Dep.) 260:20-22; P-535 (T.M. Dep.) 89:21-90:18, 110:3-112:6); P-544 (C.H. Dep.) 75:16-24.)

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[4] Defendants have objected to the following portions: 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.

29. The Adult Homes limit the development of relationships with nondisabled persons, including limiting employment and social contacts. (Tr. 2916:5-8 (Kaufman); P-538 (B.J. Dep.) 50:7-19; Tr. 2374:8-22 (Geller); P-535 (T.M. Dep.) 89:21-90:18, 106:23-107:3, 110:3-112:6; S-151 (E. Jones Report) at 3.) Defendants' experts acknowledged that, by virtue of the very nature and certain characteristics of the Adult Homes, choices in acquaintances and the development of social contacts are limited. (S-54 (Kaufman Report) at 10-11; Tr. 2899:10-13 (Kaufman).) 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-538 (B.J. Dep.) 50:7-19; P-540 (P.B. Dep.) 45:19-21; P-542 (L.G. Dep.) 78:17-23; P-543 (R.H. Dep.) 96:12-97:9; P-534 (L.H. Dep.) 57:21-58:14; P-535 (T.M. Dep.) 35:21-23; P-545 (J.M. Dep.) 54:21-24, 71:11-20; P-569 (G.H. Dep.) 120:7-16, 123:11-18, 126:24-127:3; P-536 (D.N. Dep.) 15:20-16:4.)

30. It is widely understood—and witnesses for both sides testified—that Adult Homes are institutional and limit community integration. Defendants themselves have recently referred to Adult Homes as "institutional settings" that are overused and in which people are "stuck." (P-59 (OMH Guiding Principles for the Redesign of the OMH Housing and Community Support Policies, "OMH Guiding Principles") at 1; S-71 (Statewide Comprehensive Plan, 2006-1010) at OMH 0043287; D-182 (2009-1019 Mental Health Update & Executive Budget Testimony of OMH Commissioner M. Hogan) at OMH 0043466.) The State has long characterized Adult Homes as institutions. In government reports published in 1979, for example, New York State and City officials referred to adult homes as "de facto mental institutions" and "satellite

mental institutions." (P-142 (Private Proprietary Homes for Adults: A Second Investigative Report ("Hynes Report")) at DAI 2906; P-170 (The Adult Home Industry: A Preliminary Report) at DAI 3571; *see also* Tr. 2045:21-22, 2051:1-5, 2052:16-20, 2053:7-9 (Burstein) (repeatedly referring to the Home as a "facility"); P-59 (OMH Guiding Principles) at 1 ("As a consequence of poor access to community housing, inadequate levels of mental health housing, and clinical programs that do not support people in getting/keeping housing successfully, many people with a mental illness are 'stuck' in . . . institutional settings" including "adult homes").)

31. The Assistant Executive Director of a large New York City mental health provider, whom defendants called as a trial witness, described the Adult Homes in Coney Island as "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 enclosing materials for 1/13/04 OMH meeting); Tr. 2236:12-2238:24 (Bear).)

32. Defendants presented two experts to attempt to rebut the widely held views of people with experience in New York's mental health system that Adult Homes are segregated settings. Defendants' experts highlighted, for example, that the New York City Adult Homes are located in urban settings and that because residents are not locked in the facilities, they have opportunities to come and go. (*See, e.g.*, S-54 (Kaufman Report) at 9.) But even if the Adult Homes are not as restrictive as some psychiatric hospitals in some respects, they nonetheless are segregated, institutional settings that impede integration in the community and foster learned helplessness. The State's supported housing program is a far more integrated setting than Adult Homes. (*See* Tr. 2162:9-16 (Newman) (agreeing that 120 people with serious mental illness living in a

congregate setting in which there are no residents without mental illness constitutes a segregated setting), Tr. 2162:17-21 (agreeing that supported housing provides "maximum opportunities" for community integration.).)

33. Defendants' experts also opined that the setting in which a person with disabilities lives is irrelevant to the question of integration because people can feel isolated in any kind of setting. (Tr. 2899:21-2900:10 (Kaufman); Tr. 2292:14-22 (Geller).) The opinions of defendants' experts, however, are based on flawed analyses, and the Court accords them little weight. One of defendants' experts, Alan Kaufman, considered no verifiable standard at all in forming his opinions. (Tr. 2920:16-2921:20.) Defendants' other expert, Dr. Geller, explicitly rejected the applicable legal standard for integration, testifying that he believes the Supreme Court's finding in the *Olmstead* opinion that "confinement in an institution severely diminishes the everyday life activities of individuals" was wrong. (Tr. 2373:16-24; S-52 (Geller Report) at 2 (opining that, because there is no such thing as an integrated or non-integrated setting, "[t]he questions faced in this case … are not whether or not adult homes are institutions with all the connotations thereto; or whether or not adult homes are 'segregated settings,' whatever that might mean; or whether or not those who reside in adult homes could reside in apartments with varying degrees of support; or whether or not supported housing *per se* has a more positive effect on rehabilitation and recovery; or whether or not New York State had negative experiences with impacted adult homes; or whether or not New York State, pursuant to the *Americans with Disabilities Act*, the *Olmstead* decision and all other considerations has created a panoply of residential types throughout New York State.").) Mr. Kaufman himself concedes, however, that, by and large,

residents of supported housing feel that they are far more integrated than residents of group homes. (Tr. 2915:2-2916:4.)

34. With respect to the institutional and segregated nature of Adult Homes, defendants' experts and other witnesses were largely in agreement with DAI's experts, the current and former Adult Home residents, and other witnesses at trial. (*See, e.g.,* Tr. 2162:9-16 (Newman).) Defendants' experts acknowledged the institutional characteristics of the Adult Homes. (Tr. 2356:21-23 (Geller) ("Q. Dr. Geller, did you find that adult homes share some characteristics with institutions? A. Absolutely"); Tr. 2358: 21-23 ("Q. And in your opinion, do adult homes foster learned helplessness? A. Absolutely."); Tr. 2425:15-17 ("Q. Do you agree that there are many people with mental illness stuck in adult homes? A. Absolutely."); Tr. 2427:14-15 ("Q. Do you agree that there is an overuse of adult homes? A. Absolutely."); *see also* 2380:20-2371:17 (adult homes have an institutional feel and institution-like characteristics, and are in some respects segregated settings); Tr. 2895:11-2896:13 (adult homes have some characteristics of large psychiatric hospitals and institutions, including a regimented food service schedule, dispensing of medication, lack of opportunity for residents to do their own laundry and housekeeping, lack of full freedom concerning choice of roommate); S-54 (Kaufman Report) at 8-9 (the size, physical layout, furnishings and decorations of large adult homes give them a similar appearance to institutional settings; adult homes also share certain routines with mental health institutions, including inflexible schedules for meals and other daily activities, assigned dining hall seating, routinized program activities, public address announcements, and constant presence of medical and mental health staff). Defendant's expert Alan Kaufman noted that there is generally no

expectation that individuals in Adult Homes will move to another setting. (Tr. 2910:14-2911:9 (Kaufman).)

35. Defendants' experts also acknowledged that characteristics of Adult Homes themselves impede the development of social contacts and work opportunities. (Tr. 2899:3-17 (Kaufman) (adult homes are large institutions that impose certain artificial limitations on residents' ability to interact with others); S-54 (Kaufman Report) at 10 ("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. 2374:15-22 (Geller) ("Q. So you would agree that living in a place where the phone is answered 'Brooklyn Adult Care Center' diminishes your work options and social contacts? A. Yes. Q. And you would agree then that having visiting hours diminishes opportunities to cultivate social or family relationships, right? A. Right.").)

36. As DAI's experts concluded, the Adult Homes are segregated settings that impede community integration. Elizabeth Jones, who spent 75 hours in 23 Adult Homes in both scheduled and unannounced visits explained:

> I can't state strongly enough that these facilities are institutions. These facilities are like the institutions that I worked in when I started my career. These are settings that are caught in time almost. They are not like even the psychiatric settings of today where I've been a director. These are outdated institutional facilities that restrict and constrain people's freedom and their ability to learn and exercise skills. These are the buildings and the places that were here in the '70s when my career started, when the court cases were first entered into. These facilities do not represent current practice in the mental health field.

Tr. 54:19-55:5; *see also* Tr. 809:23-810:3 (Duckworth) ("The adult homes have . . . some of the elements of a homeless shelter and some of the elements of a state hospital. The culture is quite institutional in some ways, even more institutional than a state hospital in my opinion.").)

37. Linda Rosenberg, Senior Deputy Commissioner of OMH from 1997 to 2004, described Adult Homes as "institutional living at, potentially, its worst." (Tr. 645:23-24). She observed that Adult Homes "impede community integration" and are "little ghettos" with "people sitting out front from the adult home, smoking, going back in, sitting in the lobby, not much going on and not much exposure to the rest of the world." (Tr. 645:25-646:9.) Residents live in bedrooms with strangers, eat meals only at set times, live exclusively with other people with serious mental illness, and are completely "defined by their illness." (Tr. 644:25-645:8.)

II. Supported Housing is A Far More Integrated Setting Than Adult Homes

38. Supported housing is a far more integrated setting than an Adult Home. Individuals in supported housing live in their own apartment and receive services to support their success as tenants and their integration into the community. Most supported housing in New York is "scattered site," – that is, it is in the form of rental apartments scattered in various buildings throughout the community. (Tr. 236:12-15 (Tsemberis).) Scattered-site supported housing is the focus of DAI's claim and the Court's analysis. As used below, "supported housing" refers to the scattered-site supported housing that DAI seeks for its constituents.

39. The State is currently focusing on supported housing more than other forms of housing because it is cost-effective, it is a best practice, and it is what consumers

want. (Tr. 2159:1-19 (Newman).) DAI's expert, Elizabeth Jones, explained that the modern practice in the mental health field is to start with housing and "add and subtract the supports as that person needs them." (Tr. 139:8-15 (E. Jones); *see also S*-150 (D. Jones Report) at 25.) Likewise, Linda Rosenberg testified that supported housing reflects "the most current thinking in the field." (Tr. 650-18-651:3.)

40. Consistent with that view, OMH began to implement a supported housing program in 1990. (S-11 (Supported Housing Implementation Guidelines, 1990); *see also* S-150 (D. Jones Report) at 26.) Michael Newman, Director of OMH's Bureau of Housing Development and Support, testified that supported housing is the current focus of OMH's housing development because it is a "successful," "cost-effective" program that gives residents "the same privacy rights as any other tenant in a landlord-tenant relationship." (Tr. 2159:5-2160:4; *see also* Tr. 3172:18-3173:4 (Myers) (testifying that OMH's development efforts are centered on supported housing and SROs, and noting that supported housing is "less expensive" than other housing models).)

41. 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. 851:11-25 (Duckworth).)

42. Residents of supported housing sometimes live alone and sometimes share their apartment with one or more roommates. (Tr. 290:10-18 (Tsemberis).) They choose their own roommates. (*Id.*). Sometimes they lease the apartment directly from the

landlord, and sometimes they lease the apartment from the provider. (Tr. 316:7-14, 317:16-21 (Tsemberis).)

43. One of the key principles of the State's supported housing program is to "separat[e] housing from support services by assisting the resident to remain in the housing of his choice while the type and intensity of services vary to meet the changing needs of the individual." (S-11 (Supported Housing Implementation Guidelines) at 2.) Supported housing providers and other community mental health providers offer support services that vary depending upon the needs of the resident. (S-33 (2007 RFP) at OMH 42726.)

44. In addition to support services provided by the supported housing providers, residents of supported housing can receive other support services, such as Assertive Community Treatment ("ACT") or case management services. (Tr. 1833:10–12 (Dorfman) ("All residents in mental health housing, if appropriate, are eligible and can access all the mental health community support services."); Tr. 1414:20–1416:10 (Reilly) (supported housing residents can receive ACT or case management services); Tr. 3170:19–3171:14 (Myers) (some people in supported housing receive ACT or have an intensive case manager).)

45. ACT is a form of treatment that delivers comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings. (S-97 (description of ACT from OMH website); *see also* Tr. 855:13–857:13 (Duckworth).) An ACT team is a multi-disciplinary team, typically including members from the fields of psychiatry, nursing, psychology, and social work with increasing involvement of substance abuse and vocational rehabilitation specialists, that provides

services tailored to meet the client's specific needs. (*Id.*) The purpose of ACT is to deliver comprehensive and effective services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional service delivery approaches. (*Id.*)

46. ACT teams can assist recipients with a wide range of service needs, including teaching medication management. (Tr. 938:14–15 (Duckworth); Tr. 1535:21–1538:24 (Madan).) ACT teams can also assist with daily activities such as personal care and safety, grocery shopping and cooking, purchasing and caring for clothing, household chores, using transportation, using other community resources, and managing finances. (P-372 (ACT Program Guidelines) at 3-4.)

47. ACT teams see clients on average about twice per week but can see individuals as often as twice per day if necessary. An ACT team assigned to a person with mental illness recently discharged from the hospital would typically see that person once or twice a day. (Tr. 228:20–229:15 (Tsemberis).)

48. The Pathways to Housing supported housing program uses ACT with roughly 80% of its incoming clients. (The remaining 20% receive less intensive case management.) (Tr. 230:11–25, 243:9–245:10 (Tsemberis).) Pathways routinely and successfully helps people overcome difficulties with activities of daily living such as laundry, cooking, or using public transportation, and further does not regard such challenges as "difficult issues" to deal with. (*Id.*)

49. 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'd like for dinner, decorate their own apartment and have overnight guests. (Tr. 251:11-18 (Tsemberis).) They have the 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); Tr. 2751:20-25 (I.K.) ("I can limit what I eat or I can expand my choices. I can have as much salad as I like. I can have as little grease as I like. I can eat foods that were not permitted in the home . . . . I do my own shopping. I do my own food selection. It's free. It's freedom for me. It's freedom. It's being able to actually live like a human being again."); Tr. 501:22-502:13 (G.L.) ("Q. You've lived five years, approximately, in the adult home, two years and some in Pathways housing, do you have a preference between the two? A. Definitely where I am now. Q. Why is that? A. I have much more freedom. Q. To do what? A. Anything, everything. Q. Would you ever….A. 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 anytime. Q. And that means something to you? A. Yes. Q. Would you ever voluntarily come back to an adult home? A. No.").)

50. 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.)

51. Residents of supported housing live and receive services in integrated settings. (Tr. 654:22-655:9 (Rosenberg); Tr. 2915:10-2916:4 (Kaufman).) 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).) In the words of Michael Newman, Director of OMH's Bureau of Housing Development and Support, supported housing provides "maximum opportunities" for community integration. (Tr. 2162:17-21.)

III. Virtually All Of DAI'S Constituents Are Qualified For Supported Housing

52. The Court finds that virtually all Adult Home residents are qualified to be served in defendants' supported housing programs.

A. Supported Housing Is for Persons with Significant Needs

53. Supported housing provides individuals with mental illness with a permanent place to live coupled with flexible support services customized to each

resident's specific needs. (*See* S-101 (1990 Supported Housing Guidelines (reformatted 2005) ("2005 Supported Housing Guidelines") at OMH 37514; S-33 (2007 RFP) at OMH 42726–28 (describing supported housing).)

54. New York's supported housing program is specifically targeted to people with mental illness who have significant needs. (Tr. 1505:2–9 (Madan); S-101 (2005 Supported Housing Implementation Guidelines) at OMH 37515 (supported housing is an "approach" designed to ensure that individuals with serious and persistent mental illness[5] can choose where they want to live); S-17 (2005 RFP) at OMH 37306-307 (requesting supported housing proposals targeting "high-need individuals").)

55. Contrary to defendants' contentions, there is no requirement that individuals receiving supported housing be independent or have minimal support needs. (*See, e.g.*, S-101 (2005 Supported Housing Implementation Guidelines) at 4 (explaining that supported housing is directed at people with serious and persistent mental illness); S-17 (2005 RFP) at OMH 37307 (defining target population as "high need"); S-33 (2007 RFP) at 4 (explaining that target population may need ACT or Blended Case Management, and may have a co-occurring substance problem); S-67 (2008 RFP) at OMH 43109 (same); *see also* Tr. 1506:22:1507:10 (Madan) (agreeing that description of supported housing in S-33 is accurate).) Defendants have targeted for placement in supported housing individuals that, according to them, are "high-need," defined as "a

[5] To be categorized as having a severe and persistent mental illness ("SPMI"), an individual must (a) be 18 years of age or older, (b) have a designated mental illness, and (c) either (1) receive SSI or SSDI due to a designated mental illness, (2) currently have certain functional limitations due to a designated mental illness, or (3) have had certain functional limitations prior to receiving psychiatric rehabilitation and supports and/or medication. (S-17 at OMH 37314.)

person who, as a result of psychiatric disability, presents some degree of enduring danger to self or others or has historically used a disproportionate amount of the most intensive level of mental health services." (S-17 (2005 RFP) at OMH 37307; *see also* Tr. 3170:19–3171:16 (Myers) "There are . . . people that live in supported housing that have extensive psychiatric needs.").)

56. Nor is there any reason why a person with mental illness who has significant needs could not live in supported housing with appropriate supports. As Dr. Tsemberis pointed out, "you 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. 266:17–20; *see also* Tr. 265:25–266:5 (Tsemberis) (pointing out that most people with severe mental illness in the United States live at home with family); Tr. 139:8–16 (E. Jones) ("[Y]ou start with a place for the person to live and you add and subtract the supports as that person needs them."); Tr. 812:3–6 (Duckworth) ("[M]y experience has taught me that just about everybody can make it in Supported Housing with the appropriate level of flexible supports.").) Even defendants' expert, Dr. Geller, conceded that "those who reside in adult homes could reside in apartments with varying degrees of support." (Tr. 2370:17–19.)

B. The Court Credits the Conclusions of DAI's Experts that Virtually All Adult Home Residents Could Move to Supported Housing

57. DAI presented at trial three expert witnesses, Dr. Kenneth Duckworth, Dennis Jones, and Elizabeth Jones, all of whom testified that virtually all Adult Home residents could be appropriately served in supported housing. The Court finds the conclusions of these experts to be credible.

1. Kenneth Duckworth

58. Dr. Kenneth Duckworth is a licensed psychiatrist with 20 years of experience serving people with serious mental illness. Dr. Duckworth is triple board certified by the American Board of Psychiatry and Neurology in Adult Forensic, and Child and Adolescent psychiatry and has worked in numerous different treatment settings including hospital inpatient, outpatient, supported housing, day treatment, emergency triage and homeless outreach. Dr. Duckworth has interviewed, directly treated, supervised and consulted about the treatment of thousands of people with schizophrenia, bipolar illness, schizoaffective disorder, and depression, among other serious psychiatric disorders. Dr. Duckworth has also served as the Medical Director and Acting Commissioner for the Massachusetts Department of Mental Health, where he was involved with, among other things, placement of hospital patients in more integrated settings and the design and implementation of Programs of Assertive Community Treatment (PACT)—Massachusetts's version of New York's Assertive Community Treatment (ACT) program—throughout Massachusetts. (S-152 (Duckworth Report) at 1–4 & S-155 (Duckworth Resume).) In short, Dr. Duckworth is an experienced medical professional with substantial professional experience directly relevant to assessing whether individuals with mental illness are capable of living in supported housing; he is well qualified to opine on this issue.

59. In this case, Dr. Duckworth undertook an extensive analysis of whether Adult Home residents could be served in supported housing. Dr. Duckworth's analysis included a review of the mental health records of between 260 and 270 Adult Home residents, visits to five Adult Homes, interviews with Adult Home residents, a visit to the

Pathways to Housing supported housing program, and the review of numerous documents relating to the case, including deposition transcripts of Adult Home residents, materials concerning New York's supported housing programs, and responses to RFPs issued by OMH for supported housing. (S-152 (Duckworth Report) at 4–5 & Ex. 2 (list of documents considered); Tr. 932:15–22 (Duckworth) (testifying that he also read some RFP responses since drafting this report).)

60. Dr. Duckworth concluded that "there are no material clinical differences between adult home residents and supported housing clients." (S-152 (Duckworth Report) at 5; *see also* Tr. 854:11–21 ("Q. And how, if at all, did the clients you visited at Pathways compare to the adult home residents you visited in this case? A. Again, these populations are identical. . . . They all want something for themselves, it seems to me, frequently to live more independently would be the most common theme but the populations don't differ in any impressive way that stood out to me.").)

61. Dr. Duckworth further concluded "virtually all of the [Adult Home residents] I looked at I felt would make it in Supported Housing. I looked for things that would contraindicate a person living in Supported Housing and I found relatively few of them." (Tr. 809:17–20; *see also* S-152 at 18-19. ("[I]t is clear to me that existing supported housing programs in New York could appropriately serve virtually every adult home resident that I encountered."); *see also* S-80 (Duckworth Reply Report) at 2; S-149 (Duckworth Corrected Reply Report) at 1.)

62. Based on Dr. Duckworth's considerable experience in the mental health field and his extensive analysis of the Adult Homes and New York's supported housing

programs, the Court credits Dr. Duckworth's conclusions, including his conclusion that virtually all Adult Home residents could be served in supported housing.

2. Elizabeth Jones

63. DAI's expert Elizabeth Jones has over 30 years of experience in the field of mental disability, including positions as the Superintendent/Director of three institutions and the court-appointed Receiver of a psychiatric institution. Ms. Jones has focused a substantial part of her work on the management of institutions and the planning, development and management of community services for people with mental illness and mental retardation. Ms. Jones has also managed the day-to-day operations of two community mental health systems, in which she had a leadership role in planning, developing and implementing services in integrated settings as an alternative to institutional care. Ms. Jones has served as an expert consultant regarding institutional conditions and the development of alternative community-based programs in Massachusetts, Texas, North Dakota, Iowa, Michigan, Romania, Bulgaria and Paraguay. (S-151 (E. Jones Report) at 1 & S-154 (E. Jones Resume).) Ms. Jones is well qualified to render an expert opinion in this case on the question of whether DAI's constituents are qualified to be served in supported housing.

64. In forming her expert opinion in this case, Ms. Jones visited 23 impacted Adult Homes for a total of approximately 75 hours. These visits included, in addition to six "formal" announced tours of Adult Homes that defendants' experts also participated in, seventeen unannounced "informal" visits to various Adult Homes. (Tr. 45:4-46:4 (E. Jones); *compare* Tr. 2295:9-2296:11 (Geller) (describing a total of eight visits to Adult Homes, each with a "rather large group" that included attorneys and experts for both

parties and staff and owners of the Adult Homes).) During her visits, Ms. Jones personally interviewed 179 residents, some for as long as two hours. (S-151 (E. Jones Report) at 1-2.) In addition, Ms. Jones employed three social workers who observed conditions and interviewed an additional 62 residents in Seaview Manor, Riverdale Manor and Garden of Eden adult homes and prepared summaries of their observations for Ms. Jones's review. Ms. Jones also considered deposition transcripts and numerous other documents relating to the issues in this case in forming her expert opinion. (S-151 (E. Jones Report) at 1–2 & Ex. 3 (list of documents reviewed).)

65. The social workers employed by Ms. Jones also reviewed a number of resident records from three of the Adult Homes. (Tr. 50:10–23 (E. Jones).) Ms. Jones then reviewed the social workers' notes on those records, and also reviewed roughly 20 or 25 of those records herself. In responding to the expert report of defendants' expert Jeffrey Geller, Ms. Jones reviewed over one hundred additional records of Adult Home residents. (*Id.*)

66. On the basis of her research and experience, Ms. Jones concluded that "virtually all" Adult Home residents could be served in a more integrated setting (Tr. 100:16-21); *see also* S-157 (E. Jones Reply Report) (concluding that "virtually all" of the residents she reviewed in her sample "could be served" in supported housing).)

67. Ms. Jones found that "there was no reason that [adult home residents] couldn't live in supported housing if the appropriate supports were provided to them" (Tr. 113:12–20), and that she "saw nothing in [her] visits to the adult homes that would lead [her] to believe that people required 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. 80:23–81:3.) According to Ms. Jones, while there were some Adult Home residents who would need help with medication management, or various health related services, the "array of supports [that would be needed] are nothing unfamiliar to what's commonly found in a mental health system today." (Tr. 82:22–24.) Ms. Jones further concluded that there are "many" Adult Home residents "who could go to [supported] housing with little support." (Tr. 83:25–84:9.)

68. Ms. Jones also found that Adult Homes are not designed for people with high needs. To the contrary, Adult Homes "do not provide intensive supervision to people, . . . they have restrictive rules and practices, but they do not provide individualized attention to people. So, many people have a place to stay and they have their meals and their medicine, but not a whole lot more than that." (Tr. 80:7–12; *see also* S-157 (E. Jones Reply Report) at 1 (noting that she "does not think that the adult home setting provides supports to the extent cited as necessary in Dr. Geller's report").)

69. Based on Ms. Jones expertise and her extensive investigation, the Court credits Ms. Jones's conclusions, including her conclusion that virtually all Adult Home residents could be served in supported housing.

3. Dennis Jones

70. DAI's expert Dennis Jones served as the top mental health official for the state of Indiana from 1981 to 1988 and the top mental health official for the state of Texas from 1988 to 1994. He was also appointed by a federal district court as the transitional receiver for the Washington D.C. mental health system from 2000 to 2002 and later became a federal court monitor in the same action, a position he still holds today. As part of his role as transitional receiver, Mr. Jones developed a plan to

completely restructure the public mental health system in the District of Columbia. Mr. Jones also served from 1994 to 2003 as the Administrator/CEO of the largest community mental health center in Indiana. (S-150 (D. Jones Report) at 1–2 & Ex. 1 (Resume of Dennis Jones); *see also* Tr. 984:1–14.) Mr. Jones is well qualified to opine on the ability of New York's supported housing programs to serve adult home residents.

71. After extensive investigation, which included review of documents, visits to four Adult Homes, conversations with Adult Home residents and visits to community mental health providers, including supported housing providers (*see* S-150 (D. Jones Report) at 3–5 & Ex. 2 (listing materials considered)), Mr. Jones concluded that "virtually all mentally ill adult home residents are able to live in integrated community settings such as supported housing" (S-150 (D. Jones Report) at 10; *see also* Tr. 995:7–13 ("Q. Did you reach a conclusion about whether or not virtually all of the adult home residents residing in the adult homes at issue in this case can live in supported housing with various supports? A. I did. Q. And what was your opinion? A. That—that virtually all could.")).

72. Based on Mr. Jones's extensive experience and careful analysis, the Court credits Mr. Jones's conclusion that virtually all Adult Home residents could be served in supported housing.

C. Defendant OMH's Own Former Senior Deputy Commissioner Believes that Virtually All Adult Home Residents Could Move to Supported Housing

73. OMH's own former Senior Deputy Commissioner, Linda Rosenberg, also testified credibly that virtually all Adult Home residents would be qualified for supported

housing. (Tr. 710:13–15 ("Q. And would it be fair to say that virtually all adult home residents would be qualified for Supported Housing? A. Absolutely.").)

74. Ms. Rosenberg served from 1997 to 2004 as the Senior Deputy Commissioner for OMH, where she oversaw the "community system of care for people with serious mental illnesses," including OMH's housing services as well as, at one point, all of New York's state hospitals. (Tr. 636:6–18.) Ms. Rosenberg has had extensive experience dating back to the 1970s with Adult Homes and Adult Home residents, as a result of her OMH position as well as previous positions with community mental health clinics and state psychiatric hospitals. (Tr. 640:4–642:24.)

75. Ms. Rosenberg testified that, in her experience, individuals were placed in Adult Homes based on "luck of the draw," and that Adult Home residents "by and large have similar characteristics" to residents of supported housing. (Tr. 709:2–12.)

76. Ms. Rosenberg further testified that Adult Homes offer "less support in many cases" than supported housing, "because you are left on your own devices—you are not connected to an ACT Team necessarily or even a case manager, maybe sometimes you are, and . . . the home has meals but doesn't have much more than that going on anyway. It isn't as if you are tak[en] care of in an intensive way, unless the home brings in a home health care agency . . . ." (Tr. 709:16–21.)

77. The Court finds that, based on her years of experience as a high-ranking OMH official, including extensive experience with adult homes, the testimony of Ms. Rosenberg that virtually all Adult Home residents could be served in supported housing is credible.

D. Defendants' Own Adult Home Workgroup Concluded that Large Numbers of Adult Home Residents Should Be Served In More Integrated Settings

78. Shortly after *The New York Times* published in 2002 a series of articles by Clifford Levy critical of living conditions in Adult Homes,[6] the Governor of New York convened the Adult Care Facilities Workgroup to conduct a comprehensive review of Adult Home policies, programs and financing. (Tr. 1369:19–22 (Reilly); 1672:23–1673:4.) Joseph Reilly, an OMH employee and staff member of the Workgroup, testified that the Workgroup was convened in a "crisis atmosphere." (Tr. 1369:15–18.)

79. The Adult Care Facilities Workgroup was comprised of a "blue ribbon panel" of various stakeholders in the mental health system, including clinicians, mental health providers, and Adult Home operators. (Tr. 1618:21–1619:9 (Wollner).) The Workgroup members were selected by the Governor's office and included well-known New York State experts on mental health. (Tr. 1674:20–24, 1688:21-1689:4 (Wollner).) The Governor's office was active in shaping the Workgroup's agenda. (Tr. 1673:15–19 (Wollner).)

80. The Workgroup was staffed by no fewer than 38 OMH and DOH employees. (Tr. 1675:19–23 (Wollner); S-103 (Report of the Adult Care Facilities Workgroup, August 1, 2002 ("Workgroup Report") at DOH 86210–14 (listing staff).) These employees did not merely provide ministerial assistance to the Workgroup; they made editorial and conceptual contributions to the Workgroup and put together the final

[6] Although the Levy articles themselves are not in evidence, DAI's expert Dr. Duckworth testified on cross examination that "if even half of [what was reported in the Levy articles] was true, half, I [had] never seen anything as so egregious in my travels in mental health." (Tr. 947:21-948:1.)

Workgroup report. (D-394 (Schimke Dep.) 153:20–154:12.) The Co-Chair of the New Models Sub-workgroup, Karen Schimke, viewed the final Workgroup report as a document "submitted by the Health Department to the Health Department." (*Id.*)

81. The Adult Care Facilities Workgroup proposed that 6,000 individuals with mental illness living in adult homes be helped to move to more integrated settings. (S-103 (Workgroup Report) at DOH 81644; P-591 (Joint Stipulations of Fact) ¶ 13.)

82. The Workgroup's proposal was based on its findings that Adult Home residents had similar characteristics to individuals living more independently, a finding that was made after substantial study, deliberation, and research that included presentations from a variety of experts and field visits to various types of housing. (D-394 (Schimke Dep.) 123:4–8; S-103 at DOH 86217–23 (listing presentations to and site visits by the New Models Subworkgroup); Tr. 1370:4–1375:2 (Reilly) (describing research activities of the New Models Subworkgroup); *see also* Tr. 1376:18–21 (Reilly) (agreeing that the Workgroup "relied on a broad array of information that it gathered [after] diligent effort").)

83. The Workgroup report noted that "[t]he operational construct for [adult home residents with mental illness] was predicated on the belief that all needed congregate level care and are too fragile to live more independently." It rejected this premise, finding that "[a] great many people with many of the same issues and needs live every day in integrated, community settings across New York State." (S-103 at DOH 86141; *see also* D-394 (Schimke Dep.) 300:4–16 (agreeing that the workgroup developed a consensus to reject the "existing paradigm that most of the residents with mental illness

who are in adult homes are at a very low end of independence or ability for independence").)

84. Upon its completion, the Workgroup Report was presented to the Commissioner of DOH at the time, Antonia Novello, and was accepted by her. (D-394 at 181:2–21 (noting that Novello "applauded the work of the group").)

85. No member of the Workgroup objected to or dissented from the Workgroup's finding that large numbers of Adult Home residents should be served in more independent settings. (*See* Tr. 1376:13–15 (Reilly) ("Q. Was there a dissenting report appended to the Workgroup's report? A. There was only one report.").)

E. Defendants' Own Survey of Adult Home Residents Establishes that Adult Home Residents Do Not Have Impairments that Would Preclude them from Supported Housing

86. In December 2002, defendants commissioned a study from New York Presbyterian Hospital (the "Assessment Project") to collect data regarding adult home residents. Defendants paid a total of $1.3 million to New York Presbyterian Hospital for the survey. (P-591 (Joint Stipulations of Fact) ¶ 7; Tr. 1678:14–16 (Wollner); P-583 (Bruce Dep.) 123:18–124:3 (stating that the cost of the Assessment Project totaled $1.3 million).)

87. Linda Rosenberg testified that in her view, the Assessment Project was done to "deflect[] . . . what had become a crisis for the Governor's office." (Tr. 739:30-740:4)

88. The Assessment Project was conducted by Dr. Martha Bruce, an expert in population-based survey design and sampling procedures who had previously been involved in designing between 15 and 20 such surveys. (P-583 (Bruce Dep.) 16:22-25.)

In addition, defendants themselves had "a great deal of input" into the design of the survey. (*Id.*)

89. The Assessment Project assessed 2,611 residents in nineteen adult homes. (P-591 (Joint Stipulatios of Fact) ¶ 8; P-583 (Bruce Dep.) 64:9–11.)

90. One of the purposes of the Assessment Project was to assess adult home residents' housing needs and desires. (P-583 (Bruce Dep.) 66:20–68:13; 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 (same).) Adult Home administrator Hinda Burstein testified that when the assessors from the Assessment Project came to her Adult Home, they informed the residents that "they would be interviewing them to see who would possibly qualify in the future for independent housing, and they did let them know that there would be independent housing available to them at some point." (Tr. 2107:17–2108:10.)

91. The survey established that the vast majority of Adult Home residents could be served in supported housing:

- 74.1% of residents participated in the survey, a very high response rate. (P-583 (Bruce Dep.) 73:3–16.)
- Although the vast majority of adult home residents had mental illness, only 7% of residents had severe cognitive impairments; 66.4% had no cognitive impairments at all. (P-583 (Bruce Dep.) 103:16; 104:12–14;

P-586 (Adult Home Assessment Project PowerPoint Presentation) at NYPH 1494.)[7]

- Only a small percentage of residents reported needing assistance with activities of daily living. (P-583 (Bruce Dep.) 101:19–102:16; *see also* P-586 at NYPH 1492.)
- 68.4% of those surveyed had done some meaningful work in the previous two years. (Tr. 1028:12–1029:1 (D. Jones).)
- 67% of those surveyed had one or no hospitalizations in the last three years, demonstrating a relatively stable psychiatric population. (Tr. 1029:21–1030:10 (D. Jones).)

92. The high degree of independence exhibited by many Adult Home residents is particularly striking given the tendency of individuals to appear more dependent and disabled when they are observed in institutional settings such as Adult Homes. (Tr. 122:14–17 (E. Jones); D-394 (Schimke Dep.) 54:13–55:2.)

93. In short, the Assessment Project data demonstrates that the vast majority of Adult Home residents are not seriously impaired and could be served in supported housing. (Tr. 1051:6–13 (D. Jones) (Assessment Project data demonstrates that "the amount of supports that people are going to need [in supported housing] are within what I would consider the range of what the New York system can accommodate").)

94. Indeed, the generally high cognitive and ability levels of Adult Home residents reflected in the Assessment Project data demonstrates that there is "a huge

[7] These statistics were not self-reported, rather they were the results of mental status examinations administered by the surveyors. (Tr. 893:10-894:7 (Duckworth).)

mismatch" between Adult Home residents and the custodial setting in which they reside. (Tr. 1037:18–25 (D. Jones).) Dennis Jones—who has run the mental health systems of two states and the District of Columbia—credibly testified that OMH should have regarded this data as indicating "a big problem" requiring "a very serious multi-year initiative." (Tr. 1038:1–4.)

95. The testimony of Dr. Ivor Groves confirmed that the Assessment Project data demonstrates that virtually all Adult Home residents could live in supported housing.

96. Dr. Groves has more than 35 years experience working in mental health and related areas of human services. Dr. Groves worked in a large state hospital for nine years and managed a publicly operated human services programs for 15 years, including five years in the highest mental health position in the state of Florida. Dr. Groves has served both as a project director of program evaluations and assessments and as a consumer of evaluations and assessments of adult mental health consumers and programs. He is currently a consultant developing and evaluating mental health and related human services programs for children and adults. (S-156 (Expert Report of Ivor Groves) at 1.)

97. In conducting his investigation, Dr. Groves reviewed Assessment Project data as well as the instruments and methodology for that assessment. Dr. Groves also visited two Adult Homes where he met with several Adult Home residents, visited the Pathways to Housing supported housing program, and read summaries of interviews of Adult Home residents by Elizabeth Jones. (S-156 (Groves Report) at 1-2; Tr. 3085:18–23.)

98. Based on his review of the Assessment Project, Dr. Groves found that Adult Home residents "are not a seriously impaired population in the vast majority; meaning, they don't have severe cognitive deficits and they don't have real significant problems in daily living skills." (Tr. 3072:7–17 (Groves).) Dr. Groves testified that, in his view, "the vast majority of [adult home residents] could live in supported housing with appropriate supports." (Tr. 3074:19–20; *see also* S-156 (Groves Report) at 4 (testifying that his opinion was that "most, if not all, of the residents of Adult Homes could live in the community with appropriate levels of support").) The Court finds Dr. Groves conclusions regarding Assessment Project to be credible.

F. There Is No Material Difference Between Adult Home Residents and Supported Housing Residents

99. The evidence presented at trial establishes that Adult Home residents are no more disabled than individuals already served by defendants in supported housing.

100. Several witnesses testified, and the evidence demonstrates, that there is generally little distinction between the psychiatric characteristics of Adult Home residents and supported housing residents. (Tr. 287:12–23 (Tsemberis); Tr. 854:11–21 (Duckworth); Tr. 709:8–12 (Rosenberg); D-394 (Schimke Dep.) 50:6–52:19; S-103 (Workgroup Report) at DOH 86141.)

101. People with mental illness are often placed in Adult Homes not for clinical reasons, but because the adult home is the only housing available when they are discharged from the hospital. (Tr. 646:14–18 & 709:8–12 (Rosenberg); D-394 (Schimke Dep.) 10:10–11:10; P-68 (Stone Memo).)

102. To cite just one example, resident S.K. testified at trial that when she was discharged from the psychiatric center, although she "wanted to really get an apartment of my own," the only option offered to her was an adult home. (Tr. 372:10–18.) In raising four children, S.K. did all of the cooking, cleaning, and shopping for her family, and, in addition, worked for nine years as a home health aide, in which she assisted with cooking, cleaning and medication assistance. (Tr. 362:13–365:14.) S.K. further testified that she is fully capable of managing her own money and doing her own cleaning. (Tr. 380:15–16; 382:16–17.) She testified that the only support she would need in her own apartment would be "somebody to call in on me once in while just to see how thing[s] are doing. I'd like to have somebody there that I could call." (Tr. 390:16–20.) Nevertheless, S.K. was placed in an Adult Home upon her discharge from the hospital.

103. All of the other current and former Adult Home residents who testified at trial (including defendants' witness, I.K.) also testified that they were given little or no choice about being placed in an Adult Home. (Tr. 448:10–12 (G.L.) (only choices were a long term psychiatric facility or an adult home); Tr. 551:25–552:5 (S.P.) (only choice offered was adult home); Tr. 2685:6–8 (I.K.) (adult home "was the only thing offered" to her upon discharge from the hospital).)

104. Nor are Adult Homes designed to provide individuals with mental illness with the intensive levels of care that defendants (wrongly) claim Adult Home residents require. (D-394 (Schimke Dep.) 289:4–15 (adult homes were designed to house the "frail elderly" and not people with psychiatric disabilities); *see also* P-68 (Stone Memo) (adult homes developed because "community resources weren't up to speed with state operated bed reductions" caused by deinstitutionalization); Tr. 647:24-648:9 (Rosenberg) (New

York did not create adequate community supports for deinstitutionalization and "adult homes kind of filled the gap").)

105. To the contrary, because supervision in Adult Homes is minimal, individuals in Adult Homes must be able to live with some degree of independence. (Tr. 142:9-11 (E. Jones) (adult homes provide "minimal supervision"); Tr. 709:16–21 (Rosenberg) (adult home residents have "less support in many cases" than supported housing residents; they are "left [to] their own devices[] a lot of the time"); Tr. 1731:14–18 (Wollner) (adult homes appropriate for individual "who has a mental illness who is able to live independently or with some supportive services").)

106. Indeed, Adult Homes are prohibited from admitting people who require high levels of assistance with daily living or significant medical care, or who pose a danger to themselves or others. (S-141 (18 NYCRR § 487.4) (listing categories of individuals whom Adult Homes may not admit).)

G. Supported Housing Can Serve Adult Home Residents Requiring Varying Levels of Support

107. The evidence showed that New York's supported housing programs are remarkably flexible and are more than capable of serving virtually all Adult Home residents, including those that might have relatively high needs. (Tr. 851:8–862:3 (Duckworth); *see also* Tr. 288:13-289:5 (Tsemberis) (if state issued an RFP to provide supported housing to adult home residents with mental illness, many agencies could serve those individuals); D-399 (Lasicki Dep.) 203:1–9 (executive director of an association of non-profit mental health residential program providers has "no doubt" that member organizations could serve adult home residents.).)

108. OMH's own Requests for Proposals ("RFP"s) demonstrate the flexible nature of supported housing. These RFPs describe exactly whom OMH expects supported housing providers to serve, and they make clear that supported housing should not be limited to those with minimal support needs. For example, OMH's 2007 RFP for supported housing for Adult Home residents states:

> Recipients of Supported Housing *may* be able to live in the community with a minimum of staff intervention from the sponsoring agency. *Others may need the provision of additional supports such as Assertive Community Treatment (ACT) team or Blended Case Management (BCM) services.* Many recipients will be coping with co-occurring substance abuse disorders and be at various stages of recovery.

(S-33 at OMH 42726-27 (emphasis added).) That RFP goes on to note that "[s]ervices provided by the sponsoring agency will vary, depending upon the needs of the recipient." (*Id.*) Other OMH supported housing RFPs contain identical or substantially similar language. (*See* S-67 (2008 RFP) at OMH 43109; S-17 (2005 RFP) at OMH 37307.)

109. The responses by providers to OMH's supported housing RFPs further demonstrates the flexible nature of supports available to residents of supported housing. In these responses, the supported housing providers make clear that they are willing and able to serve individuals in supported housing who require very high levels of support. (*See, e.g.*, P-286 at OMH 42961 ("a significant range of functional limitations characterize the SPMI population that directly impact their ability to engage in activities associated with normal daily living"); P-394 at 2 (noting that target population "have been traditionally non-compliant with treatment while in the community (including medication regimes, seeking appropriate follow-up services, etc.)"); P-395 at 2 (targeting

individuals "who have the highest service needs and the least likelihood of succeeding in other housing programs"), P-400 at 5-6 (service needs of clients include "how to navigate public transportation, how to shop for and prepare food, and how to access emergency services"); P-439 at 3 (target population "will need some assistance in developing or re-developing activities of daily living. Some will require assistance in developing or re-developing skills in self care"), P-440 at 2 ("service needs of these populations are varied" and may require ACT or intensive case management services); P-442 at 2 (target population may have ACT services and may need service planning regarding "medication compliance, symptom awareness and management, and appropriate community integration"); P-445 at 2 ("the functional limitations of this population are often varied in regard to type and severity and are often a complex mix of issues"); P-530 at 1 (target population may need assistance with "daily living skills," may have "historically used a disproportionate amount of the most intense level of mental health services" and may "have some enduring degree of danger to self or others."); P-532 at OMH 0043075 (target population is "institutionalized" and may require range of services, including medication management, substance abuse, budgeting, and socialization).)[8]

110. Like the RFPs themselves (*see* ¶ 108**,** *supra*), several of these supported housing providers specifically indicate in their RFP responses that supported housing

[8] That there might be supported housing providers in New York who limit their services to individuals with minimal needs does not rebut DAI's showing that even its highest needs constituents are qualified for supported housing. This is especially true in light of the significant number of supported housing providers that are committed to and capable of serving individuals with very high needs. (*See* Tr. 129:1-20 (E. Jones) (noting that while some supported housing providers provided "more limited supports," most of the providers responding to the RFPs "work with people that are among the most challenging to provide supports to and supported apartments").)

residents with especially high service needs may need Assertive Community Treatment (ACT) while living in supported housing. (*See*, *e.g.* P-395 at 7; P-439 at 3; P-440 at 2; P-442 at 2 (responses to RFPs).)

111. Linda Rosenberg also confirmed that supported housing providers know how to utilize ACT services to serve individuals with intensive support needs. (Tr. 655:13–656:21.) She testified that OMH in or around 2004 issued RFPs for supported housing and ACT that provided incentives to providers to combine the two services. (*Id.*) OMH received "lots of responses" to these RFPs. (*Id.*) According to Ms. Rosenberg, providers "know how to do [supported housing plus ACT], it is something that they have "developed expertise in," and it is something that is "consistent with their missions." (*Id.*)

112. The evidence also showed that while individuals from more institutional settings sometimes require many visits when first moving into supported housing, those visits are usually decreased as the resident becomes adjusted to more independent living. (Tr. 229:7–15 (Tsemberis) (frequency of visits to someone discharged from the hospital would "reduce over time"); Tr. 715:13–20 (Rosenberg) ("I think, people [from adult homes who moved to supported housing] would ultimately need little support, they might go to a clinic, get some treatment. They might have a case manager who checked in with them once or twice a month or telephone called them."); Tr. 2672:22–2673:4 (Lockhart) (services to new residents of Federation supported housing were able to be decreased over time); S-33 (2007 RFP) at OMH 42727 ("It is expected that the need for services provided by the sponsoring agency will decrease over time as the recipient is more fully integrated in the community.").)

113. Case management services, including intensive case management, are also currently available to supported housing residents, including any adult home residents who might move to supported housing. (Tr. 1830:4–22, 1832:10–12 (Dorfman) ("All residents in mental health housing, if appropriate, are eligible and can access all the mental health community support services"); Tr. 1414:20–1415:20 (Reilly) (supported housing residents can receive ACT or case management services); Tr. 3170:19–3171:16 (Myers) (some people in supported housing receive ACT or have an intensive case manager).)

114. The evidence shows the case management services available to residents of supported housing are also flexible and that case managers can visit supported housing residents as often as once or even twice a day as necessary. (Tr. 2172:18–2173:8 (Newman); D-399 (Lasicki Dep.) 94:5–97:21 (supported housing provides "fluid" case management services); *see also* Tr. 2672:20–21 (Lockhart) (case managers in Federation of Organizations supported housing visited at least one resident as often as twice a day).)

115. While many Adult Home residents would not need ACT or other support services to live in supported housing (Tr. 83:24-84:10 (E. Jones); Tr. 856:14–16 (Duckworth)), the availability of ACT services means that even the highest-needs Adult Home residents could successfully be served in supported housing. (*See, e.g.*, D-399 (Lasicki Dep.) 102:12-20 (explaining that ACT teams can help someone with medication compliance); P-395; P-439; P-440; P-442 (responses to RFPs).)

H. Supported Housing Providers Can and Do Serve Adult Home Residents

116. The evidence at trial also showed that New York supported housing providers do not view Adult Home residents as having needs incompatible with supported housing; indeed, several of them already successfully serve Adult Home residents.

117. Dr. Tsemberis of the Pathways to Housing supported housing program testified that Pathways has served five former Adult Home residents, all of whom "did very well" in supported housing. (Tr. 281:25- 282:22.)

118. Another supported housing provider, Transitional Services for New York, Inc., in a response to an RFP by OMH, described its experience transitioning three Adult Home residents into supported housing as very similar to transitioning other individuals:

> TSI . . . successfully transitioned three individuals into Supported Housing from local Adult homes. All three of these individuals have remained successfully housed and their transition into independent living was similar to the non-adult home referrals. These three tenants required assistance at a level typical of a referral coming from a long term resident of an apartment treatment program; adjusting their budgeting to meet their monthly financial obligations, developing resources in the community to meet their treatment needs, developing a new daily routine, accessing recreational resources in their new neighborhood and developing vocational supports to return to work.

(P-286 (TSI's RFP Response) at OMH 42975.)

119. In 2007, *seven different supported housing providers* submitted proposals in response to a legislatively mandated OMH Request for Proposals[9] to create 60

[9] The 60-bed initiative was imposed on OMH by the legislature; OMH did not request it. (Tr. 3354:10–17 (Schaefer-Hayes); Tr. 1461:3–9 (Madan); Tr. 2142:6–9 (Newman).)

supported housing beds for Adult Home referrals. Each of these providers plainly believed that it was capable of serving Adult Home residents in its supported housing programs. (Tr. 1509:18–1511:20 (Madan); P-293 (OMH responses to agency proposals submitted in response to 2007 RFP).)

120. OMH awarded contracts to three of these seven providers. (Tr. 1782:11–15 (Dorfman); Tr. 1511:17-20 (Madan).) Those supported housing beds were subsequently developed, and *all 60 of those beds are now either filled or in the process of being filled by adult home residents*. (Tr. 1794:20–24 (Dorfman) (45 beds filled and 15 residents currently in the process of moving into the remaining beds).)

121. The Court also heard testimony from two former Adult Home residents who are now successfully living in supported housing:

122. Former resident G.L. moved from an Adult Home to a Pathways to Housing supported housing in 2006. (Tr. 443:13–18.) Prior to living in the Adult Home, G.L. did his own cooking and cleaning, managed his own medications, made and kept medical and mental health appointments, and handled his own money. (Tr. 446:21–447:17; 492:11–14.) After living in an Adult Home for five years, G.L. successfully transitioned to supported housing. (Tr. 441:3–4.) He currently manages his own medication and finances and does his own cleaning, shopping, cooking, and laundry. (Tr. 463:21–464:21; 485:24–486:6; 495:8–27; 496:18–21; 498:8–9.) G.L. has been successful in supported housing without using ACT services. (Tr. 459:6–7.) G.L. is plainly qualified to be served in supported housing.

123. Former resident I.K. has also recently successfully moved from an Adult Home to supported housing. After 16 years in an Adult Home, I.K. now does her own

laundry and shopping, and cooks her own meals. (Tr. 2685:9–21; 2751:10–23.) I.K. testified that she is extremely happy living in supported housing. (Tr. 2750:24–2751:25 ("I love it . . . It's freedom. It's being able to live like a human being again.").) I.K. is plainly qualified to be served in supported housing.

I. Defendants' Own Witnesses Conceded that Significant Numbers of Residents Could Be Served In Supported Housing

124. The Court finds that defendants' own witnesses do not seriously dispute that there are many Adult Home residents who could be served in supported housing with appropriate supports. (Tr. 2409:13–17 (Geller) ("About 50 percent of the individuals who would otherwise be eligible could go to some form of supported housing either immediately, after transitional residence, with ACT, or with intensive ACT."); Tr. 1304:15 (Reilly) (there are "undisputably" Adult Home residents who could be served successfully in supported housing); Tr. 1521:3–8 (Madan) (acknowledging that Adult Home residents have been successfully housed in supported housing); Tr. 2084:12–13 (Burstein) ("[O]ften the [adult home] residents have the ability to live independently"); P-564 (Tacoranti Dep.) at 225:2–226:8 (agreeing that, based on her experience moving Adult Home residents to supported housing during Adult Home closures, there are current Adult Home residents who could be served in supported housing); P-583 (Bruce Dep.) 111:18–25 (there are individuals in adult homes who are qualified and willing to move to supported housing).)

J. OMH Does Not Require Individuals Leaving Institutional Settings to Proceed Through a "Linear Continuum"

125. The Court rejects defendants' contention at trial that Adult Home residents are not qualified for supported housing because individuals with mental illness coming

from institutional settings must move through a "linear continuum" of gradually less restrictive service settings over a period of years before they may "graduate" to fully integrated housing. (*E.g.*, Tr. 1249:23–1253:6 (Reilly) (describing the so-called "linear continuum").)

126. Although remnants of this outdated approach may still persist in the programs of some community providers, the credible evidence is that defendants' contention that individuals must move through a "continuum" of gradually less restrictive service settings is a litigation position that is inconsistent with OMH's own current practices and principles. (*See, e.g.*, P-590 (2008–2009 Executive Budget Recommendation Highlights Testimony) at 4; S-67 (2008 RFP) at OMH 43108).)

127. As early as 1990, when OMH created its Supported Housing Implementation Guidelines, it acknowledged the limitations of the continuum model:

> Although many individuals have received beneficial rehabilitation from the community residence program, which has helped them to live successfully in the community, the limitations of this approach have become apparent. People do not want to move each time they make progress in their rehabilitation; often affordable housing is not available for people to 'transition' into; and many people do not want or may not require the structure of a residential program.

(S-11 (1990 Supported Housing Implementation Guidelines) at 1; S-101 (2005 Supported Housing Implementation Guidelines) at 3.)

128. Linda Rosenberg, the former Senior Deputy Commissioner of the Office of Mental Health testified that, by the time she left OMH in 2004, the linear continuum "was really being abandoned by both New York and most places." (Tr. 755:6-8.) According to Ms. Rosenberg: "[t]he whole issue of a continuum is also an old idea. It

used to be thought that people had to move from . . . large congregate settings, to smaller congregate settings, to having a few roommates to eventually graduating to their own apartment. Nobody really thinks that much anymore. First of all, it would be like asking me to move every few months or every year or so just because I have to. So, it's quite disruptive, and also there is no evidence to show that people do better in the long run with you going through the continuum and, in fact, [people] could be placed directly in their own apartments with the right supports can be quite successful." (Tr. 653:7-18.)

129. Ms. Rosenberg also made clear that OMH did not develop different types of service settings as part of any deliberate effort to create a "linear continuum" through which individuals needing housing would transition; rather, OMH over time began creating more integrated forms of housing as its thinking evolved about the best way to promote recovery. (Tr. 755:14–756:7.)

130. In recent testimony to the legislature, *OMH's own commissioner* disavowed the "linear continuum" model touted by defendants in this litigation. In his January 29, 2008 testimony, OMH Commission Michael Hogan stated that while "many staff and advocates have come to believe" in the linear continuum model, that model is "inherently problematic" because "moving is especially stressful for people with psychiatric disabilities and can contribute to problems and re-hospitalization." According to Hogan, New York has now shifted its focus to creating "safe, decent and affordable housing that is available long term, linked to flexible services that can be increased or decreased as needed"—in other words, supported housing. (P-590 (2008–2009 Executive Budget Recommendation Highlights Testimony) at 4.)

131. OMH's supported housing RFPs further demonstrate that defendants do not really believe that individuals leaving institutional settings must transition through gradually less restrictive service settings before "graduating" to supported housing. In recent years, OMH has issued several RFPs for supported housing that specifically target individuals leaving institutions such as psychiatric centers, Article 28 hospitals, prisons, and adult homes. (*See, e.g.*, S-33, S-67, S-17; *see also* Tr. 1530:22–1531:1 (Madan) (in some of its RFPs OMH has required supported housing providers to accept referrals from psychiatric centers and prisons).)

132. DAI's experts, all of whom have worked in the mental health field for decades, testified that the "linear continuum" approach is no longer widely accepted. Dr. Duckworth testified that "the idea that people need to go through transitional housing, another move, another step, I think has been debunked pretty definitively in our field." (Tr. 846:25–27.) Elizabeth Jones testified that the continuum approach is "outdated" and the accepted approach in the states where she has worked is to provide individuals with permanent housing and add or subtract supports based on their specific needs. (Tr. 136:25–138:10.) Dennis Jones testified that the continuum model is "archaic" and that New York's views on it have "changed pretty significantly" in the last five to ten years. (Tr. 1140:1–6.)

133. Even Frances Lockhart, the former Federation of Organizations employee called by defendants to testify that Federation still followed the "continuum" approach in operating its programs, acknowledged that Federation sometimes accepts individuals into their supported housing programs directly from psychiatric centers without requiring those individuals to go through a continuum. (Tr. 2670:25–2671:10.)

134. Finally, to the extent the linear continuum of care model has ever been OMH policy, Adult Homes are simply not a part of that continuum. (D-394 (Schimke Dep.) 48:20–49:18; Tr. 872:3–7 (Duckworth) (adult homes are "not part of a continuum of care").) The evidence shows that Adult Homes are not transitional residences designed to prepare residents for more independent living; rather, they are permanent "destinations" in which residents are expected to "age in place" until they die. (Tr. 75:25–76:6 (E. Jones) (Adult Homes "permanent placements" not designed for transition; people stay "20 or 30 years with no hope of moving to a community setting"); Tr. 872:8 (Duckworth) (Adult Homes are "destinations"); Tr. 2910:14–2911:9 (Kaufman) (agreeing that OMH views Adult Homes as "permanent" placements and "does not view adult homes as rehabilitati[ve] settings designed to transition consumers from supervised to independent settings"); Tr. 2951:18–19 (Zucker) (Adult Homes are "permanent placements where people are expected to age in place, which means stay there until they die").) Certainly no evidence was elicited at trial showing that any Adult Home residents actually move through any continuum.

K. Dr. Geller's Analysis of Whether Adult Home Residents Are Qualified to Move Is Deeply Flawed and Not Credible

135. The Court declines to credit Dr. Geller's conclusion that only about half of adult home residents could ever be served in supported housing. The Court finds that Dr. Geller's conclusions ignore important evidence, and are based on a fundamental misapprehension about the characteristics of current Adult Home residents.

136. Dr. Geller drew his conclusions without adequately investigating the ability and willingness of New York's supported housing providers to serve Adult Home

residents. In forming his opinion about the capabilities of New York's supported housing providers, Dr. Geller reviewed only two responses to OMH's supported housing RFPs, both of which categorically excluded Adult Home residents from applying for beds developed under those RFPs. (Tr. 2412:5–17, 2414:17–25.) Dr. Geller conceded that he was unaware of, and did not review a single response to, OMH's 2007 RFP to create 60 supported housing beds specifically for Adult Home referrals. (Tr. 2415:18–2416:10.) Nor did Dr. Geller visit Pathways to Housing. (Tr. 2379:13–15.)

137. In concluding from two inapplicable RFP responses that New York's supported housing providers could not provide the level of services that Adult Home residents purportedly would require, Dr. Geller also did not consider that supported housing residents can obtain services such as ACT or intensive case management to assist them with support needs that are beyond the capabilities of the supported housing provider. (Tr. 2412:5-2414:1.)

138. Dr. Geller's conclusion that many Adult Home residents were not appropriate for supported housing is flawed for the additional reason that it was based on his mistaken belief that some Adult Home residents posed an immediate danger to themselves or others. (Tr. 2368:1–3 (asserting individuals who pose a danger to themselves or others can be placed in adult homes); *see also* Tr. 2328:25–2330:7 (contending that DAI's expert failed to take into account whether adult home residents placed in supported housing might "jump off a roof" or "set fires").) In fact, as Dr. Geller acknowledged on cross-examination, Adult Homes are not permitted to admit such individuals. (Tr. 2368:25-2369:4.)

139. Dr. Geller's analysis of the service needs of certain Adult Home residents is also flawed, and likely overestimates the amount of services they would require in supported housing. Dr. Geller estimated the number of hours of services various Adult Home residents would require if they moved to supported housing without considering the extent to which the residents *currently* receive these services in the Adult Home. (Tr. 2403:25–2404:22.) Particularly in light of the evidence that Adult Homes provide very minimal assistance with activities of daily living, (*see supra* ¶¶ 104-06), Dr. Geller's conclusion likely substantially overstates the amount of services Adult Home residents would require in supported housing. (*See* Tr. 89:16–20 (E. Jones) (Geller analysis flawed because adult home residents were not receiving in the adult home the services Geller claimed they would need in supported housing).)

140. Indeed, DAI's experts provided several examples of residents whom Dr. Geller had deemed unfit for supported housing but who in fact appeared to have fairly limited support needs. (*See* Tr. 122:21–123:15 (E. Jones) (describing a resident Geller classified as needing 24/7 support despite evidence that the individual lived fairly independently at the adult home); Tr. 842:23–850:23 (Duckworth) (discussing three examples in which Geller mistakenly determined that an Adult Home resident could not live in supported housing).)

141. In short, the evidence adduced at trial, including the testimony of DAI's experts, testimony of OMH's own current and former employees, and admissions contained in defendants' own documents overwhelmingly demonstrates that New York's supported housing program can and does serve individuals with a wide range of support needs and that the support needs of Adult Home residents could, in virtually every case,

easily be addressed in supported housing. The Court therefore finds that virtually all of DAI's constituents are qualified for supported housing.

IV. The Vast Majority of Adult Home Residents Would Choose to Live in Supported Housing if Given an Informed Choice

142. This Court finds that the vast majority of Adult Home residents would, if given an opportunity to make a truly informed choice, choose to live in an independent setting such as supported housing rather than in an Adult Home.

A. Most Adult Home Residents Had Little Or No Choice In Moving To An Adult Home

143. By and large, people with mental illness entered Adult Homes neither by choice nor because a mental health professional determined that the Adult Home was the most appropriate setting to serve their needs. DAI's constituents entered Adult Homes because they had nowhere else to go. According to Linda Rosenberg, OMH's former Senior Deputy Commissioner, when thousands of patients were discharged from the state's psychiatric centers, "housing was scarce" and "beds were available" in the Adult Homes. (Tr. 646:10:18; *see also* P-68 (Stone Memo) (explaining that "adult homes developed in response to a need – lack of community based housing resources"); *id.* ("Deinstitutionalization happened and the community resources weren't up to speed with state operated bed reductions."); D-394 (Shimke Dep.) 10:15-11:10 ("Residents in adult homes, particularly residents with psychiatric disabilities, often were placed there simply because it was . . . four o'clock on a Friday afternoon and they had no other options, not because it was necessarily the place of choice.").)

144. DAI's expert Elizabeth Jones reported that she "met very few residents who were offered options other than an adult home." (S-151 (E. Jones Report) at 3.)

Many residents had previously been "confined to a state or community psychiatric hospital and were eager to leave that setting," or had been "homeless and were desperate for an alternative to a shelter." (*Id.*)

145. Numerous Adult Home residents testified that they had little or no choice regarding whether to move in to an adult home.

146. Former Adult Home resident, I.K., explained that when she was discharged from the hospital, an Adult Home was "the only thing offered" to her as a housing option. (Tr. 2685:6-8 (I.K.).) The only alternative she was offered to the Adult Home was "another adult home." (Tr. 2685:22-2686:1 (I.K.).)

147. Similarly, G.L. testified that he was given "two choices" when he was discharged from the hospital: a "long term psychiatric facility" or an Adult Home. (Tr. 448:8-12 (G.L.).) Because he had "already been in a psychiatric facility" and "had no desire to go back into one," he "decided to take [his] chances with the adult home," although he had "absolutely no idea" what it would be like. (Tr. 449:14-18 (G.L.).) *See also* P-537 (P.C. Dep.) 46:12-47:9 (upon discharge from hospital, social worker told her that she should could either move to an adult home or go to a shelter), 187:21-188:14 (she knows that many residents at her adult home "want to move into different housing," but believes "[t]here are not that many programs for disabled people with mental disabilities in the city"); P-536 (D.N. Dep.) 192:15-201:6 (upon discharge from hospital, was told if she did not take adult home placement, she would not be allowed in that hospital again); P-541 (S.B. Dep.) 137:15-138:18 (resident was discharged from the hospital to a nursing home because he had "nowhere else to go," and social worker at the nursing home arranged for him to move to an adult home when his "insurance ran out");

P-540 (P.B. Dep.) 30:16-31:10 (when she was discharged from hospital, she was sent to Ocean House adult home because her social worker "picked it for [her]," and she was not accepted anywhere else).

B. The Majority of Adult Home Residents Would Choose to Live in Supported Housing if Given a Meaningful Choice

148. The Adult Home Assessment Project found that, of the approximately 2,000 residents with mental illness reviewed, more than 56% expressed an interest in leaving the Adult Home, with 35.5% desiring to move to their own apartment and another 21.2% wanting to move in with family. (P-583 (Bruce Dep.) 94:23-95:6.) A total of approximately 75% of the residents assessed either expressed an explicit interest in living elsewhere or did not express a preference for living in the Adult Home where they were residing. (Tr. 1050:13-1051:13 (D. Jones) (noting that an analysis of the Columbia Presbyterian Assessment data showed that 75% of adult home residents assessed were not opposed to moving).)

149. These statistics, impressive in their own right, likely far underestimate the numbers of Adult Home residents who would express a preference for moving if given a truly meaningful choice.

150. The surveyors conducting the assessments did not educate Adult Home residents about supported housing or other housing options prior to asking them whether they would like to move out of the Adult Home, nor did they inquire as to whether the residents had any understanding of these options. (P-583 (Bruce Dep.) 97:19-98:13.)

151. It is clear from the record that, in fact, most Adult Home residents are entirely uninformed about other housing options and about the wide range of assistance

that would be available to them in supported housing and other settings. (*See*, *e.g.*, Tr. 663:5-12 (Rosenberg) (testifying that "for many people in adult homes," the Adult Home Assessment Project "may have been the first time they heard the words 'Supported Housing,' and I'm sure most of the people had no idea in the world [what] Supported Housing was . . . ."); Tr. 2663:15-2664:16 (Lockhart) testifying that residents who have not participated in a case management program would not likely be familiar with alternative housing opportunities); S-151 (E. Jones Report) at 11 (residents "have not been informed about the array of housing options provided by the state of New York, the benefits available to them, or the complement of providers experienced in supporting adults with mental illness"). This testimony supports the Court's previous finding that "OMH does not provide information about alternative housing options to adult home residents 'on a routine basis'." *Disability Advocates*, 598 F. Supp. 2d at 345.

152. As Dr. Kenneth Duckworth explained, because the residents who were assessed were not presented with a "legitimate alternative that was concrete and believable," the 56% of residents who reported a preference to move out of the Adult Home is merely "a floor" with regard to who would truly be willing to move if given the proper "coaching" and "encouragement." (Tr. 810:5-13, 872:10-873:8, 874:18-20, 876:24-877:5.) Indeed, Dr. Duckworth estimates that "probably four out of five" residents would be willing to move to more independent settings if provided with a meaningful option. (Tr. 874:21-875:1.) According to Dr. Duckworth, "the only way we can know the actual choice individuals would make is if we support them in a true choice, including by making options available." (S-81 (Duckworth Reply Report) at 6.)

153. Elizabeth Jones likewise opined that, of the 179 residents with whom she spoke during her visits to Adult Homes, "[t]he great majority – 91% . . . wants to live somewhere else," and would choose to do so if given the opportunity to make an informed choice. (S-151 (E. Jones Report) at 9; *see also* Tr. 44:17-25 (testifying that "virtually all of the Adult Home residents [she] spoke with would choose independent living or supported housing if they were given a choice of that").)

154. DAI's third expert witness, Dennis Jones, reached the same conclusion. In Mr. Jones' experience, "[i]ndividuals with mental illness routinely choose to live in integrated community settings when they understand their options and are assured that appropriate, reliable supports will be available during the transition and beyond." (S-150 (D. Jones Report) at 11.) Accordingly, Mr. Jones concluded that, if provided with information about the nature of supported housing along with the programmatic and financial supports available, "the great majority of adult home residents will very likely choose to move to integrated settings." (*Id.*; *see also* Tr. 1020:22-1022:6 (percentage of residents expressing a preference to live in supported housing as opposed to an Adult Home would be "much higher" than the Assessment Project data reflects if they were adequately informed).)

155. Defendants unequivocally acknowledge the importance to mental health consumers of "informed choice" with respect to the settings in which they receive services. According to OMH's website, "[r]esearch suggests that when people have adequate information regarding their options and are supported in their decision making, they are likely to make healthier and more positive choices. The person who advocates for his/her own choices in regards to services and/or course of treatment is likely to

recover more quickly." (S-97 (OMH website (describing ACT) at 3 (internal citations omitted).) "Studies conducted by [OMH]" have revealed that "[p]eople who reported the most satisfaction with their housing choices also reported significantly higher overall quality of life." (P-527 (OMH, Progress Report on New York State's Public Mental Health System, January 2001) at 20; *see also* Tr. 712:18-713:17 (Rosenberg) (testifying that if Adult Home residents were educated about what supported housing is, a "majority" would choose to live in their own apartments rather than an Adult Home).

C. Adult Home Residents Have Continually Expressed a Preference for Supported Housing

156. The conclusions of DAI's experts are powerfully underscored by the responses of Adult Home residents to the housing forums OMH has conducted in eleven Adult Homes in 2008 and 2009.

157. Hinda Burstein, the administrator of the Park Inn Adult Home, testified that after housing forums were held at Park Inn, residents were "very excited" to learn "that there's something out there for them." (Tr. 2083:19-22.) She explained that the path to independent housing for Adult Home residents has historically been unclear, fraught with "very long waiting lists" and bureaucratic hurdles. (Tr. 2083:23-25.) "[H]aving an informational setting where the residents can get all the information they would need to move on was just very, very informative, and it was very encouraging, and it gave residents a lot of hope." (Tr. 2084:1-4; *see also* Tr. 2084:12-22 ("O]ften the residents have the ability to live independently . . . and here were real-life people saying . . . 'you can come live independently,' and . . . that made them very encouraged.").)

158. Documents in the record reflect similarly enthusiastic responses to the other forums. An e-mail from an OMH employee describing a forum at Anna Erika states that when the administrator of the home asked the residents to indicate, by a show of hands, who wanted to move out of the facility, "all of the residents raised their hands," and "[s]ome of the residents comment[ed] . . . that they feel 'trapped' living in the adult home and have no money to move out on their own." (P-357 (Dorfman e-mail re: Anna Erika housing forum, June 19, 2008).) DAI expert Dennis Jones noted that the residents' responses, in light of the "intimidating" circumstances, were an indication that the residents are "pretty highly motivated" to leave the Adult Home. (Tr. 1074:17-1075:8.) *See also* P-354 (Dorfman e-mail re: Brooklyn Adult Care Center housing forum, June 3, 2008) ("Overall, the residents that were in the forum expressed much interest in obtaining supported housing."); P-355 (Dorfman e-mail re: Sanford Home housing forum, June 6, 2008) (noting that five residents in attendance "expressed a lot of interest in living independently" and asked the housing providers "a lot of on point questions"); P-356 (Dorfman e-mail re: Riverdale Manor housing forum, June 12, 2008) (describing the forum as a "success judging by the number of residents that expressed interest in housing and the numerous questions asked at the end of the forum"); P-358 (Dorfman e-mail re: Rockaway Manor housing forum, June 26, 2008) (residents "asked a lot of good questions at the end of this forum and agreed to participate in the groups that will help them move to independent living").)

159. That adult home residents are eager to move to more integrated housing is not new information. Lisa Wickens, a Deputy Director at DOH, testified that when she conducted town hall meetings with Adult Home residents about the Assessment Project

in 2002, residents asked, "When I do the assessment, when can I leave?" (P-566 (Wickens Dep.) 74:19-22.)

160. Numerous Adult Home residents offered testimony about the importance to them of living independently. (*See* P-540 (P.B. Dep.) 168:17-170:2 (she would prefer an apartment where it would be "much cleaner and you [could] be on your own and you could do what you want to do, and you don't have to be in at a certain time," and where she "wouldn't have to depend" on others to prepare her meals); P-541 (S.B. Dep.) 89:24-90:10 (he would like to have his own apartment with his girlfriend); P-542 (L.G. Dep.) 102:15-103:8 (she does not like living in the Adult Home and has wanted to move to her own apartment for a long time.); P-546 (A.M. Dep.) 203:19-204:8 (wanted to move out of the Adult Home so that he could 'grow" and become "more independent").

161. I.K., a former Adult Home resident who recently moved to supported housing, provided particularly compelling testimony regarding how moving out of the Adult Home changed her life: "Q. How do you like living in your new apartment? A. I love it. . . . Q. Do you cook your own meals now? A. Yes. . . . Q. What's different about cooking your own meals versus having them cooked for you? A. I can limit what I eat or I can expand my choices. I can have as much salad as I like. I can have as little grease as I like. I can eat foods that were not permitted in the home. . . . I do my own shopping. I do my own food selection. It's free. It's freedom for me. It's freedom. It's being able to actually live like a human being again." (Tr. 2750:24-2751:25.)

162. Other residents testified that, after expressing to case managers or other mental health providers an interest in moving to more independent housing, they received little or no assistance, and were often actively discouraged. S.K. testified that, when she

has asked her case manager about other options, the case manager "kind of just puts me off," telling her that "there's nothing available right now." (Tr. 390:21-25.) A.M. testified that when he requested assistance from his social worker with filling out the HRA 2000 form—a form that is admittedly complex and that requires input and signatures from various mental health professionals— he was repeatedly put off. P-546 (A.M. Dep.) 140:7-142:22; s*ee also* P-536 (D.N. Dep.) 150:17-153:2; 154:10-22; 155:7-156:22 (testifying that when she asked her social worker to help her obtain an HRA application, the social worker responded "we don't do that here," and told her that she should apply on her own).)

163. As OMH has acknowledged, one of the harms of long term institutionalization is that it instills learned helplessness, making it difficult for some who have been institutionalized to move to more independent settings. (D-182 (2009 Budget Testimony) at OMH 0043461-63.) Several of DAI's witnesses explained that people with mental illness who have spent much of their lives in an institutional setting tend to be highly reluctant to move on, even if they are eminently capable of living independently. (*See, e.g.*, Tr. 810:8-13, 874:9-20) (Duckworth) (explaining that people with mental illness who have suffered a "history of broken promises" at the hands of the mental health system "tend to be conservative" with respect to change); Tr. 91:5-9 (E. Jones) (testifying that reluctance "isn't uncommon when people come out of institutional settings where they've been dependent for so many years."); S-151 (E. Jones Report) at 11 ("Many people with mental illness who have been institutionalized are reluctant to make changes in their lives."); Tr. 258:18-25 (Tsemberis) (describing a "certain passivity and helplessness and demoralization that sets in" among people with mental illness who

are institutionalized).) As a result, some residents may be reluctant or ambivalent about leaving their Adult Home.

164. Such fear and reluctance is hardly unique to Adult Home residents. The State has long encountered this issue in its psychiatric facilities and has developed effective methods for combating it. Lewis Campbell, who testified regarding the administration of the State's psychiatric centers, conceded that individuals who have spent long periods of time in a psychiatric facility often become "institutionalized" – that is, they become fearful of, and resistant to, leaving the hospital, even if they are quite capable of living in an integrated community setting. (Tr. 1582:11-1583:10).) Mr. Campbell explained that it is becoming increasingly common for hospitals to incorporate into their discharge policies efforts to assist patients who are "resistive to discussion and/or involvement with the discharge plan." (Tr. 1583:16-1584:25).) The discharge policy for Manhattan Psychiatric Center, for example, includes a program called "Bridger Services," which designates a staff person to "accompany patients on formal interviews and trial visits," "network with community providers so as to provide a smooth transition for their patients," and "provide follow up during the [post-discharge transition] period to ensure a continuum of care." (D-11 at OMH 703.) The "Bridgers" "maintain services as necessary until a Community Intensive Case Manager and/or Supportive Case Manager has connected with their patient." (*Id.*) Bridger Services have been implemented in the hospital Mr. Campbell administers and are "very effective" in assisting patients with the transition to the community. (Campbell Tr. 1584:4-1585:11.)

165. Having a stable, safe and permanent place to call home is a universal desire. People with mental illness are no different than anyone else in this regard. (*See*

Tr. 294:15-19 (Tsemberis) (testifying that a 'home', and not merely 'housing', provides a "sense of ontological security," and is an essential "foundation" without which a person will not "be able to consider their treatment needs, or their higher order needs"); Tr. 851:15-23 (Duckworth) ("Most people have the dream of having their own place whether they've been saddled with schizophrenia or not. It's an American phenomen[on] to want to have your own place . . . ."); Tr. 1010:20-1011:8 (D. Jones) (when people have a safe and permanent home, they can "meaningfully go to work on the other aspects of their lives, including . . . treatment engagement").)

166. Indeed, OMH's own "guiding principles" state that "[h]ousing is a basic need and necessary for recovery. Most people want permanent integrated housing that is not bundled with support services (housing as housing)." (P-59 (OMH Guiding Principles) at 2); *see also* P-527 (OMH, Progress Report on New York State's Public Mental Health System) at 19 ("For most of us, achieving a sense of community belonging hinges on having a decent place to call home."); Tr. 2159:1-4 (Newman) (agreeing with the proposition that, "by and large, supported housing is what mental health consumers are telling the Office of Mental Health they want today").)

167. This Court concludes that the vast majority of Adult Home residents would, over time, choose to leave the Adult Home if given sufficient information and assistance. This Court further finds that, to the extent some long-term Adult Home residents express reluctance or ambivalence regarding their preferences to stay in an Adult Home or move to another setting, it is incumbent upon defendants to provide the education and support necessary to enable residents to make truly informed decisions.

V. Defendants Have No Olmstead Plan for Adult Home Residents

168. The State does not have a comprehensive or effective *Olmstead* plan to enable Adult Home residents to receive services in more integrated settings. (P-553 (Kuhmerker Dep.) 29:8-30:3.) There is no written *Olmstead* plan for Adult Home residents. (P-553 (Kuhmerker Dep.) 29:21-23 (explaining that with regard to the "comprehensive statewide plan" mandated in the MISCC statute, "there is no one specific document that one could point to").) At trial, not one witness testified to the existence of a plan—either written or unwritten—to enable DAI's constituents to move to more integrated settings.

A. Defendants Do Not Believe an *Olmstead* Plan is Required for People with Mental Illness in Adult Homes

169. Defendants have repeatedly stated that there is no need for an *Olmstead* plan for Adult Home residents because, they argue, Adult Homes are community-based facilities. (S-133 (Defs' Obj. & Resp. to P.'s First Set of Requests for Admissions) at 9; S-87 (Defs.' Amended Obj. & Resp. to Pl.'s First Set of Requests for Admissions) at 2).)

170. Indeed, the evidence presented at trial established that the State considers Adult Homes to be permanent placements rather than settings designed to transition residents to more integrated settings. (Tr. 1580:24-1581:2 (Campbell); *see also* S-54 (Kaufman Report) at 5-6; Tr. 690:23-691:3 (Rosenberg) (testifying that "certainly no one seems to leave unless they get rehospitalized or get ill and go to the hospital for a physical reason).) As defendants' expert Mr. Kaufman explained, OMH does not view Adult Homes "as designed to transition consumers from supervised to independent living." (S-54 (Kaufman Report) at 5.)

171. Consistent with defendants' view that Adult Home residents are not entitled to an *Olmstead* plan, the Most Integrated Setting Coordinating Council ("MISCC") established by the State legislature in 2002 has no plan to move Adult Home residents to more integrated settings. (S-133 at 12.) The statutorily mandated purpose of the MISCC is, among other things, to "develop and implement a plan to reasonably accommodate the desire of people of all ages with disabilities to avoid institutionalization and be appropriately placed in the most integrated settings possible." (S-133 at 12, citing N.Y. Exec. Law § 700.) The Legislature mandated that the MISCC "develop and oversee the implementation of a comprehensive statewide plan for providing services to individuals of all ages with disabilities in the most integrated setting." (S-133 at 12, citing N.Y. Exec. Law § 703.) The MISCC statute requires the MISCC to put together a plan for how the State will ensure that people are able to reside in the most integrated settings. (P-553 (Kuhmerker Dep.) 27:4-9.)

172. To date, however, MISCC has not developed, and is not developing, a plan to move residents of Adult Homes. (S-133 at 12.) In fact, the MISCC has not done anything specific with regard to assisting adult home residents to move to more integrated settings. (P-553 (Kuhmerker Dep.) 31:4-7; *id.* 53:20-54:2.) 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." (P-553 (Kuhmerker Dep.) 33:12-24; *see also id.* 31:4-15 (providing testimony pursuant to Rule 30(b)(6) that "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," other than that there were "occasional discussions"

regarding adult home residents).)) And nothing in the MISCC's 2006 annual plan shows any effort to address integration of adult home residents. (Tr. 1083:11-1087:13 (D. Jones); *see also* P-589 (MISCC 2008 Annual Report).) Indeed, the State denies that MISCC has any obligation to do so. (S-133 at 12.)

173. Defendants argue that they have demonstrated a long-standing commitment to providing community-based services to people with mental illness. (Tr. 30:4-10.) However, much of the evidence presented at trial concerning New York's commitment to providing community-based services to people with mental illness had little to do with Adult Home residents. For example, defendants presented evidence that over the last several decades, the State has reduced the census in state psychiatric hospitals and described the policies and procedures for discharging patients from psychiatric hospitals to other settings. (Tr. 1557:7-8; 1567:1-1577:25, Tr. 1559:3-1560:6 (Campbell).) This evidence is not relevant, however, to the issue of whether defendants have a comprehensive or effective plan to enable Adult Home residents to move to alternative settings. Indeed, the reduction in the census of state psychiatric hospitals over the past several decades was made possible in significant part because the State used Adult Homes as settings in which to discharge patients from the State's institutions. (Tr. 647:14-648:14 (Rosenberg); P-68 (Stone Memo); Tr. 1577:13-25 (Campbell); Tr. 1004:11-22 (D. Jones).)

174. Similarly, defendants presented evidence concerning activities of OMH's Division of Children and Family Services and forensic unit. (Tr. 3148:7-3153:23 (Myers).) Evidence of defendants' general commitment to deinstitutionalization and development of community programs and services for people with mental illness other

than Adult Home residents, however, is irrelevant to the issue of whether an *Olmstead* plan for Adult Home residents exists.

175. Defendants also cited the development of OMH community housing as part of their *Olmstead* plan. They presented evidence that between 1995 and 2009, OMH increased the number of beds in operation in its community housing program from 18,940 to 32,633 and that defendants currently fund 13,557 supported housing beds. (Tr. 1936:12-1941:22 (Newman); D-350 (OMH Community-based Bed Chart, Mar. 31, 2009).) But because of the way defendants administer the supported housing program, Adult Home residents have gained access to very few supported housing beds.

176. The State develops new supported housing beds through a request for proposal ("RFP") process. (Tr. 1927:16-1929:8 (Newman) (explaining that RFPs "are the State of New York's way to allocate resources").) When OMH develops supported housing, it identifies a target population for the housing as a "priority" that will receive a preference for new housing being developed. (*See, e.g.,* S-17 (2005 RFP).) The system is administered to effectuate the target or priority populations, and it is very unlikely that somebody who is not a member of a priority population will receive a supported housing bed. (Tr. 2189:3-23 (Newman); Tr. 1532:10-1533:3 (Madan) ("We expect that the providers who are awarded beds under this particular—under any one particular RFP adhere to the priority populations listed in that RFP. . . . [A]ny opening would be filled by someone who belongs to one of the priority categories"); Tr. 1312:25-1316:6 (Reilly) ("So there are priority populations that when a referral is being made to a residential provider that the residential provider is expected to have – to accept a referral from these priority populations…").)

177. Adult Home residents have not, historically, been a target group for supported housing. (*See* S-11 (1990 Supported Housing Implementation Guidelines); S-101 (2005 Supported Housing Implementation Guidelines); Tr. 2176:1-11 (Newman).) The Supported Housing Implementation Guidelines developed in April 1990 set forth a number of target populations to be served in Supported Housing, including "individuals ready to leave certified community residences; individuals discharged from psychiatric centers; and individuals who are currently homeless, living in shelters, depots or on the streets." (S-11 at 3.) The target populations did not include Adult Home residents. (*Id.*)

178. Adult Home residents were not identified as a target population until 2005. (Tr. 1534:16-22 (Madan); S-17 (2005 RFP).) Thus, prior to 2005, Adult Home residents were effectively excluded from Supported Housing beds developed by OMH. (Tr. 1532:10-1534:22 (Madan).) The designation in the 2005 RFP was only effective for *new* supported housing OMH was in the process of developing; it did not grant Adult Home residents access to older supported housing already developed by OMH. If and when beds developed under a particular RFP are vacated, they must be filled with members of the priority populations enumerated in the RFP which created the beds. (Tr. 2193:15-2195:9 (Newman); Tr. 1532:24-1534:22 (Madan).)

179. Even after Adult Home residents were designated as a priority population for newly developed supported housing, they continued, for the most part, to be denied access to supported housing because members of other priority populations received higher priority. (Tr. 660:12-23, 662:6-18 (Rosenberg); Tr. 1089:15-1091:4 (D. Jones); Tr. 2165:11-2166:17, 2198:9-2199:2 (Newman).) Indeed, Linda Rosenberg testified that

neither OMH's Single Point of Access ("SPOA") [10] program nor the designation of Adult Home residents as a priority population in RFPs had any impact on Adult Home residents' access to supported housing beds. (Tr. 662:11-13 (Rosenberg) ("[They] didn't have access before and they continued not to have access for the most part"); Tr. 3500:14-3501:6 (D. Jones) ("The state has demonstrated that it has the will and the ability to create additional supported housing slots . . . . The sad reality is that in doing that, it left behind a whole group of people over in adult homes who have not had access to that").)

180. In 2007, the New York legislature set aside 60 supported housing beds exclusively for people with mental illness residing in Adult Homes. (Tr. 1460:25-1461:9 (Madan).) OMH did not propose or advance this initiative, and defendants made clear that there is no plan to undertake a similar initiative in the future. (*Id.*; *see also* Tr. 1510:8-10 (Madan).) In fact, Adult Home residents appear no longer to be a priority population for supported housing beds. (P-748 (2009 RFP).)

181. Although defendants assert that some Adult Home residents have moved to alternative settings (Tr. 3182:16-3183:17 (Myers)), the evidence demonstrates that from 2002 to 2006, only *nineteen* Adult Home residents moved to supported housing in New York City (P-149 (OMH Response to FOIA Request Re: Movement of Adult Home Residents to OMH Adult Residential Programs since 2002); Tr. 1080:20-1081:25 (D.

[10] "SPOA" refers to a program in which all applications for OMH Housing for Persons with Mental Illness are sent to a centralized source rather than to individual supported housing providers. (Tr. 1468:3-1469:10 (Madan); *see also Disability Advocates, Inc.*, 598 F. Supp. 2d at 305.)

Jones)). According to OMH itself, the majority of Adult Home residents who moved to OMH housing from 2001-2006 were in counties outside of New York City. (P-149.)

182. It is difficult to measure the number of Adult Home residents who have attempted to receive supported housing and failed because defendants do not maintain waiting lists for residents of Adult Homes who have expressed a desire to move to more integrated housing. (S-133 (Defs.' Obj. & Responses to Pl.'s First Set of Requests for Admissions) at 10-11; S-130 (Defs.' Resp. to Pl's. Statement Pursuant to R. 56.1) ¶ 42; P-555 (Liebman Dep.) 19:2-5.) Although the Center for Community Services ("CUCS"), the SPOA provider for housing programs in New York City, maintains a list of housing program vacancies, defendants do not maintain any waiting list for any of the OMH Housing Programs, let alone one for Adult Home residents. (S-130 ¶ 67; Tr. 1464:1-1465:22 (Madan).) Kathleen Kelly, a representative of the New York City Human Resources Administration, the agency that processes applications for OMH community housing in New York City, testified that while 807 Adult Home residents applied for OMH housing between the years 2000 and 2006, HRA does not know the outcome of the applications because it does not keep track of placements, acceptances into, or rejections from OMH community housing. (Tr. 1911:14-20; 1913:2-1914:9.)

183. In 2005, the Legislature passed a law that would have required OMH to establish a community housing waiting list for adults "who have been referred to or applied for but have not yet received supported, supportive, supervised or congregate housing services." (S-23 (Veto of Assembly Bill No. 2895-A) at 1.) Unfortunately, Governor Pataki vetoed that bill "based on objections raised by OMH." (*Id.*)

B. The Programs Available to Adult Home Residents Do Not Constitute An *Olmstead* Plan

184. Notwithstanding their assertion that an *Olmstead* plan for Adult Home residents is not required, the State has also argued that certain of defendants' activities are "targeted specifically at adult home residents" to enable them to be integrated in the community and to move from Adult Homes. (Tr. 30:19-25.)

185. For example, the State presented evidence concerning programs that residents attend outside the Adult Homes, such as continuing day treatment programs and mental health clinics. Defendants argued that such programs are intended to teach Adult Home residents the skills to be able to live in more independent settings. But the evidence showed that these programs are ineffective and wasteful. (Tr. 1380:9-1382:24 (Reilly) (agreeing that there were substantial problems with continuing day treatment programs in New York State).) Many programs provided to Adult Home residents are grossly infantilizing. (P-568 (M.B. Dep.) 54:15-55:23; P-569 (G.H. Dep.) 73:8-20; P-537 (P.C. Dep.) 43:14-43:6; Tr. 2561:24-2562:9 (Waizer) (explaining that computer skills groups consist of software "we would use with my granddaughter, for a three- or four-year-old").) The continuing day treatment programs that enroll Adult Home residents are characterized by deficient treatment planning; group TV and movie watching; and coloring books. (*See generally* P-93 (New York State CQC, Continuing Day Treatment Review); D-65 (DOH Letter to Jewish Board re Continuing Day Treatment Programs); Tr. 1432:7-1435:6 (Madan) (explaining citations by OMH of a continuing day treatment program provider for deficiencies in medication management training, client assessments and treatment plans).) Although many residents were interested in finding work or learning skills for work, less than 20% of these programs' treatment plans reviewed in a

study had treatment objectives for finding work, and only 14% had objectives for obtaining vocational training. (P-93 at 13.) Indeed, the Chief Fiscal Officer of OMH explained that the State has shifted resources away from supporting continuing day treatment programs because they are outdated. (Tr. 3317:1-3318:7 (Schaefer-Hayes).)

186. Defendants also pointed to certain initiatives undertaken by the State related to Adult Homes, including the Case Management Initiative and the EnAble Program. In 2002, OMH created the Case Management Initiative, which was designed to provide independent service coordinators, who are not employed by the Adult Home, to be responsible for working with Adult Home residents to identify goals, coordinate services and put together a service plan. (Tr. 1307:-1308:13 (Reilly). The program also included a mental health peer to work with the case manager. (Tr. 1308:14-1309:14 (Reilly).) The State initially implemented the program for 690 residents in three homes, Brooklyn Adult Care Center, Riverdale Manor and Queens Adult Care Center. (Tr. 1321:2-14; Tr. 1325:11-19 (Reilly).) The program was eventually implemented in eight additional Adult Homes, and as of 2007, provided services for 2100 Adult Home residents. (Tr. 1338:22-1339:1 (Reilly).) OMH has no plan to expand the program into additional Adult Homes. (Tr. 1834:24-1835:5 (Dorfman).) Thus, the Case Management Initiative can only assist less than half of the Adult Home residents at issue in this case.

187. The initial RFP for the Case Management Initiative does not mention, as part of the services to be provided, assistance with locating alternative housing for Adult Home residents interested in moving. (Tr. 1384:19-1385:25 (Reilly).) Additionally, defendants have not determined whether the Case Management Initiative has actually been effective at assisting Adult Home residents to move to more integrated settings. (Tr.

1835:15-18 (Dorfman); Tr. 1704-23-1705:2 (Wollner) testifying that he does not know of any analysis); Tr. 2918:19-2919:6 (Kaufman).)

188. But the Case Management Initiative will not enable them to achieve independent living as long as there are few, if any, supported housing beds available to them. (Tr. 1172:1-1173:2 (D. Jones) ("[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.").)

189. Currently, the vacancy rate in supported housing is less than 2% (Tr. 1503:9-1504:2 (Madan)), and as described above, because of the way the supported housing program is administered, Adult Home residents are by and large unable to access supported housing.

190. In the majority of impacted Adult Homes, which do not have the Case Management Initiative, there is no effective assistance with accessing supported housing. (Tr. 2917:3-2918:4 (Kaufman) (testifying about his observations that Adult Home staff 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) (witness who oversaw a 25-bed supported housing apartment program from 2000 to 2008 testified 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 to follow up on residents' expressed desires to move to more integrated housing, (Tr. 1500:13-1502:3 (Madan); Tr. 1365:16-1366:11 (Reilly)), they conceded that they have no idea whether residents receive any information from those case managers about alternatives. (Tr. 1835:15-18 (Dorfman).) Moreover, because some Homes have been cited for a failure to follow up on residents' expressed desire to move (*see supra*, ¶¶ 162 (Joint Stipulations of Fact ¶ 22))**,** the assumption that those case managers *are* effective at assisting residents is unwarranted. Indeed, several current and former Adult Home residents testified that standard case management is ineffective at moving people to supported housing. (Tr. 390:23-391:17 (S.K.) (testifying that she spoke with her case manager about moving to alternative housing about a year ago, but has not heard anything further from the case manager); P-540 (P.B. Dep.) 123:7-21 (testifying that the Adult Home's case manager is not effective). Indeed, if defendants truly believed that the existing programs and activities were effective, they would not have undertaken the Case Management Initiative in eleven Adult Homes.

191. Defendants have also referenced the EnAble Program as part of their *Olmstead* plan for Adult Home residents. (Tr. 3404:16-25 (Rule 50 arguments).) The Department of Health initiated the EnAble program in 2004 to provide $100,000 to a few Adult Homes in order to provide certain activities and services within the facilities. (Tr. 2902:18-2903:9 (Kaufman) (describing the provision of teaching kitchens and laundry facilities in a few Adult Homes); Tr. 2084:23-2085:6 (Burstein) (explaining her understanding that the EnAble Program is "an opportunity for adult homes to receive

funding from the Department of Health to do projects or programs for the enhancement of the residents").)

192. Only eight Adult Homes at issue in this litigation have received EnAble grants, (D-132, D-133, D-135-139), and the State has not determined whether the EnAble Program has resulted in any Adult Home resident moving to more integrated settings as a result of any Enable grant in any Home. (Tr. 1717:5-13 (Wollner).)

193. Even if the EnAble Program were teaching independent living skills, the training is meaningless as long as Adult Home residents do not have the opportunity to apply the skills. Both parties' experts testified that independent skills training is effective only if coupled with the opportunity to apply such skills in real life. (Tr. 67:20-69:6 (E. Jones) ("These are more artificial activities that have been set up with the idea that you can teach people skills in the adult home that they will then take with them to a community placement if that ever becomes available and actually, that's not the practice in the mental health field. We know that people with serious mental illness have difficulty in generalizing information and that the most successful way to teach people skills and to help them recover skills and retain skills is to have them practice them on an ongoing basis in the place where they live or work"); (Tr. 2360:9-2361:1 (Geller) ("[I] believe the system needs to have that person exist in an environment where they can use the skills and, in addition, have whatever additional resources for security that they need"); 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).) So training residents in how to cook, for example, is not helpful because they are not permitted to cook their own meals in the Homes. (P-552 (Kerr

Dep.) 190:2-5 (explaining that DOH prohibits Adult Home residents from cooking their own meals.)

194. In fact the recent initiatives developed by defendants will not be effective because the Adult Home model is at odds with the development of independent living skills, discourages residents from moving to more independent settings, and actually fosters dependence. Adult Homes are for-profit institutions, and as such, they have no incentive to support residents to move on. (Tr. 1384:19:1385:25 (Reilly) (explaining that a concern of OMH in implementing the Case Management Initiative was that Adult Homes would be resistant to permitting the program to operate in the Homes); (P-536 (D.N. Dep.) 150:17-152:21 (testifying that adult home staff is unhelpful with assisting residents to move out); P-541 (S.B. Dep.) 97:11-98:24 (testifying that adult home staff was unhelpful when resident expressed desire to move).) The Adult Home model is a dependency-based model that impedes the prospect of moving to other settings. (Tr. 2734:21-2735:2 (I.K.) (former adult home resident currently living in supported housing who explained that she was initially ambivalent about moving out of the Adult Home "because the adult home fosters complete dependency upon them to do everything for you, discourages independence, does not provide information about services to help you get out of the home"); Tr. 1011:9-1013:11 (D. Jones) ("I think there are many aspects of what happens in adult homes that really has to do singularly with, to use a little bit kinder word, with sort of maintenance of the status quo. . . . [W]e want today to look like yesterday and tomorrow to look like today . . . .").)

195. Instead of evidencing components of a commitment or plan to enable Adult Home residents to move to more integrated settings, the recent State initiatives

targeted specifically to Adult Home residents evidence a commitment to supporting the continued use of Adult Homes as settings in which to provide services to people with mental illness.

VI. The Evidence Shows that the Requested Relief Would Cost No More Than the Current System

196. The State has the burden of proving its fundamental alteration defense, including the financial impact of the costs of the relief sought by DAI. The State has not, however, done an analysis to determine the financial impact of serving people in supported housing instead of Adult Homes. (Tr. 3368:7-3369:8 (Schaefer-Hayes).)

197. Defendants' witnesses assert that if the State were required to serve thousands of Adult Home residents in scattered-site supported housing, the State's costs to serve those persons would increase. (*See* D-398 (Chart prepared by Gregory Kipper); D-441 (Chart prepared by Martha Schaefer-Hayes); Tr. 2774:20-2775:1 (Kipper); 3341:6-3342:9 (Schaefer-Hayes).) DAI's witnesses assert, however, that the State fails to take into account savings that would occur in a number of areas if adult home residents were served instead in supported housing. (*See generally* P-773 (D. Jones Summary of Cost Evidence); S-150 (D. Jones Report) at 20-28; S-148 (D. Jones Rebuttal Report) at 1-6.) After considering all the evidence, as described in detail below, the Court finds that it would cost no more for the State to serve DAI's constituents in supported housing instead of Adult Homes.[11]

[11] As shown below, the costs to the federal government would be significantly lower as well.

A. Funding Sources and Amounts for Adult Homes and Supported Housing

198. In general, residents of Adult Homes and supported housing use Supplemental Security Income ("SSI"), an income supplement for low income people with disabilities, to pay for all or part of the cost of their housing. (*See* P-591 (Joint Stipulations of Fact) ¶¶ 9, 28.)

199. Adult Homes are classified as Congregate Care Level III housing for the purposes of determining the SSI benefit level that Adult Home residents receive. (*Id.* ¶ 14.) Currently, Adult Home residents in New York City receive $16,416 per year in SSI; the federal government pays $8,088 of that amount, and the State pays $8,328. (*Id.* ¶ 27.) An Adult Home resident uses most of the SSI benefit to pay the Adult Home for room, board, three meals a day, housekeeping, personal care and supervision. (*Id.* ¶ 28.) Residents keep a small portion of the SSI benefit as a Personal Needs Allowance ("PNA"). (*Id.*) In 2009, in New York City, the PNA for adult home residents is $2,136 per year, or $178 per month. (*Id.*)

200. Scattered site supported housing consists of apartments scattered among various buildings. (*Id.* ¶ 11.) Scattered site rental apartments are funded directly by OMH in the form of a rental stipend, and through the individual resident's income, which often consists only of SSI. (*Id.* ¶ 29.) The State pays a per-resident stipend directly to supported housing providers. The current per bed stipend paid by OMH for supported housing is $14,654.[12] (*Id.* ¶ 33.) Individuals residing in supported housing receive the

[12] Some portion of the amount of money the State currently pays to supported housing providers as a rental stipend goes to provide case management services that are potentially eligible for Medicaid reimbursement. (Tr. 3268:17-3269:15 (Schaefer-Hayes).) If the State were to seek to make that expense coverable by Medicaid, it could share the cost of those services with the federal government. (*Id.*) OMH has

SSI Living Alone Rate and are required to pay 30% of this payment, i.e. 30% of their income, toward housing costs to the not-for-profit provider. (*Id.* ¶¶ 9, 30.) The 2009 Living Alone rate was $9,132 per year ($761 per month), of which the State's share is $1,044 per year ($87 per month). (D-347 (SSI Benefit Levels Chart effective January 1, 2009).)

201. Defendants' argument that there would be increased cost to the State is based on the premise that the only relevant costs are the OMH rental stipend and SSI. Based on that faulty premise, the State asserts it would cost an additional $7,370 for each Adult Home resident served in supported housing instead of an Adult Home, which is the amount by which the OMH rental stipend of $14,654 and the State contribution of $1,044 to SSI for an individual in supported housing exceeds the State's contribution to SSI for an individual living in an Adult Home. (Tr. 2780:22-25 (Kipper); D-441 (Chart prepared by M. Schaefer-Hayes); D-398 (Chart prepared by G. Kipper).) Defendant's analysis, however, fails to consider all of the relevant costs to the State to serve residents in Adult Homes.

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declined, however, to seek Medicaid reimbursement for that portion, arguing that the potential recovery "is not substantial enough to invest or require providers to invest in Medicaid billing systems to try to go after that." (Tr. 3276:22-3277:1 (Schaefer-Hayes).) However, Ms. Schaefer-Hayes testified that 10-15% of the rental stipend funds go to case management. (Tr. 3276:13-15.) Accordingly, the amount of Medicaid recovery to the State from the federal government if those funds were sought could be nearly $10 million. (The amount of the stipend ($14,654) x 10% x approximately 13,500 supported housing beds (*see ¶* 175, *supra*), divided by half because the State pays half of Medicaid = $9.9 million.)

B. The Evidence Shows that Medicaid Costs for People Living in Supported Housing Are Significantly Lower Than Medicaid Costs for Adult Home Residents

202. Residents of Adult Homes and 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.) For Medicaid-eligible individuals, the State pays for half the costs of Medicaid-funded services, including primary care, hospital care, psychiatric care, prescriptions, psychologists, Medicaid transportation, case management, and various other medical services. (*See generally* P-63 (DOH Analysis of Medicaid Expeditures in Impacted Adult Homes ("State's Analysis").) Defendants' comparison of the costs of Adult Homes versus supported housing ignores Medicaid costs. (Tr. 2788:15-19, 2789:20-23 (Kipper); Tr. 3382:25-3384:8 (Schaefer-Hayes); Tr. 3438:22-3439:16 (D. Jones Rebuttal).)

203. At DAI's request, the State undertook a comparison of the Medicaid costs for residents of Adult Homes and residents of supported housing for the fiscal year 2004-2005.[13] (Tr. 3421:8-12 (D. Jones Rebuttal); *see* P-63 (State's Analysis).) In that analysis, the overall annual Medicaid costs for a person residing in an Adult Home was, on average, roughly $15,000 higher than the average Medicaid costs for an individual with mental illness in supported housing. (P-63 (State's Analysis) at DOH 0131663-64; P-773 (D. Jones Summary of Cost Evidence) at 1; Tr. 3424:2-14 (D. Jones Rebuttal); S-55 (Kipper Report) at 8; *see also generally* P-228 (New York State Commission on Quality of Care, *Adult Homes Serving Residents with Mental Illness: A Study on Layering*

[13] The 2004-2005 data is the latest data available. (*See* Tr. 3440:21-3441:1 (D. Jones Rebuttal).

of Services, August 2002) at 17 (finding that adult home residents receive services that are "costly," "sometimes unnecessary," and that appear in many instances to be "revenue driven"); S-103 (Workgroup Report) at DOH 86205-86209 (discussing potential Medicaid savings from reforming services to adult home residents); 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 ("ALP Report")) at i (finding that assisted living services provided to adult home residents "were not commensurate with the increased charges to Medicaid").)

204. As demonstrated in Table 1 below, the total average Medicaid expenditures, including the State and federal shares, were $31,530 per Medicaid-eligible individual in the Adult Homes at issue, and $16,467 per Medicaid-eligible individual with mental illness in supported housing. (P-63 (State's Analysis) at DOH 131663-64; *see also* S-150 (D. Jones Report) at 21; S-55 (Kipper Report) at 8.) In fact, the State pays more for services to Adult Home residents than for services to residents of supported housing across a "spectrum of services," including in-patient hospitalization costs and pharmacy costs. (Tr. 2789:13-19 (Kipper).)

Table 1: Summary Comparison of Medicaid Expenditures in FY 2004-2005

	Average Per Person Cost	
Population Cuts	Supported Housing	Adult Homes
Resident Populations in SFY 2004-2005	$16,467	$31,530
Severely and Persistently Mentally Ill (SPMI)	$20,370	$36,109
(a) SPMI and Medically Involved	$28,108	$46,772
(b) SPMI and Not Medically Involved	$18,644	$32,163
Not SPMI	$11,882	$25,289
(a) Not SPMI and Medically Involved	$27,006	$39,677
(b) Not SPMI and Not Medically Involved	$9,628	$19,711

Source for Table 1: P-63 (State's Analysis) at DOH 131663-64).

205. The State further parsed the Medicaid data to compare persons with higher or lower medical needs and higher or lower psychiatric needs in both residential settings. (*See* P-63 (State's Analysis) at DOH 131663-64); *see also generally* Tr. 3471:8-72:18 (D. Jones Rebuttal).) No matter which sub-category it analyzed, there were significant savings—between $10,000 and $18,700, depending on the category—for residents of supported housing. (P-63 at DOH 131663-64.)

206. The parties dispute whether and to what extent serving Adult Home residents in supported housing would reduce the amount the State spends on Medicaid costs. (*E.g.* S-55 (Kipper Report) at 8; S-150 (D. Jones Report) at 21-22.) The dispute centers around the question whether the higher cost for Adult Home residents is due to the setting in which a person with mental illness is served or the characteristics of a person living in that setting. Defendants' expert, Gregory Kipper, concluded that "those costs wouldn't necessarily change due to a change in your address, a change in your housing situation." (Tr. 2789:22-23 (Kipper).) DAI's expert, Dennis Jones, however,

testified that it is the *nature of the provision of services* in Adult Homes that causes the disparity, not the residents themselves. (Tr. 3425:2-3426:10 (D. Jones Rebuttal).)

207. One of the primary reasons for the increased Medicaid expenditures in Adult Homes is what Mr. Jones described as the "dependency-based model" of Adult Homes, as compared to the "recovery-based model" of supported housing. (Tr. 1010:17-1011:18 (D. Jones), 3425:2-3426:10, 3475:7-3476:23 (D. Jones Rebuttal).) Mr. Jones testified that the recovery model looks at people's strengths: looking at what they are capable of doing and how best to promote those strengths. (Tr. 3475:9-18 (D. Jones Rebuttal).) It is the opposite of a dependency-based model as found in adult homes, which says "I'll do it for you, I'll bill Medicaid for it." (Tr. 3476:17-19.) Mr. Jones illustrated the concept this way:

> If you want somebody to learn how to ride the bus, you don't pull up with a van every day and say, Hop in, we're going, and bill Medicaid. That's an old-style model. You go out and you help people to learn how to ride public transportation. You do that in stages, teaching and training.

(Tr. 3476:7-12.) According to Mr. Jones, "[i]t's the difference between doing for and doing with." (Tr. 3476:3-4.) The dependency-based model is a significant factor causing the high Medicaid costs found in Adult Homes.

208. Another reason why Medicaid expenses are higher in Adult Homes is because of the great deal of "layering of services" that occurs in Adult Homes that does not occur in supported housing. (Tr. 712:4-11 (Rosenberg); 3425:2-3426:10 (D. Jones Rebuttal).) In August 2002, the New York Commission on Quality of Care issued a report titled *Adult Homes Serving Residents with Mental Illness: A Study on Layering of Services* (the "Layering Report"). (P-228.) The Layering Report found that it was "not

uncommon to see multiple practitioners and providers . . . located on-site in adult homes and acting independently of each other" in serving a "captive adult home population." (P-228 at CQC 96.) Calling the service system in Adult Homes "fundamentally flawed," the report concluded that "many residents received multiple layers of services from different providers that were costly, fragmented, sometimes unnecessary, and often appeared to be revenue-driven, rather than based on medical necessity." (*Id.* at CQC 114; *see also* Tr. 710:16-711:10 (Rosenberg) (describing layering of "all of the medical services, all of the support services that could be billed through Medicaid that the adult home operator [ ] brought into the home," with the most egregious instances involving unnecessary cataract surgery); Tr. 3491:13-3492:10 (D. Jones Rebuttal) (describing significant Medicaid over-utilization occurring in adult homes but not supported housing); *see also* S-103 (Workgroup Report) at DOH 86205-86209; P-94 (ALP Report).) The Layering Report, which used then current figures, found that it cost the State $37,000 per year for an Adult Home resident to live in an Adult Home when Medicaid billing was added to room and board charges. (P-228 at CQC 101.)

209. Linda Rosenberg, the former Senior Deputy Commissioner for the Office of Mental Health, explained that there is a fiscal relationship between Adult Home operators and providers that rent space in the homes to provide Medicaid-billable services to adult home residents. (Tr. 712:13-17 (Rosenberg).) For example, she testified that on a site visit to an Adult Home, she observed that the Adult Home had arrangements with providers "where they could come into the home and would treat everybody in the home; and it was unclear, you know, how much the residents had a say in whether that's who they wanted to treat them or would they have preferred to go see somebody else." (Tr.

645:9-21 (Rosenberg).) One Adult Home resident testified that the Adult Home administrator makes appointments for him every three weeks to see the doctor assigned to him by the home in an office connected to the Home, and that Medicaid pays for those appointments. (Tr. 566:9-567:4 (S.P.).)

210. Ms. Rosenberg also testified that Adult Home residents at times had home health aides billed to Medicaid that worked for agencies owned by the Adult Home operators, and that the residents were unaware they had a home health aide. (Tr. 709:22-710:4 (Rosenberg); *See also* 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).) As Mr. Jones explained, "You've got very aggressive private for profit providers who are operating in largely a fee for service Medicaid world who are highly [incented] to bill as much Medicaid as they can bill. You put [that together with the dependency model] and you end up here with an exceedingly high cost for Medicaid." (Tr. 3425:14-18.) Ms. Rosenberg said it this way: "[I]t's institutional living, and in some ways because they're for-profits[,] [i]t's institutional living at, potentially, its worst." (Tr. 645:22-24 (Rosenberg).)

211. Defendants have not done any analysis to determine whether their theory of the cause of the disparity in Medicaid costs between persons living in supported housing and persons living in Adult Homes has any validity. (S-55 (Kipper Report) at 8; S-144 (Kipper Reply Report) at 4-5; Tr. 3388:17-22 (Schaefer-Hayes); Tr. 3459:20-3460:23 S-150 (D. Jones Report) at 21 ("New York has not done any detailed fiscal analysis on the relief sought.").) Instead, defendants dismiss the possibility of cost savings if current Adult Home residents were served instead in supported housing as

"speculative." (S-55 (Kipper Report) at 8; S-144 (Kipper Reply Report) at 5; Tr. 3384:15-21, Tr. 3398:20-3399:11 (Schaefer-Hayes); *see also* S-148 (D. Jones Rebuttal Report) at 4.) Defendants' witnesses, merely, assumed that Adult Home residents are somehow different from persons living in supported housing, and that difference must explain the increased costs of Medicaid in Adult Homes. That notion, however, is belied by the facts. When the State analyzed the comparative costs for 2004-2005, even persons deemed to have higher psychiatric needs and higher medical needs were served much more cheaply in supported housing than they were in Adult Homes. (P-63 (State's Analysis) at DOH 131663-64; *see also* P-773 (D. Jones' Summary of Cost Evidence) at 1; S-148 (D. Jones Rebuttal Report) at 4.) Moreover, whether a person lives in a supported apartment or an Adult Home is not a function of his or her functional abilities or medical needs. Instead, as Linda Rosenberg testified, whether a person with mental illness lives in supported housing or an Adult Home is "the luck of the draw for the most part." (Tr. 709:8-12.) As she explained, if one were to visit both a supported apartment and an Adult Home, "the residents would by and large have similar characteristics." (*Id.*)

212. As shown in Table 2 below, after adding the average Medicaid cost for a person in supported housing ($16,467) to the amount of the stipend ($14,654) and the amount of SSI paid to a resident of supported housing ($9,132), the total amount paid by the State and federal governments is $40,253. (P-773 (D. Jones Summary of Cost Evidence) at 2; Tr. 3437:23-3438:2 (D. Jones Rebuttal).) The State share of the cost is 100% of the stipend ($14,654), half of the Medicaid ($8,234), and $1,044 of the SSI, for a total State cost of $23,932. (P-773 at 2.)

Table 2: Supported Housing ("SH") Average Per Person Costs vs. Baseline Adult Home ("AH") Average Annual Costs

Supported Housing		
	State	Total
SH Stipend	$14,654	$14,654
Medicaid	$8,234	$16,467
SSI	$1,044	$9,132
TOTAL	**$23,932**	**$40,253**

Adult Homes		
	State	Total
SH Stipend	$0	$0
Medicaid	$15,750	$31,530
SSI	$8,328	$16,416
TOTAL	**$24,078**	**$47,946**

213. After adding the Medicaid cost for a person in an Adult Home ($31,350) to the cost of SSI for a person in an Adult Home ($16,416), the total paid for a person served in an Adult Home is $47,946. (P-773 at 2.) The State share of the cost is half of the Medicaid ($15,750) and $8,328 of the SSI, for a total State cost of $24,078. (*Id.*)

214. When the cost of Medicaid is included, it saves the State of New York $146 to serve an individual in supported housing instead of an Adult Home. (*Id.*; *see also* Tr. 3439:6-16 (D. Jones Rebuttal).) The overall cost is $7,693 less when the federal government share is also included. (P-773 at 2.)

C. The State Also Fails to Consider Other Savings

215. 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. (Tr. 3439:17-3440:3, 3459:20-3460:23 (D. Jones Rebuttal); *see generally* P-773 at 3-12.)

216. For example, the State has spent at least $28 million on a program called the Quality Incentive Payment ("QuIP") program since its inception (Tr. 1671:8-10, 1710:12-15 (Wollner); P-773 at 3-12), and $26.4 million since this lawsuit was filed (P-

733 at 3-12). QuIP money is allocated as a funding subsidy to Adult Home operators that "maintain compliance with DOH regulations." (S-55 (Kipper Report) at 5; *see also* S-148 (D. Jones Rebuttal Report) at 2-3.) QuIP funds are allocated to those Adult Homes who apply for and are awarded grants based on the number of SSI-eligible residents living in the home. (S-148 at 2.) Homes receiving grants under the QuIP program are authorized to use funds for capital improvements in Adult Homes, such as new roofs or new furniture, and for training and education of adult home staff.[14] (Tr. 1709:20-1710:6 (Wollner).) QuIP money goes to Adult Home owners and operators, not to Adult Home residents. (Tr. 1709:17-19 (Wollner).) QuIP money is not designed to assist Adult Home residents to move to more integrated settings; that "was not the intent of the legislation." (Tr. 1710:23-1711:3 (Wollner).)

217. DOH has spent at least $26.4 million on QuIP since the inception of this litigation. (P-773 at 3-12.) DOH spent $4 million on QuIP in 2002-2003, of which $972,742 was distributed to Homes at issue in this litigation. (P-773 at 3; P-264 (QuIP Final Payment List 2002-2003).) DOH allocated $6 million to QuIP in 2003-2004, of which $1,982,129 was spent in Homes at issue in this litigation. (P-773 at 4; P-263 (QuIP Final Payment List 2003-2004); *see also* S-148 (D. Jones Rebuttal Report) at 3.) DOH allocated $2.75 million to QuIP in 2005-2006 (P-773 at 8); $2.75 million in 2006-2007 (P-773 at 9; Tr. 1709:2-5 (Wollner)); $5.5 million in 2007-2008 (P-773 at 11); and $5.46 million in 2008-2009 (P-773 at 12). In 2003-2004, QuIP funds allocated to Homes

[14] As with other programs related to Adult Homes, there have been allegations that QuIP funds have not been put to their intended use, but instead have been used by some homes to subsidize operating expenses like workers compensation. (Tr. 1711:7-17 (Wollner).)

at issue in this litigation amounted to $542.81 per resident. (S-148 (D. Jones Rebuttal Report) at 3.)

218. In conducting its analysis of the comparative cost of serving a person in an Adult Home or in supported housing, the State did not consider the cost of the QuIP program. (Tr. 2786:16-2787:3 (Kipper); S-148 (D. Jones Rebuttal Report) at 2-3; S-55 (Kipper Report) at 9 n.6; S-144 (Kipper Reply Report) at 2-3; D-441 (Chart prepared by M. Schaefer-Hayes); Tr. 3381:11-3382:24 (Schaefer-Hayes).)

219. The State has also allocated substantial additional funds for capital improvements. (P-773 at 3-12.) In 2004-2005, the Legislature appropriated $1.5 million for an Infrastructure Capital Program. (P-773 at 6; Tr. 1707:1-12 (Wollner); P-659 ("Dear Colleague" letter from David Wollner announcing the availability of funding under the program).) Six of the Homes at issue in this litigation received Infrastructure grants. (P-773 at 6; P-245 (ACF Infrastructure Improvements—List of Approved Applications).) In 2006-2007, the State spent $2.8 million on air conditioning for Adult Homes (P-773 at 9; *see also* Tr. 1709:2-5 (Wollner) (testifying that the State had spent $2 million).) Many of the Homes at issue in this litigation received funds for air conditioning. (P-773 at 9-10; P-722 (DOH Press Release, "51 Adult Care Facilities Share $2.8 Million in Grants to Increase Air Conditioning in Resident Rooms," dated Apr. 25, 2007).) The State did not consider the cost of these programs in conducting its cost analysis in this case. (S-144 (Kipper Reply Report) at 3; Tr. 2786:16-2787:3 (Kipper); S-148 (D. Jones Rebuttal Report) at 3; D-441 (Chart prepared by M. Schaefer-Hayes); Tr. 3381:11-3382:24 (Schaefer-Hayes); *see also* Tr. 3460:20-24 (D. Jones Rebuttal).)

220. The "EnAbLE" program—Enhancing Abilities and Life Experiences—is a grant-funded program that is administered by DOH. (Tr. 1647:17-25 (Wollner).) The program provides funding to Adult Home operators for numerous activities, initiatives, and programs targeted at adult home residents. (*Id.*; *see also* Section VB, ¶¶ 191-193, *supra* (describing the program).) The State has spent many millions of dollars on EnAbLE since its inception. (*See* P-773 at 3-12.) The State spent $2 million on EnAbLE in 2004-2005, and three homes at issue in this litigation received grants (P-773 at 6; *see also* P-244 (NYSDOH—Office of Health Systems Management, Enhancing Abilities Life Experience (EnAbLE) Program Grant Awards) (listing awards to Queens Adult Care Center, Park Inn, Rockaway Manor, and Ocean House[15]); $2.75 million in 2005-2006 (*see* P-773 at 8 (discussing allocation for "general adult home initiatives"); Tr. 1650:1-11, 1714:8-10 (Wollner)); $2.2 million in 2006-2007 (P-773 at 9; *see also* Tr. 1714:11-13 (Wollner) (stating that $2.75 million was allocated)), of which $491,908 was allocated to Homes at issue in this litigation (P-773 at 9; D-136; D-135; D-137; D-138; D-139 (letters notifying adult homes that EnAbLE grants have been approved)). Additional funds were allocated for EnAbLE as part of a $6.55 million budget package in 2007-2008 (P-773 at 11), and $3 million was allocated to the program in 2008-2009 (*id.* at 12).

221. In conducting its analysis of the comparative cost of serving a person in an Adult Home or in supported housing, the State did not consider the cost of the EnAble

[15] Interestingly, this award to Ocean House was made shortly before Ocean House was closed because of "very serious concerns as it relates to quality of care that was not provided to the residents" and "allegations of fraud and misuse of governmental funding that had been provided to the owners and operators." (Tr. 1729:14-17 (Wollner).)

program. (S-144 (Kipper Reply Report) at 3; Tr. 2786:16-2787:3 (Kipper); Tr. 3460:20-24 (D. Jones Rebuttal); S-148 (D. Jones Rebuttal Report) at 3; D-441 (Chart prepared by M. Schaefer-Hayes); Tr. 3381:11-14 (Schaefer-Hayes).)

222. The State has also invested in Adult Homes through its Case Management Initiative. The initiative was originally funded with $1.2 million in 2003-2004 to roll out case management in three Homes at issue in this litigation. (P-773 at 4-5.) $1.275 million was allocated to case management in 2004-2005. (*Id.* at 7.) In 2005-2006, the State allocated $5.25 million to case management. (*Id.* at 8; S-127 (OMH Aid to Localities 2005-2006 Enacted Budget—Summary of Legislative changes) at 1.) The State has spent at least $5.25 million per year since 2005 on the Case Management Initiative. (Tr. 1702:23-1703:4 (Wollner).) On a per resident basis, the State spends approximately $1,514 annually in direct State aid for each Adult Home resident that receives services through the Case Management Initiative. (D-348 (2008-2009 Case Management Funding Models).)

223. The State did not consider the cost of the Case Management Initiative in conducting its analysis of the comparative cost of serving a person in an Adult Home versus the cost of serving a person in supported housing. (S-144 (Kipper Reply Report) at 2; Tr. 2786:16-2787:3 (Kipper); Tr. 3460:20-24 (D. Jones Rebuttal); S-148 (D. Jones Rebuttal Report) at 2.)

224. In addition to the other specific programs described, in 2003-2004, the State budget allocated $2 million to Adult Home initiatives. (P-773 at 4.) In 2005-2006, the State allocated $350,000 "for services and expenses to promote programs to improve the quality of care for residents in adult homes." (P-773 at 8; P-756 at 76 (Excerpt from

Senate Bill 554-E).) For example, the State spent approximately "a couple hundred thousand dollars" on medication management training for Adult Home staff. (Tr. 1718:2-22 (Wollner).) The program was not designed to help Adult Home residents to learn how to self-administer medication. (Tr. 1719:1-7 (Wollner).) Rather, the program was necessary because of the nature of concerns about medication handling by Adult Home staff. (Tr. 1719:20-1720:7 (Wollner).) These costs also were not included in the State's analysis. (*See generally* D-398 (Chart prepared by G. Kipper); D-441 (Chart prepared by Schaefer-Hayes); S-55 (Kipper Report) at 8-9.)

225. In the past, the State has demonstrated its ability to redirect funds as individuals move from one setting to another. When State hospitals have closed hospital beds, the Reinvestment Act of 1993 enabled the State to transfer money from the budget for State hospitals to the budget for OMH community services. (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).) In total, the State was able to redirect more than $210 million in savings from the closure of psychiatric hospital beds into community programs. (Tr. 1613:15-24 (Wollner); Tr. 3262:8-3265:4, 3316:7-14 (Schaefer-Hayes); S-25 (Excerpt from New York State 2004-2005 Executive Budget, Appendix I: Agency Presentations re: OMH) at 120-21 (describing reinvestment); S-26 (Excerpt from New York State 2005-2006 Executive Budget, Appendix I: Agency Presentations re: OMH) at 120-21 (same).) In 2005, OMH closed 100 beds in psychiatric centers and used the savings to fund 600 Supported Housing beds. (Tr. 3373:1-7 (Schaefer-Hayes); *see also* Tr. 3370:14-3371:4 (Schaefer-Hayes).) Ms. Schaefer-Hayes also testified that OMH has internally reallocated items in its budget in order to shift resources away from outdated

programs to more effective programs. (Tr. 3317:1-3318:7 (Schaefer-Hayes); *see also* S-150 (D. Jones Report) at 27-28 (describing $10 million savings by OMH through implementation of the PROS program).)

226. The evidence shows that the State could follow a similar strategy here. Dollars currently allocated to those residents under DOH's budget for Adult Home care could be moved from DOH's budget to OMH's budget for service in supported housing. Both Linda Rosenberg, the former Senior Deputy Commissioner of OMH and Martha Schaefer-Hayes, the Chief Fiscal Officer of OMH, testified that money can be transferred from one State agency to another when the need arises. (Tr. 731:14-732:23 (Rosenberg) (testifying that with proper coordination, money could be moved from the DOH budget to the OMH budget), Tr. 3370:6-13; 3395:2-23 (Schaefer-Hayes) (money can be moved from one agency to another if legislature and the governor agree).)

D. The Requested Relief Would Not Adversely Affect Other Persons with Serious and Persistent Mental Illness

227. Defendants argue that the relief DAI requests would force them to cut back on services to other needy populations. (*See*, *e.g.* Tr. 29:24-25 (Defendants' Opening Statement).) However, as described above, the evidence in this case is to the contrary. Mr. Jones, the only expert to conduct an analysis that considers all the relevant costs, showed convincingly that serving Adult Home residents in supported housing instead of Adult Homes would not increase the State's costs. (*See supra*, ¶¶ 202-214.) Accordingly, defendants' argument that the relief would entail cutbacks fails. The State would not be required to cut programs or prejudice others who seek supported housing. (*See* S-150 (D. Jones Report) at 21-22; S-148 (D. Jones Rebuttal Report) at 1-6.)

E. The State is Capable of Expanding its Supported Housing Program to Meet the Need of Adult Home residents

228. New York is capable of expanding its supported housing program to meet the needs of Adult Home residents. DAI's expert, Dennis Jones, concluded that "the community provider system has the demonstrated ability to expand services (housing, clinical, and support) to serve persons with mental illness now living in adult homes . . . ." (S-150 (D. Jones Report) at 20-21; *see also* Tr. 656 (Rosenberg) (Supported housing providers "know how to do it"); D-399 (Deposition of Antonia Lasicki) 203:1-9 (testifying that she did not "have any doubt that [her] member organizations [housing providers] could serve any client who's in an adult home with mental illness"); Tr. 281:11-282:25 (Tsemberis) (testifying that Pathways has served people who have come from Adult Homes and they have done well in supported housing), 287:12-23 (Tsemberis) (stating that Adult Home residents would do very well in supported housing), 288:14-289:6 (Tsemberis) (testifying that if the State issued an RFP to provide supported housing to Adult Home residents with mental illness, many agencies could serve them).) As Mr. Jones described, the "very clear and consistent message" he got in conversations with providers was::

> We know how to do this, we believe in the philosophy around community integration, we have a strong track record of doing it, and what we need from the state here, as a part of all of this, is to come up with a clear plan, which would presumably be a multi-year plan, be very clear about how it's going to get funded so there's no question about commitment, do it in an incremental way, and support it. And if you can do those things at a state leadership level, we can and will deliver . . . . The local providers were not in the least bit hesitant about expressing . . . their ability to serve folks who are today in adult homes, not in the least.

(Tr. 3477:19-3478:9 (D. Jones Rebuttal).)

229. Mr. Jones testified that New York is capable of developing supported housing beds for Adult Home residents at a rate of approximately 1500 per year for several years. (Tr. 3478:10-3479:14; 3482:5-3487:21) (D. Jones) (noting that OMH had received responses to its 2005 supported housing RFP that proposed to develop a total of 1500 beds, that many supported housing providers have established working relationships with landlords, and that OMH has a history of taking on "big projects" such as the New York/New York Initiative, which planned for the development of 9000 beds in its third phase alone).) Mr. Jones, who is familiar with the real estate market in New York City, indicated that it would be possible to identify a sufficient number of units of appropriate housing to achieve this goal. (Tr. 3482:18-3483:1)

CONCLUSIONS OF LAW

In its Memorandum and Order of February 19, 2009, (the "Order"), the Court resolved a host of legal issues concerning the meaning and application of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. *See Disability Advocates, Inc.* v. *Paterson*, *et al.*, 598 F. Supp. 2d 289, 311-22, 331, 333-39 (E.D.N.Y. 2009). The Order fully explains the Court's resolution of those issues. Below, the Court sets forth the core legal holdings in its Order and applies them to the facts shown at trial.

I. The Americans with Disabilities Act and Section 504

230. The Americans with Disabilities Act (ADA) was enacted to "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). In enacting the ADA, Congress recognized that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). Congress found that "individuals with disabilities continually encounter various forms of discrimination, including . . . segregation. *Id.* § 12101(a)(5).

231. Title II of the ADA prohibits discrimination in connection with access to public services, requiring that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity or be subjected to discrimination by any such entity." 42 U.S.C. § 12132; *Disability Advocates*, 598 F. Supp. 2d at 311.

232. To establish a violation of Title II of the ADA, a plaintiff must prove that (1) he or she is a "qualified individual" with a disability; (2) that the defendants are subject to the ADA; and (3) that he or she was denied the opportunity to participate in or benefit from the defendants' services, programs, or activities, or was discriminated against by defendants, by reason of his or her disability. *Henrietta D.* v. *Bloomberg*, 331 F. 3d 261, 272 (2d Cir. 2003); *Disability Advocates*, 598 F. Supp. 2d at 311.

233. Section 504 of the Rehabilitation Act ("Section 504") similarly prohibits disability-based discrimination, providing that: "No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . ." 29 U.S.C. § 794(a). Because claims under the two statutes are treated identically unless – unlike here – one of the "subtle differences" in the two statutes is pertinent to a claim, the Court treats the claims under Section 504 as identical to the ADA claims. *Henrietta*, 331 F.3d at 272; *Disability Advocates*, 598 F. Supp. 2d at 311 n. 25.

234. One form of discrimination "by reason of…disability" is a violation of the "integration mandate" of Title II of the ADA and Section 504. This mandate—arising out of Congress's explicit findings in the ADA, regulations of the Attorney General implementing Title II, and the Supreme Court's decision in *Olmstead* v. *L.C.*, 527 U.S. 581 (1999)—requires that when a state provides services to individuals with disabilities, it must do so "in the most integrated setting appropriate to their needs." 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d); 28 C.F.R. § 41.51(d); *Olmstead*, 527 U.S. at 607.

235. Delineating the scope of the integration mandate, the Supreme Court in *Olmstead* explicitly held that "[u]njustified isolation . . . is properly regarded as discrimination based on disability." *Id.* at 597. The Court noted that "in findings applicable to the entire statute, Congress explicitly identified unjustified 'segregation' of persons with disabilities as a 'for[m] of discrimination.'" *Id.* at 600. The Court recognized that "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." *Id.*

236. In its analysis of the integration mandate, the Supreme Court deferred to the Attorney General's interpretation of Title II. *See id.* at 598 ("It is enough to observe that the well-reasoned views of the agencies implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.") (internal quotation marks and citations omitted). Thus, following *Olmstead*, courts have looked to the language of the Attorney General's regulations, as well as the holding in *Olmstead* as the standard by which to determine a violation of the ADA's integration mandate. *Townsend* v. *Quasim*, 328 F.3d 511, 516, 520 (9th Cir. 2003) ("[t]he plain language of the integration regulation [28 C.F.R. § 35.130(d)], coupled with the reasoning and holding of *Olmstead*, direct our analysis in this case."); *Joseph S.* v. *Hogan, et al.*, 561 F. Supp. 2d 280, 289-290 (E.D.N.Y. 2009) ("A failure to provide placement in a setting that enables disabled individuals to interact with non-disabled persons to the fullest extent possible violates the ADA's integration mandate.").

237. The Attorney General's regulations implementing Title II provide that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[16] 28 C.F.R. § 35.130(d) ("integration regulation"); *see also* 42 U.S.C. § 12134(a) (requiring Attorney General to issue implementing regulations). The regulations define the "most integrated setting" as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A.

238. A state's compliance with the integration mandate is excused only when it would result in a "fundamental alteration" of the state's service system. *Olmstead*, 527 U.S. at 603. The "fundamental alteration" defense is derived from the "reasonable modifications" regulation, which states that "[a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7). According to the Supreme Court:

> Sensibly construed, the fundamental-alteration component of the reasonable modifications regulation would allow the State to show 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.

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[16] As Congress directed, *see* 42 U.S.C. § 12134(b), this regulation is consistent with a similar regulation implementing Section 504 of the Rehabilitation Act, which requires recipients of federal funds to administer programs and activities "in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 C.F.R. § 41.51(d).

Olmstead, 527 U.S. at 604.

II. DAI's Constituents are Individuals with Disabilities

239. The ADA defines "disability," with respect to an individual, as "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual, (B) a record of such an impairment, or (C) being regarded as having such an impairment." 42 U.S.C. § 12102(2). In recently amending the ADA, Congress mandated that the definition of disability "shall be construed in favor of broad coverage of individuals under this Act, to the maximum extent permitted by the terms of this Act." 42 U.S.C. § 12102(4)(A).

240. By virtue of a major mental illness, such as schizophrenia, bipolar disorder, depression and others, DAI's constituents have mental impairments that substantially limit one or more major life activities, including thought processes. The Adult Homes are intended for people who are substantially unable to live independently without supports.[17] *See generally* 18 N.Y.C.R.R. § 487.4 (listing admission standards); 18 N.Y.C.R.R. § 487.2 (defining "adult home"); *see also generally* Tr. 837:19-838:16, 854:11-21, 814:5-10, 824:4-827:19, 828:7-835:11, 839:7-840:7, 847:10-26 (Duckworth); Tr. 52:8-53:15 (E. Jones); Tr. 282-83 (Tsemberis) (testifying that Adult Home residents suffer from the same sort of mental illness as clients of Pathways); S-33 (2007 RFP) at

[17] The evidence is clear that, with appropriate and varying supports, DAI's constituents could live in supported housing, which is designed for people (a) 18 years of age or older, (b) with a designated mental illness, and who (c) either (1) receive SSI or SSDI due to a designated mental illness, (2) currently have certain functional limitations due to a designated mental illness, or (3) have had certain functional limitations prior to receiving psychiatric rehabilitation and supports and/or medication. (S-17 (2005 RFP) at OMH 37314.)

OMH 42726.) Furthermore, due to their "mental disability," residents with mental illness in "impacted" adult homes are eligible for OMH services, which must be available in the homes. *See* 18 N.Y.C.R.R. §§ 487.4(n), 487.7(b)–(c); *see also* Tr. 2203:12-2208:17 (Bear) (describing mental health programs serving people with mental illness in Adult Homes); Tr. 2620:2-2623:12 (Lockhart) (same); Tr. 2498:20-2500:25, Tr. 2504:5-2405:13 (Waizer) (same).)

241. Moreover, defendants plainly consider DAI's constituents to have disabilities. Indeed, in an effort to rebut DAI's claims, defendants have argued throughout these proceedings that, due to their disabilities, DAI's constituents are not capable of living in supported housing. (*See e.g.*, Tr. 20:1-8 (Defs.' Opening Statement), 3403:20-3404:10 (Schaefer-Hayes); *see also* Tr. 2308:22-2311:18, 2343:8-2344:21 (Geller); S-52 (Geller Report) at 36-38; S-53 (Geller Reply Report) at 6-15.) Thus, it is undisputed that DAI's constituents qualify for protection under the ADA and the RA.

III. Defendants are Subject to the ADA and the RA

242. Title II of the ADA applies to "any State or local government" and "any department, agency, special purpose district, or other instrumentality of a State or States or local government." 42 U.S.C. § 12131(1). Accordingly, all defendants in this action are subject to the ADA.[18] *Pa. Dep't of Corrections* v. *Yeskey*, 524 U.S. 206, 209 (1998); *see also Innovative Health Sys., Inc.* v. *City of White Plains*, 117 F.3d 37, 45 (2d Cir. 1997) (holding that zoning decisions are subject to the ADA and noting that "programs, services, or activities" is a "catch-all phrase that prohibits all discrimination by a public

[18] Defendants do not dispute that their actions are covered by the ADA. Their dispute is with the Court's and DAI's interpretation of the ADA's requirements.

entity, regardless of the context."), *rev'd on other grounds by Zervos* v. *Verizon New York*, 252 F.3d 163, 171 n.7 (2d Cir. 2001). Additionally, defendants have stipulated that their programs or activities "receiv[e] federal financial assistance." (P-591 (Joint Stipulations of Fact) ¶¶ 36 & 37.) As such, defendants are covered by Section 504. 29 U.S.C. § 794(a).

243. In its February 19, 2009 Order, this Court held that Title II applies to DAI's claims in this case. *Disability Advocates*, 598 F. Supp. 2d at 317 ("The court concludes that Title II of the ADA applies to the claims in this case."); *id*. at 319 (holding that DAI's "claim falls squarely under Title II of the ADA"). In doing so, the Court rejected defendants' argument that the State is not liable under the ADA because the Adult Homes are privately owned, and found that it is "immaterial that DAI's constituents are receiving mental health services in privately operated facilities." *Id*. at 317; *Rolland v. Cellucci*, 52 F. Supp. 2d 231, 237 (D. Mass. 1999). Public entities are required under the ADA to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

244. As the Court previously held, defendants' actions at issue here – including the allocation of State resources among various service settings – involve "administration." Defendants, as required by New York law, administer the State's system of mental health care, including residential and treatment services provided by both public and private entities. *Disability Advocates*, 598 F. Supp. 2d at 317. They plan how and where services for individuals with mental illness will be provided, and they allocate the State's resources accordingly. *Id*. Defendants are also required under State

law to develop a "comprehensive, integrated system of treatment and rehabilitative services for the mentally ill" that assures "the adequacy and appropriateness of residential arrangements" and relies on "institutional care only when necessary and appropriate." N.Y. Mental Hyg. L. § 7.01; *see also id.* § 7.07; *Disability Advocates*, 598 F. Supp. 2d at 318 ("The State cannot evade its obligation to comply with the ADA by using private entities to deliver services that are planned, implemented, and funded as part of a statewide system of mental health care").

IV. Defendants Have Discriminated Against DAI's Constituents by Reason of their Disability

245. Defendants have violated the ADA in carrying out their planning and administrative duties and activities. They have designed and operated a service system for individuals with mental illness that ensures that thousands of individuals with mental illness will needlessly live and receive services in the institutional setting of an Adult Home, instead of the more integrated setting of supported housing. *See supra* ¶¶ 175-183.

A. Adult Homes are not the Most Integrated Setting Appropriate to the Needs of DAI's Constituents

246. As discussed above, *supra* ¶¶ 234-37, the Attorney General's regulations implementing Title II of the ADA provide that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) ("integration regulation"); *see also* 42 U.S.C. § 12134(a) (requiring Attorney General to issue implementing regulations). An integrated setting is "a setting that enables individuals

with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A.

247. In its February 19, 2009, the Court resolved the parties' dispute regarding the meaning of the federal regulations defining Title II's "integration mandate." The Court rejected defendants' argument that the appropriate standard is whether persons with disabilities have opportunities for contact with nondisabled persons, concluding that "the proper inquiry is whether DAI's constituents are in the 'most integrated setting appropriate to their needs,' defined as 'enabl[ing] individuals with disabilities to interact with non-disabled persons to the fullest extent possible.'" *Disability Advocates*, 598 F. Supp. 2d at 321 (citing 28 C.F.R. § 35.130(d) & App.) (finding that "the federal regulations mean what they say").

248. Defendants did not seriously try to prove that Adult Homes were as integrated as supported housing. (*See, e.g.*, Tr. 18:6-7 (Defs.' Opening Statement) (framing the issue as whether Adult Home residents "have ample opportunities for contact with nondisabled persons"); Tr. 3402:24-25 (Defs.' Rule 50 motion) (framing the issue as simply "whether or not they are in an integrated setting").) Defendants' interpretation of the standard renders the "*most* integrated" and "fullest extent possible" requirements of the regulation meaningless. As the Court previously held, "[i]nquiring simply 'whether' individuals with disabilities have any opportunities for contact with non-disabled persons ignores the 'most integrated setting' and the 'fullest extent possible' language of the regulations." *Disability Advocates*, 598 F. Supp. 2d at 321.

249. Defendants also took issue with the Supreme Court's finding that confinement in an institution diminishes everyday life activities of individuals. (Tr.

3403:10-11 (Defs.' Rule 50 motion) ("integration isn't necessarily determined by where someone lives"); Tr. 2373:16–24 (Geller) (Supreme Court was "wrong" that "confinement in an institution severely diminishes the everyday life activities of individuals including family relations, social contact, work options, economic independence, educational advancement and cultural enrichments"). The Court finds that defendants' interpretation of the integration mandate is inconsistent with the ADA, the federal regulations, and the Supreme Court's decision in *Olmstead*. It is also inconsistent with the evidence in this case. Numerous witnesses, including defendants' witnesses, testified that Adult Home residents are defined by the institutional setting in which they live and that the very setting itself diminishes opportunities for contacts with nondisabled persons. (Tr. 645:6-10 (Rosenberg) ("[W]e know now that people with serious mental illness … don't have to be defined by their illness; and yet, when you're in an adult home, that's completely what you're defined by."); (P-538 (B.J. Dep.) 50:7-19 (testifying that when people in the neighborhood find out where she's from they avoid her); S-54 (Kaufman Report) at 10 (stating "that adult homes can artificially limit the interactions of residents and constrict the diversity of friends and acquaintances"); Tr. 2374:15-22 (Geller) (acknowledging that certain characteristics of the Adult Homes diminish work options and social contacts, as well as opportunities to cultivate social or family relationships); P-673 at JBFCS at 354.)

250. The Court finds that the large, impacted Adult Homes at issue in this case do not enable interactions with non-disabled persons to the fullest extent possible, and that the State's supported housing programs offer a setting that enables interactions with nondisabled persons to a far greater extent.

251. Adult Homes are institutions. They house well over 100 people, all of whom have disabilities and most of whom have mental illness. (*See supra* ¶¶ 9-14.) They are designed to manage and control large numbers of people and do so by establishing inflexible routines, restricting access, and limiting personal choice and autonomy. (*See supra* ¶¶ 18-20.)

252. Residents line up to receive meals, medication and money at inflexibly scheduled times during the day. (*See supra* ¶¶ 18-19.) They are assigned seats in the cafeteria, roommates and treatment providers. (*See supra* ¶¶ 18, 22.) They have next to no privacy or autonomy in their own daily lives, and they are discouraged, and most often prohibited, from managing their own activities of daily living, such as cooking, taking medication, cleaning and budgeting. (*See supra* ¶¶ 19, 26.)

253. Defendants maintain that Adult Homes residents are in an integrated setting because they are free to come and go from the Adult Homes and because they have access to rehabilitative services intended to facilitate integration. Defendants' argument is inconsistent with both the law and the facts. As stated above, the applicable law requires the State to provide services in a setting that enables interaction with nondisabled persons to the *fullest extent possible*. But even under defendants' standard, Adult Home residents have significant restrictions on their ability "to come and go as they please," and the "rehabilitative" programs available to them do not facilitate integration. Given the inflexible schedules and rules to which residents must adhere, they have many practical limits on when they can come and go from the facility. (*See supra* ¶¶ 18, 20.) Given the lack of privacy and the restrictions on when and where visitors can be received, the residents' ability to develop and maintain relationships with people outside

the Adult Home is limited. (*See supra* ¶¶ 19, 20, 35, 36.) Given the very nature of the Adult Homes, the opportunities to develop social and work contacts are extremely limited. (*See supra* ¶¶ 24, 27-29.) The evidence established that the mental health programs to which Adult Home residents have access do not facilitate integration. In addition to the evidence demonstrating serious problems with such programs, both sides experts' agreed that teaching skills in a setting in which they cannot be applied or practiced is ineffective and does not foster independent living skills or integration. (*See supra* ¶¶ 25-26.) Moreover, even if Adult Homes are in some ways less restrictive than psychiatric hospitals, they are not nearly as integrated as the State's supported housing programs. (*See supra* ¶ 32.)

254. Supported housing is an integrated, community-based setting. People who live in supported housing have the autonomy to live like non-disabled persons and to participate in their communities like non-disabled persons. (*See supra* ¶¶ 38-42.) Simply put, they are not defined by the setting in which they receive services. Indeed, defendants' witnesses themselves testified that supported housing is a more integrated setting than Adult Homes. (Tr. 2915:2-2916:4 (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."); (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).)

255. As discussed below, DAI's constituents could be successfully served by defendants in supported housing. Thus, it is evident that defendants are not serving DAI's constituents in the most integrated setting appropriate to their needs. Without

question, supported housing is a more integrated setting in which to live and receive services than Adult Homes. Supported housing provides far greater opportunities for interaction with non-disabled persons and enables far greater integration into the community life. As OMH's Director of Housing Development testified, supported housing provides "maximum opportunities" for integration into the community. (Tr. 2162:17-21 (Newman) (supported housing "is a type of housing that provides residents with maximum opportunities to be integrated in the community….").)

B. DAI's Constituents are Qualified for Supported Housing

256. Virtually all of DAI's constituents are qualified to live in supported housing—a far more integrated setting than the adult homes where they presently live—because they meet the essential eligibility requirements of the program.

257. Under the ADA, an individual is qualified when he or she "with or without reasonable modifications to rules, policies or practices . . . meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2). In *Olmstead*, the Court found the plaintiffs "qualified individual[s]" because they met "the essential eligibility requirements" to receive community-based services. *Olmstead*, 527 U.S. at 601-603.

258. The evidence in this case demonstrates that DAI's constituents meet the essential eligibility requirements of New York's supported housing program and that virtually all could be successfully served in supported housing.

259. Supported housing is specifically designed and intended for individuals with severe mental illness who have varying levels of need for supportive services; it is not limited to individuals with minimal support needs**.** (*See supra*, ¶ 53-56, 107-123.)

Particularly if combined with ACT or intensive case management—services that are available to every supported housing resident—supported housing is capable of serving individuals with very high needs. (*See supra* ¶¶ 107-15.) Defendants' own RFPs for supported housing—some of which specifically target adult home residents and other institutionalized populations—make clear that supported housing is intended to serve a broad range of individuals, including those with "high needs." (*See supra*, ¶ 108.)

260. Nor do DAI's constituents have especially high or unusual support needs relative to other populations with mental illness. To the contrary, the evidence shows that Adult Home residents have very similar characteristics and needs as current supported housing residents. (*See supra* ¶¶ 60, 99-106.) The Assessment Project commissioned by Defendants shows that the vast majority of Adult Home residents have few if any cognitive impairments and that only a small percentage of residents need assistance with activities of daily living. (*See supra*, ¶¶ 86-98.) These findings are not surprising, as Adult Homes do not provide residents with a particularly intensive level of support: services are generally limited to little more than meals and medication management. (*See*, *supra*, ¶¶ 68, 104-105.) Indeed, Adult Homes are not permitted to admit individuals who require high levels of assistance with daily living or significant medical care, or who pose a danger to themselves or others. (*See*, *supra*, ¶ 106.)

261. Although some Adult Home residents moving to supported housing may require initial assistance in re-learning independent living skills lost while living in institutional Adult Homes, the need for such assistance will likely dissipate over time and can in the meantime effectively be addressed by existing support services. (*See supra*, ¶¶ 109, 110, 112.)

262. That Adult Home residents meet the essential eligibility requirements of supported housing is further evidenced by the fact that New York's supported housing providers *already serve* Adult Home residents. (*See supra* ¶¶ 116-123.) As a result of initiative created by the legislature, 60 Adult Home residents are either currently being served in, or will imminently be served in, supported housing. (*See supra*, ¶¶ 119-120.) When OMH issued the RFP to create these 60 beds for Adult Home referrals, seven different supported housing providers responded with proposals to serve this population. (*Id.*) Further, the evidence showed that although few Adult Home residents have had real access to supported housing outside of the 60-bed initiative, the handful of residents who have managed to obtain supported housing have lived there successfully. (*See supra*, ¶¶ 121-123.)

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

C. DAI's Constituents Are Not Opposed to Receiving Services In More Integrated Settings

264. As the Supreme Court explained in *Olmstead*, the ADA does not impose accommodations on individuals who do not want them, and accordingly it does not force individuals who oppose moving to a more integrated setting to do so. *See Olmstead*, 527 U.S. at 587, 602. DAI does not seek to impose supported housing on Adult Home residents who, after having a meaningful opportunity to make an informed choice, oppose moving to supported housing. The evidence shows, however, that the vast majority of DAI's constituents, would choose to live in supported housing if given a meaningful choice. (*See supra* ¶¶ 143-167.)

265. Analyses conducted by both DAI's experts and defendants themselves demonstrate that large numbers of Adult Home residents would choose to live in settings other than the Adult Homes. (P-583 (Bruce Dep.) 94:23-6; S-151 (E. Jones Report) at 11.) DAI's expert, Elizabeth Jones, concluded that based upon her interviews of 179 residents of 23 Adult Homes, more than 90% of the residents want to live someplace other than the Adult Home. (S-151 (E. Jones Report) at 3.) Based on his analysis, Dr. Duckworth concluded that four out of five Adult Home residents would be willing to move to more independent settings if provided with a meaningful option. (Tr. 874:21-875:1.)

266. These findings are confirmed by the enthusiastic responses of residents to the recent housing forums held by OMH in connection with the legislative set-aside of 60 supported-housing beds. Hinda Burstein, the Park Inn Adult Home administrator, described the reactions of Adult Home residents to the housing forum as follows:

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

(*See*, *e.g.*, Tr. 2083:19-2084:22 (Burstein); *see also* P-357 (E-mail regarding Anna Erika forum); P-354 (E-mail regarding Brooklyn Adult Care Center forum).) Additionally, numerous Adult Home residents have described their desire to live more independently. (*See supra* ¶¶ 159-162; s*ee also, e.g.*, P-540 (P.B. Dep.) 168:17-170:2; P-541 (S.B. Dep.)

89:24-90:10; P-542 (L.G. Dep.) 102:15-103:8; P-546 (A.M. Dep.) 203:18-204:8; Tr. 2750:24-2751:25.)

267. Accordingly, the Court finds that, with accurate information and a meaningful choice, the vast majority of Adult Home residents would choose to live and receive services in a more independent setting, such as supported housing, rather than an adult home.

D. The Relief Sought Would Not Fundamentally Alter Defendants' Service System

268. The Court fully analyzed the law of fundamental alteration in its Memorandum & Order on Summary Judgment, and will not repeat that analysis here. *See Disability Advocates*, 598 F. Supp.2d at 333-56. In short, the "fundamental alteration" defense is derived from the "reasonable modifications regulation," which states that [a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 32.130(b)(7). In *Olmstead*, the Court explained:

> Sensibly construed, the fundamental-alteration component of the reasonable modifications regulation would allow the State to show 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.

Olmstead, 527 U.S. at 604.

269. The United States Supreme Court also explained in *Olmstead* that a state might show that a proposed modification was a fundamental alteration if it demonstrated that it already had a "comprehensive, effectively working plan" for placement of persons with mental illness in "less restrictive settings" (an "*Olmstead* plan") and a "waiting list that moved at a reasonable pace." 527 U.S. at 605-606.

270. While this Court concluded on summary judgment that an *Olmstead* plan is not a *requirement* in order for the state to mount a fundamental alteration defense, "[a] state's efforts to comply with the integration mandate with respect to the population at issue are nonetheless an important consideration in determining the extent to which the request relief would be a permissible 'reasonable accommodation' or an impermissible 'fundamental alteration.'" *Disability Advocates*, 598 F. Supp. 2d at 339, citing *Martin* v. *Taft*, 222 F. Supp. 2d 940, 985-86 & n.42 (S.D. Ohio 2002). Moreover, the Court agrees with the Third Circuit's view that a state *must* make efforts to comply with the integration mandate in order to show that specific relief requested would be too costly. *Disability Advocates*, 598 F. Supp. 2d at 339 ("If a state does not make a genuine attempt to comply with the integration mandate in the first instance, it cannot establish that compliance would be a fundamental alteration of its programs and services . . . .") citing *Pennsylvania Protection and Advocacy, Inc.* v. *Pennsylvania Dep't of Pub. Welfare*, 402 F.3d 374, 381 (3d Cir. 2005).

271. Finally, as this Court concluded on summary judgment, "[w]here 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; *see also Messier* v. *Southbury Training School*, 562 F. Supp. 2d 294, 345 (D. Conn. 2008) (holding that where community placement can be accommodated through existing programs, it would not be a fundamental alteration to require the state to assess class members for determination whether they were appropriate for those programs).

272. After considering all of the evidence in this matter, for the reasons described below, the Court finds that the State has not shown that the relief DAI seeks would amount to a fundamental alteration of its policies, practices, or procedures or that immediate relief would be inequitable to others.

1. Defendants Do Not Have an *Olmstead* Plan to Enable Adult Home Residents to Receive Services In Integrated Settings

273. The evidence at trial established that defendants do not have an *Olmstead* plan to enable DAI's constituents to receive services in the most integrated setting appropriate to their needs. To the contrary, defendants have routinely and systematically excluded Adult Home residents from their efforts to comply with the integration mandate. (*See supra* ¶¶ 168-195.)

274. Courts have made clear that an *Olmstead* plan must communicate a commitment to integration "for which [the state] can be held accountable by the courts." *Frederick L.*, 364 F.3d 487, 500 (3rd Cir. 2004). "General assurances" and expressions of "good faith intentions" are not enough. *Frederick L.* v. *Dep't of Pub. Welfare*, 422 F.3d 151, 158 (3d Cir. 2005). Instead, an *Olmstead* plan must set forth "reasonably specific and measurable targets for community placement." *Id.* It must, "at a bare minimum," specify four things: "(1) the time-frame or target date for placement in a more

integrated setting; (2) the approximate number of patients to be placed each time period; (3) the eligibility for placement; and (4) a general description of the collaboration required between the local authorities and the housing, transportation, care, and education agencies to effectuate integration into the community." *Id.* at 160; *see also Olmstead*, 527 U.S. at 605-06 (describing a plan as a "comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that move[s] at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.").

275. As described *supra*, Section V (¶ 169), no witness testified at trial concerning *any* plan to enable Adult Home residents to move to more integrated settings, much less a plan that contains the legally required components described above. To the contrary, defendants do not even believe an *Olmstead* plan is necessary for Adult Home residents because they believe Adult Homes already provide permanent, integrated housing. (*See* ¶¶ 169-183.) Consistent with that view, the Most Integrated Settings Coordinating Council ("MISCC"), a state entity whose statutorily mandated purpose is "to develop and implement a plan to reasonably accommodate people of all ages with disabilities … to be appropriately placed in the most integrated settings possible," has no plan that covers Adult Home residents. (*See supra* ¶¶ 171-172.)

276. At trial, defendants presented testimony from various State officials describing various activities conducted by their respective agencies and divisions, many of which had no apparent connection to Adult Home residents, nor any connection to enabling DAI's constituents to receive services in the most integrated setting appropriate to their needs. (*See* ¶¶ 173-174, 184-195.)

277. A few defense witnesses discussed the development of community housing beds, including supported housing beds. (*See supra*, ¶¶ 175-176.) The evidence demonstrated, however, that Adult Home residents have been systematically excluded from the vast majority of those beds. (*See* ¶¶ 177-183.) Despite their inclusion as a target population for supported housing (for the first time) in 2005, Adult Homes residents continued to be denied access to the program because other populations of mentally ill persons received higher priority. (*See* ¶¶ 178-179.) Excluding the 60 supported housing units allocated to Adult Homes residents by the New York Legislature, only a handful of other Adult Home residents have been able to obtain supported housing. (*See supra*, ¶ 181; P-149.) Additionally, it now appears that Adult Home residents have been once again excluded from newly developed supported housing beds. (*See supra* ¶ 180; P-748 (2009 RFP.) Thus, while the State has developed a number of supported housing beds in recent years, because Adult Home residents have not been afforded meaningful access to those beds, those efforts cannot realistically be considered part of a commitment or *Olmstead* plan designed to enable Adult Home residents to receive services in the most integrated setting appropriate to their needs.

278. Defendants also presented evidence about certain programs they license and/or fund, such as case management, the EnAbLE program, continuing day treatment programs, and mental health clinics, arguing that those programs teach Adult Home residents independent living skills. (*See supra*, ¶¶ 185-194.) The evidence showed, however, that these programs suffer from serious deficiencies and have not meaningfully aided Adult Home residents to move to more integrated settings.

279. Continuing day treatment programs, for example, are, by the State's own admission, "outdated," ineffective, and wasteful. ((Tr. 3318:7 (Schaefer-Hayes); Tr. 1380:9-1382:20 (Reilly); *see also supra* ¶ 25) The State made no real effort at trial to demonstrate that CDTs or clinics had any effect at all on enabling Adult Home residents to move to more integrated settings.

280. Defendants also put on evidence at trial about OMH's Case Management Initiative, which it rolled out in 2002 and has gradually expanded to eleven of the homes at issue in this litigation. (*See supra*, ¶¶ 186-190.) The Case Management Initiative has obvious shortcomings, including the fact that it is not present in all of the homes at issue in this litigation and in fact, does not even reach all of the residents in the homes it is in. (*See supra*, ¶ 190.) Most importantly, there was no evidence at trial that the Case Management Initiative has been effective at assisting Adult Home residents to move to more integrated settings. (*See supra*, ¶ 187.)

281. Finally, the State argues that its EnAbLE program is also designed to, among other things, teach Adult Home residents independent living skills. (*See supra*, ¶ 191.) With grants from the EnAbLE program, a small number of Adult Homes have installed teaching laundry rooms and kitchens, and purchased vans to take residents to community activities. (*Id.*) No evidence was adduced at trial, however, that showed that the program has actually been effective at teaching residents independent living skills. (*See supra*, ¶ 192.) Moreover, experts for both parties agree that independent skills training is effective only if recipients of the training have a meaningful opportunity to exercise such skills in real-life situations (*See supra* ¶¶ 193-194; Tr. 65:14-69:11 (E. Jones); Tr. 2360:9-2361:1 (Geller)). The State was unable to say whether *any* Adult

Home resident in any one of the Adult Homes to receive grants under the EnAbLE program had moved to more integrated settings as a result of the program. (Tr. 1717:5-13 (Wollner).)

282. The Court is unpersuaded that these programs and initiatives, singly or collectively, amounts to an *Olmstead* plan for Adult Home residents. Even if these programs are viewed as *some* effort by the State to comply with the integration mandate, they are a far cry from an effective *Olmstead* plan.

283. Because the State has not made a genuine attempt to comply with *Olmstead*'s integration mandate with regard to Adult Home residents, it cannot establish that compliance would be a fundamental alteration of its programs and services. *See Disability Advocates,* 598 F. Supp. 2d at 339. For that reason alone, its defense fails.

2. The Relief DAI Seeks Would Cost No More Than Defendants' Current System and Would Not Adversely Affect Defendants' Other Constituents

284. Even if the State had genuinely attempted to comply with *Olmstead*'s integration mandate, the State's fundamental alteration defense would nonetheless fail because the requested relief here would cost no more than the manner in which DAI's constituents are currently being served.

285. The fundamental alteration standard set forth under *Olmstead* permits a state to show 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." *Olmstead*, 527 U.S. at 604. In considering the resources available to the State, the relevant budget is the "mental health budget," which includes any money the State

receives, allots for spending, and/or spend on services and programs for individuals with mental illness. *Disability Advocates*, 598 F. Supp. 2d at 350. That means that for purposes of this case, the resources available to the State include funds that OMH, DOH, the Governor, or the Legislature spend on persons with mental illness. The analysis includes not only current spending on mental health services and programs, but also savings that will result if the requested relief is implemented. *Id.*

286. Defendants have the burden of demonstrating by a preponderance of the evidence that the relief DAI seeks on behalf of Adult Home residents would inequitably affect the allocation of resources among defendants' other constituents. This they have not done. Neither defendants nor their experts conducted a sufficient analysis of the financial impact of the relief sought by DAI. (*See supra* Section VI (¶¶ 196-97).)

287. The perfunctory cost analysis presented by the State failed to consider a number of costs associated with providing services to people with mental illness residing in Adult Homes, including Medicaid costs. (*See supra*, ¶¶ 202-214.) If the cost of Medicaid services for individuals in Adult Homes and supported housing is considered, the cost to the State of serving an Adult Home resident in supported housing is on average actually $146 *cheaper* than the cost of serving that resident in an Adult Home. (P-773; *see also supra* ¶¶ 212-214.)

288. DAI also demonstrated that in addition to the savings to be realized in Medicaid costs if Adult Home residents moved to supported housing, there are millions of dollars currently being spent by the State on programs and services for Adult Homes that the State also failed to consider in its analysis. (*See supra*, ¶¶ 215-26.) For example, the State has spent more than $28 million on the QuIP program, which is used to fund

capital improvements in adult homes. (*See supra*, ¶¶ 216-218.) In addition, many millions of dollars have been spent on the Infrastructure Capital Program, the EnAbLE program, on air conditioning for homes, and on the Case Management Initiative. (*See supra*, ¶¶ 220-221.) Although these costs are not as easily analyzed on a per person basis, clearly any savings that could be realized in these programs as a result of the movement of Adult Home residents to supported housing would also lead to substantial savings to the State.

289. Upon the review of all the facts and opinions related to the cost of the proposed relief in this case, the Court finds that it would cost the State no more to serve Adult Home residents in supported housing, and indeed will likely cost less. Accordingly, implementation of the relief will not interfere with defendants' ability to serve other individuals with mental illness.

3. The Relief DAI Seeks Would Not Alter the Nature of the Services that Defendants Currently Provide

290. Finally, the relief DAI seeks—access to supported housing for residents of Adult Homes—clearly would not alter the nature of the services defendants currently provide. (*See supra*, ¶¶ 227-229.) That DAI is seeking access to an existing program is not, in and of itself, a fundamental alteration. As this Court concluded on summary judgment, "[w]here 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, Inc.*, 598 F. Supp. 2d at 336; *Messier*, 562 F. Supp. 2d at 345.

291. Nor does the argument that such relief would require a "set-aside" of supported housing beds for Adult Home residents render it a fundamental alteration of the State's programs. Defendants regularly use set-asides to allocate supported housing beds to particular target populations (including homeless individuals with mental illness and individuals with mental illness discharged from prisons, from psychiatric facilities, and in one instance, Adult Home residents). (*E.g.* Tr. 1460:8-24 (Madan); S-145 (2008 RFP.) As this Court held on summary judgment: "That Defendants have already issued a set-aside of supported housing beds for adult home residents and other target populations is evidence that doing so is not a 'fundamental alteration' of their programs and services. *Disability Advocates,* 598 F. Supp. 2d at 355-56; *see also Messier*, 562 F. Supp. 2d at 344-45 (noting that defendant agency's "public commitment to further enhancing a system of community placement" was "entirely inconsistent with its fundamental alteration claim.").)

292. In sum, the evidence at trial established that (1) DAI's constituents are not in the most integrated setting appropriate to their needs; (2) virtually all of DAI's constituents are qualified for supported housing; and (3) the relief sought by DAI will not work a fundamental alteration of the State's mental health service system.

CONCLUSION

293. The injuries experienced by DAI's constituents are immediate and severe. As a direct result of defendant's long-standing policies and practices, thousands of people with mental illness have been, and remain, unnecessarily segregated in the institutional settings of Adult Homes. (*See supra* Section I.) DAI's constituents have been subjected to isolation and stigma, and relegated to settings that foster dependence and impede the

opportunity to become participating members of their communities and to realize their full potential. (*Id.*) Entry of judgment in favor of DAI is warranted.

294. The Court has thoroughly reviewed the record in this case to identify the actions necessary to afford DAI's constituents adequate and timely relief. It has considered, among other evidence, the testimony of DAI's expert, Dennis Jones, the former Commissioner of Mental Health in the States of Indiana and Texas, the testimony of Linda Rosenberg, the former Senior Deputy Commissioner of the Office of Mental Health in New York State, and the testimony of State employees and mental health service providers concerning the process of developing supported housing beds and the designation of priority populations. (Tr. 1038-39, 1069-71, 1092, 3467, 3485 (D. Jones) (describing the importance of a clear process, timeline and plan; attention to the commitment of resources; in-reach into Adult Home to build trust, ensure accurate information, and conduct housing assessment; and expansion of housing); Tr. 697-698 (Rosenberg) (describing a process for identification of residents and housing providers, and education about supported housing and its benefits); (Tr. 1275-1283 (Reilly) (describing the process of facilitating the transfer of Adult Home residents to other settings when an Adult Home closes); (Tr. 1511, 1531 (Madan) (describing the RFP process and the number of supported housing providers who applied to serve Adult Home Residents).) The Court concludes that the following relief is necessary to protect the rights of DAI's constituents and to remedy the existing violations of their rights.

295. Judgment will be entered for DAI. The Court will issue a permanent injunction, directing defendants to take such steps as are necessary to enable DAI's constituents—people with mental illness residing in, or at risk of entry into, all impacted

adult homes in New York City with more than 120 beds—to receive services in the most integrated setting appropriate to their needs. These steps shall include the expansion of supported housing and the end to practices that steer individuals with mental illness into Adult Homes instead of supported housing.

296. The injunction will issue against the Office of Mental Health, the Department of Health, and the individual defendants in their official capacities. Concerted action by all defendants is needed to ensure adequate relief.

297. Defendants shall have 90 days to develop a plan that will enable DAI's constituents to receive services in the State's supported housing program. The plan will be finalized as provided in paragraph 298 below.

298. The plan shall contain and describe the following elements:

(a) *Goal of plan and period of transition.* The Court recognizes that it will take time to remedy the legal violations found by the Court. The Court has determined that four years is a reasonable and sufficient time for defendants to correct these violations. Accordingly, the plan will ensure that, within four years of its approval: (i) all current Adult Home residents who desire placement in supported housing have been afforded such a placement if qualified, (ii) all future Adult Home residents who desire placement in supported housing are afforded such a placement if qualified, and (iii) no individual who is qualified for supported housing will be offered placement in an Adult Home at public expense unless, after being fully informed, he or she declines the opportunity to receive services

in supported housing. "Future Adult Home residents," for purposes of this paragraph, includes both individuals admitted to the Adult Homes during the four year transition period and individuals admitted to the Adult Homes after the four year transition period who desire placement in supported housing.

(b) *Duration of plan*. Defendants' obligation to operate their service system consistent with paragraph (a) shall be permanent and ongoing. Such persons who initially decline the opportunity to receive services in supported housing will have their preferences regularly reviewed pursuant to paragraph (h) of this order.

(c) *Expansion of supported housing*. Defendants will develop at least 1,500 supported housing beds per year until such time as there are sufficient supported housing beds for all DAI constituents who desire such housing. The plan will ensure that no fewer than 4,500 supported housing beds are developed. The Court is persuaded that, over time, at least 4,500 DAI constituents who qualify for supported housing will chose to receive services in supported housing. The plan will describe steps to be taken to ensure that, when current residents move from Adult Homes, the Homes will not be refilled with similar individuals who, if fully informed, would choose instead to receive services in supported housing.

(d) *Supported Housing Providers*. Supported housing providers will be identified and awarded contracts to: provide scattered site supported housing and supports, secure residents of such housing access to needed services, and conduct in-reach to residents of Adult Homes. For some DAI constituents, needed services will include Assertive Community Treatment (ACT).

(e) *Eligibility for supported housing*. DAI's constituents shall be treated as qualified for supported housing, unless they have one of the following specific characteristics: severe dementia, a high level of skilled nursing needs that cannot be met in supported housing with services provided by Medicaid home care or waiver services, or are likely to cause imminent danger to self or others. If a constituent has one of the foregoing characteristics, they will nonetheless be treated as eligible for supported housing if, upon an assessment by a supported housing provider, the assessor has determined that they could be served successfully in supported housing.

(f) *Educating DAI's constituents about supported housing*. Defendants shall require case managers, clinicians, adult home staff and others who discuss housing options with DAI's constituents to accurately and fully inform them about supported housing, its benefits, the array of services and supports available to those in supported housing, and the SSI**,** rental subsidy, and other income they will receive while in supported

housing. Defendants shall carefully monitor whether DAI's constituents are being pressured to refrain from exploring alternatives to adult homes, and, if so, take corrective action.

(g) *Transition to supported housing*. Once supported housing providers have been selected, they will conduct in-reach in the Adult Homes to build trust and actively support DAI's constituents in moving to supported housing, including explaining fully the benefits and financial aspects of supported housing and accompanying DAI's constituents on visits to supported housing apartments. The supported housing providers will assess constituents' interests in supported housing and, for those interested, identify, develop and provide the services needed for a successful transition to supported housing.

(h) *Reviewing housing preferences on a regular basis*. For any DAI constituents who express opposition to, or ambivalence about, moving to supported housing, defendants will ensure that supported housing providers review the individuals' preferences frequently and that the reasons for individuals' opposition are explored and addressed.

(i) *Detailed description of the responsibilities of the different State agencies in carrying out the plan*. The plan will include a detailed description of the responsibilities of each of the defendants in carrying out

the plan, including the development of inter-agency agreements, requests for proposals and funding necessary to implement the relief.

(j) *Timeline for accomplishing all aspects of the plan.* The plan will include timelines for accomplishing all tasks.

299. The Court will appoint an independent and impartial Special Master who is experienced in the development, management, and oversight of community programs serving people with mental illness, including supported housing. *See* Fed. R. Civ. P. 53. The Special Master shall be compensated by the defendants at a rate to be set by the Court. Within 20 days of this Order, the parties shall submit to the Court their joint recommendation or separate nominations for a Special Master. The parties shall endeavor to agree on a single candidate for Special Master. If the parties cannot agree, plaintiff and defendants shall each submit to the Court the names of no more than two qualified professionals or organizations. Each party will have seven days to comment on the qualifications of the other party's candidate, following which the Court shall then select the Special Master from the names submitted by the parties.

300. The duties and powers of the Special Master will be detailed in an order accompanying the Special Master's appointment. The duties shall include monitoring defendants' compliance with this Order, identifying potential areas of non-compliance, facilitating the resolution of compliance issues without Court intervention, and recommending appropriate action by the Court in the event an issue cannot be resolved by discussion and negotiation among the Special Master

and the Parties. When the parties submit their nomination(s) for Special Master, they shall also submit to the Court a joint proposed order or separate proposed order detailing the duties and powers of the Special Master.

301. No less than every sixty days, defendants shall provide the Special Master, plaintiff and plaintiff's counsel with a detailed report containing data and information sufficient to evaluate defendants' compliance with the Order. The report shall contain, among other components, information describing, (a) the number of DAI constituents offered supported housing, (b) the number of DAI constituents who have accepted supported housing, (c) the identity of the supported housing providers serving such individuals and providing in-reach to adult home residents, (d) reasons why DAI constituents, if any, declined supported housing, (e) in-reach efforts, (f) the number of new admissions to each Adult Home and source of payment, and (g) the current census of each Adult Homes. The Special Master shall file twice a year reports with the Court to enable the Court and plaintiff to evaluate defendants' compliance or non-compliance with the Order. The Special Master may file additional reports as necessary, and reports of the Special Master shall be served on all parties.

302. Within 90 days of this Order, defendants shall provide the Special Master, plaintiff and plaintiff's counsel with a draft of the plan. Within 30 days of receipt, the Special Master and plaintiff will comment on the sufficiency of the plan to ensure adequate relief. If the Special Master or plaintiff raises concerns about the sufficiency of the plan, the parties, with the aid of the Special Master, shall try to resolve these concerns. If the concerns have not been resolved within six months

of the date of this Order, the matter shall be submitted to the Court, along with a recommendation from the Special Master.

303. The plaintiff shall be awarded attorneys' fees and costs. 42 U.S.C. § 12205 (2006); 29 U.S.C. § 794a(b) (2006). The parties are directed to confer and submit to the Court a briefing schedule for DAI's fee application.

304. All of the foregoing constitutes the Court's findings of fact and conclusions of law. To the extent that the factual recitals also constitute legal conclusions and to the extent legal conclusions also constitute factual recitals, such recitals, findings and conclusions will be so construed.

Dated: July 13, 2009

Respectfully submitted,

By: /s/ Anne S. Raish

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