UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

Original Filed By ECF

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DISABILITY ADVOCATES, INC.,

Plaintiff,

- against -

ELIOT SPITZER, in his official capacity as Governor of the State of New York, RICHARD F. DAINES, in his official capacity as Commissioner of the New York State Department of Health, and MICHAEL F. HOGAN, in his official 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 CV 3209 (NGG) (MDG)

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MEMORANDUM OF LAW IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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Preliminary Statement

This memorandum of law is respectfully submitted on behalf of defendants, the Governor of the State of New York, the Commissioners of Health and Mental Health, and the Department of Health and the Office of Mental Health, in support of their motion for summary judgment.

In this action, Disability Advocates, Inc., an organization purportedly suing on behalf of at least 2,000 residents of privately owned and operated adult homes in New York City, claims that the State agencies are discriminating against these residents on the basis of their mental disability, in violation of the Americans with Disability Act and the Rehabilitation Act. Specifically, plaintiff alleges that residents who live in adult homes that have over 120 beds and more than 25% or 25 residents with mental disabilities are not in the most integrated setting appropriate to their needs, and that defendants have discriminated against them by "failing to take adequate measures to redress continued poor conditions in ... adult homes [serving individuals with mental disabilities] that, upon information and belief, they do not tolerate in adult homes that primarily serve individuals with physical disabilities."

Plaintiff's complaint is based on alleged conditions in these private homes and the conduct of the staff of these private homes. This case is therefore nothing more than a tortured attempt to transform some alleged problems with the quality or effectiveness of services at some adult homes into a claim of disability discrimination by the State. While the State agency defendants have long been committed to ensuring good conditions and services for adult home residents and have vigorously enforced the law where appropriate, the issues cited in the complaint simply do not constitute disability discrimination. Moreover, the undisputed evidence will show that adult home residents are living in integrated settings, as they are free to come and go from the facility, and many do so regularly and are actively involved in their surrounding communities. The fundamental deficiencies in plaintiff's case are further demonstrated by the fact that plaintiff has failed to come forward with any acceptable proof that a single resident is

"qualified" to live in the alternative housing that plaintiff apparently seeks on their behalf. Finally, even assuming plaintiff's claims are not fatally flawed for these reasons, to require New York State to allocate thousands of units of more expensive housing exclusively for adult home residents would fundamentally alter the State's programs, services and activities, and would unfairly re-direct scarce resources to this one group, to the detriment of the many other groups of individuals with mental disabilities who desperately need this housing.

Statement of Facts

I. Statutory and Regulatory Framework Governing Adult Homes and Relevant Aspects of the Mental Health System

A. Adult Homes

Adult homes, one of five types of adult care facilities ("ACFs") licensed by the State of New York, are authorized to provide "long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator." 18 NYCRR § 485.2(b), 487.2(a).[1] The homes at issue in this action are operated by private individuals or entities. Adult homes are residences, not medical facilities, providing rooms (often shared by two persons, but sometimes occupied by one person), meals, housekeeping and laundry services, assistance with self-administration of medications, and some assistance with personal needs such as grooming and dressing. There is 24 hour staff on site. Affidavit of Mary E. Hart ¶ 7.

The Department of Health does not own or operate the homes, but serves as a licensing and oversight agency. DOH issues operating certificates for adult homes, in the course of which it reviews whether the proposed operator has the character and competence to operate a facility. Id. § 485.6. Once a certificate is granted, DOH conducts at least one unannounced full inspection every 18 or 12 months, depending on the facility's record. Social Services Law §

[1] The other types of ACFs are enriched housing programs, residences for adults, shelters for adults, and family-type homes for adults. Id. 485.2 (c - f).

461-a(2)(a). DOH then issues an inspection report, and the facility is required to correct any violations or submit a plan of correction describing how it will correct the violations. 18 NYCRR §486.2(h-j). DOH may bring enforcement proceedings to assess civil fines, or to suspend, modify, limit or revoke an operating certificate. Id. §486.4. For most violations, no enforcement action may be taken if the facility corrects the violations within 30 days. DOH also has the authority to seek appointment of a receiver to take over operation of the facility, id. § 485.9, and to temporarily suspend an operating certificate or order that conditions be immediately remedied when residents are in imminent danger. Id. § 486.4 (b) (5-6). DOH operates a complaint hotline, and investigates complaints about adult homes. Finally, in the event that an operator elects to close an adult home, the operator must submit a closure plan to DOH for its approval. Id. § 485.5(j). DOH oversees the closure to ensure the continuation of adequate services pending closure and the safe and orderly transition of residents to alternative settings. Hart Aff. ¶¶ 37-38.

State regulations address many areas of adult home administration and operation, including resident rights, the number and qualifications of staff, and physical and environmental standards. For example, the regulations provide that residents have the right to private written and verbal communications with anyone of their choice, to manage their own financial affairs, to organize with other residents or individuals to work for improvements in adult homes, and to present grievances without fear of reprisal. 18 NYCRR § 487.5. In particular, residents have the right to "leave and return to the facility and grounds at reasonable hours." Id. § 487.5(a)(3)(xii).

Adult homes are required to provide case management services "as are necessary to support the resident in maintaining independence of function and personal choice," including "assisting each resident to maintain family and community ties and to develop new ones, encouraging resident participation in facility and community activities" and "assisting residents

in need of alternative living arrangements to make and execute sound discharge or transfer plans." Id. § 487.7(g). Adult homes are also obligated to provide a program of activities in the facility as well as in the community, and must "arrange for resident participation in community-based and community-sponsored activities." Id. § 487.7(h).

In adult homes in which at least 25 percent of the residents or 25 residents, whichever is less, have mental disabilities, often referred to as "impacted" homes, the home must ensure that the residents are linked to appropriate mental health services by entering into a written agreement with a provider of mental health services "for assistance with the assessment of mental health needs, the supervision of general mental health care and the provision of related case management services for those residents enrolled in mental health programs." Id. § 487.7(b). Many homes have mental health clinics or continuing day treatment programs operating on-site, but many residents also receive services or attend programs elsewhere.

B. Mental Health Services Available to Adult Home Residents

For decades, New York State has established and supported a wide array of community support services, including continuing day treatment programs, clinics, family support services and programs, supported employment, sheltered work programs, clubhouses, and other programs intended to enable individuals with mental illness to function in the community. See generally MHL §§ 41.03 (defining community support services); 41.42 (family support programs); 41.39 (vocational programs and sheltered workshops). See also 14 NYCRR §§ 575, 587.

Pursuant to Article 31 of the New York State Mental Hygiene Law, OMH has the authority and the responsibility to set standards for the quality of the programs that provide mental health services. The standards governing the operations of the programs are contained in various sections of Title 14 of the NYCRR. A provider of services is required to obtain an operating certificate (license) issued by OMH prior to the operation of such a program. MHL

§§ 31.22, 31.23; 14 NYCRR Part 551. OMH is then responsible for ensuring compliance with standards and determining whether to renew the providers' certificates. OMH periodically reviews the mental health providers using "Tiered Certification" which is a licensing method based on site visits, performance criteria, scoring guidelines, compliance history and a uniform process for notification and sanctions. See Affidavit of James B. McQuide; Affidavit of Robert Myers ¶¶ 120-24; Deposition of Robert Abel at 46-53. One area considered when a mental health provider's certificate is being reviewed is whether the provider has discussed housing goals with the adult home resident, including whether he or she wants to move to alternative housing. "It is my expectation that every primary therapist brings up the topic of how they [adult home resident] like where they are living. Have they thought of other possibilities? Did they ever want to live in another venue?" Abel Dep. at 102. See also Affidavit of Joseph J. Reilly ¶¶ 25-29; Abel Dep. at 103-109.

OMH's community support services are available for all individuals with mental illness, including residents of adult homes. See Myers Aff, ¶¶ 35, 98-99, 104-05, 116, 133; Affidavit of Keith Simons ¶ 39; Affidavit of Jonas Waizer, Ph.D. ¶¶ 53-55. Most such services are provided by non-profit mental health providers, certified by OMH, although some adult home residents receive services by continuing day treatment programs and clinics operated by State Psychiatric Centers. Under governing regulations, 14 NYCRR § 587.10(d), continuing day treatment programs ("CDTs") are required to offer the following services, among others: Medication education, rehabilitation readiness development, and psychiatric rehabilitation readiness determination and referral. See Reilly Aff. ¶ 33. Many of the programs attended by adult home residents teach or reinforce skills that foster independence, such as grooming, medication education, vocational training, money management or budgeting classes, computer skills,

shopping, cooking and GED classes.[2]

The mental health providers work with the residents to create personalized, goal-oriented treatment plans involving specific social, employment, educational or other goals, which may include moving to another type of housing. See 14 NYCRR §§ 587.4, 587.8. The mental health providers also inform residents about alternative housing options consistent with their needs and desires, including supported housing options and other housing programs for persons with mental illness.[3] To the extent that a resident's goal is to move out of adult homes, he or she can discuss that goal with mental health providers. The providers will assist residents who are interested in moving to alternative housing by, among other things, completing the forms that are necessary for such a move.[4] See Affidavit of Jan Tacoronti ¶¶ 31-34.

C. Housing for Persons with Mental Illness[5]

OMH licenses and funds a variety of housing and has long been committed to developing additional housing. OMH works with not-for-profit organizations to develop housing units for persons with serious and persistent mental illness ("SPMI"). Through a request for proposal ("RFP") process, OMH provides development, capital and operating funding to not-for-profit sponsors to create opportunities for persons with mental illness to access a range of quality, affordable housing. OMH funds a variety of licensed residential programs, which have a range of rehabilitative services. OMH also funds unlicensed supported housing through a subsidy to cover rent and minimal services. The different types of housing vary in their costs and in the

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[2]Bear 24-29; Levine 32-34; Lockhart 88; Rosado 108-13, 156-60. Affidavits will be cited by the witness's name and "Aff. ¶ __," Depositions, which are attached to the declarations of Scott J. Spiegelman, will be cited by the witness's name and page number or by "Dep. at __." Adult home residents are referred to by initial.

[3]Bear 53-54; Levine 31-32, 181; Lockhart 25-28, 48-50, 181-82.

[4]Levine 72-74; Lockhart 25-26, 190-191; Waizer Aff. ¶¶ 66-67

[5]Any and all types of housing funded or licensed by OMH will be referred to as "Housing for Persons with Mental Illness" or "Housing Programs".

services provided. Licensed Housing Programs include: 1) congregate treatment programs, commonly referred to as group homes or supervised community residences, 2) apartment treatment programs and 3) community residence-single room occupancy ("CR-SRO"s) programs. See generally Affidavit of Michael Newman & Exs. C, I, J.

Congregate treatment or group homes are transitional, rehabilitative programs. They are single-site facilities for up to 48 individuals, and are highly structured, providing three meals a day, as well as on-site rehabilitative services and 24 hour staff coverage. OMH provides the highest level of service funding for this type of housing. Apartment treatment programs provide transitional housing in shared apartments which usually house two to four people. Apartment Treatment sites can be scattered-site units or may occupy the entire building - i.e., the rest of the building also houses individuals with mental illnesses. In apartment treatment, residents usually do their own cooking and other household chores such as shopping, cleaning and laundry, and they receive variable levels of supervision based on their individual needs. CR-SRO programs provide extended stay housing in which residents have their own rooms designed as studio apartments or as suites with single bedrooms around shared living spaces. CR-SROs are usually located in one building and may have up to 100 beds. There is 24 hour front desk security, and required services are provided on-site (i.e., case management, life skills training). The services provided are fewer than those provided in congregate treatment or apartment treatment. See Affidavit of Christine Madan ¶¶ 6-10; Newman Aff. ¶¶ 28-33; Ex. Tacoronti-B. Many Housing Programs have admission criteria specifying, for example, a required period of sobriety prior to admission. Many also have "house rules" covering a number of subjects, such as curfews and visiting hours. Madan Aff. ¶ 12 & Exs. A&B; Bear Dep. at 96 & Exs. 9, 11.

OMH also funds supported housing, which is not licensed by OMH. Supported housing is the least expensive type of housing and offers far fewer services than licensed Housing

Programs. This housing is designed for the most independent individuals, who need only minimal support. The types of supported housing include (1) single site housing (such as single room occupancy (SP-SRO) or single site apartments); and (2) scattered-site housing. Single site supported housing is similar to SROs in that there are a number of apartments within one building, all occupied by persons with SPMI. For scattered-site supported housing, the non-profit provider rents apartments in various buildings throughout the community. There is no staff in the apartment and there are no on-site programs in this type of housing. Supported housing is designed for individuals who are capable of living independently and taking care of their personal needs with minimal support. Newman Aff. ¶ 38 & Exs. H & J at 4. The services which are included "with" the housing, and part of the same funding stream, are primarily housing-related services designed to make sure the person is able to stay in the apartment, such as negotiating issues with the landlord and assisting the person to navigate in the community. A scattered-site supported housing resident would typically be visited by a staff person only a few times per month, and possibly only once a month. Madan Aff. ¶ 10; Bear Dep. at 108. As in all Housing Programs, other services, such as mental health and medical treatment, are provided and funded separately.

Over the years, OMH has devoted increasingly large amounts of funding to developing Housing for Persons with Mental Illness. For example, since 1995, OMH funded housing has expanded from 18,940 units to more than 26,700 units in 2003. This represents more than a 67% increase. And, OMH is strongly committed to the development of additional units of Housing for Persons with Mental Illness. For example, in the 2003-2004 budget OMH's appropriation of $65 million of capital funds will be used to develop 600 beds. Newman Aff. ¶ 19. In the 2004-2005 budget, OMH budget received $75 million dollars to develop a number of beds. Id. ¶ 20.

Individuals with mental illness seeking Housing for Persons With Mental Illness must

apply by submitting an application, referred to as the HRA 2000, to the New York City Human Resources Administration ("HRA"). The HRA 2000 is accompanied by other documents including a comprehensive Psychosocial and a current Psychiatric Summary. HRA reviews each application and determines if an individual is eligible and, if so, for what level of housing.

OMH allocated funding for a Single Point of Access ("SPOA") system to identify, prioritize, and address individual case management and housing needs, particularly for difficult to serve clients. The main goals of SPOA are to improve the coordination of housing placement, and assure access to, and use of, appropriate services. Myers Aff. ¶ 52. SPOA also seeks to collect data on applicants and the application process.

In New York City, SPOA uses a database created by the Center for Urban Community Services (CUCS). The database includes information about the services offered by the housing programs, as well as intake criteria and the residence rules and requirements. CUCS also maintains a list of vacancies in the various Housing Programs. Myers Aff. ¶ 175. Although an application may be submitted directly to HRA without going through CUCS, if the application is sent to CUCS, CUCS will set up at least three interviews with housing providers for the applicant.

D. State Psychiatric Centers

The New York State Office of Mental Health operates 19 State adult psychiatric centers, three of which serve forensic patients. Over the last forty years , the census in the state psychiatric centers has decreased, as the emphasis on recovery in the community increases. Myers Aff. ¶¶ 152-56. During the 1950s, New York State Psychiatric Centers operated with a total inpatient census of approximately 93,000. By 1998, the inpatient census had fallen to 5,309. Currently, the 16 non-forensic adult psychiatric centers, most of which are located on large campuses with high security, have a total inpatient census of less than 4,200. Affidavit of

Lewis Campbell ¶¶ 9-10 & Ex. A at 9-10.

Unlike adult homes, in a psychiatric center, a patients' activities are highly structured and movements are closely monitored. For example, a patient's ability to access different parts of the hospital and its grounds, as well as the community outside of the hospital, are tightly controlled according to the level of privileges a patient has attained. Upon admission and on an ongoing basis thereafter, patients are assessed to determine their appropriate privilege level. The granting of privileges is individualized, as determined by the facility's clinical staff. Each psychiatric center has implemented its own facility wide system for establishing privileges for patients. See Campbell Aff. ¶ 12 & Exs. B-D. For example, at Bronx Psychiatric Center, some patients may be restricted to the ward if they are acutely suicidal, dangerous to others, recently admitted under the Criminal Procedure Law ("CPL"), or a serious elopement risk. See Ex. Campbell-B at 2. Patients may receive increased privileges, including permission to attend "in-building" scheduled activities without an escort. Patients may then receive out-of-building privileges, which would permit them to leave the premises unescorted for a specified period of time. Campbell Aff. ¶ 13. Moreover, in marked contrast to adult homes, even a voluntary patient must give notice of his or her intent to leave the hospital, and the patient is not released if clinical staff determines that the patient needs hospitalization. Campbell Aff. ¶ 15.

The discharge planning process is a critical aspect of patient care, which begins at admission and continues throughout the patient's stay. From the day of admission a patient's independent living skills are evaluated along with a plan for community re-integration. The psychiatrists, psychologists, social workers, nurses, and rehabilitation specialists and all other professionals involved in the patient's care examine the strengths and limitations of a patient's ability to perform activities of daily living (ADLs), home management skills, and leisure and recreational skills, as well as his or her ability to transfer these skills to a community setting and

function independently. Discharge planning requires a written service plan that addresses many of the patients' needs including, but not limited to, a recommendation of the type of residence in which the patient should live and a list of services available to the patient in such residence. MHL 29.15(g)(2). Patients discharged from psychiatric centers are not permitted to be referred to any Adult Home that is on the DOH "Do Not Refer" list. Discharges to Adult Homes from NYS State Hospitals and Transitional Living Residences in the New York City area declined from 527 in 1995 to only 58 in 2005. The percent of Adult Home discharges has declined from about 11 percent in 1995 to less than four percent in 2005. Campbell Aff. ¶ 21 & Ex. O.

II. Undisputed Facts Concerning New York City Adult Homes

A. Adult Homes

1. Adult Home Residents Move To The Homes From A Variety of Settings

Adult home residents come to live in adult homes from a wide variety of venues. Many come from private hospitals, the New York City shelter system, other adult homes or other types of housing, or from their families' homes. Burstein Dep. at 108-10; Younger Dep. at 117. Contrary to the allegations in the Complaint, in recent years only a very small percentage of residents have been referred from State Psychiatric Centers. In fact, since 2003, less than 5% of the patients discharged from New York City area State hospitals have gone to adult homes. Campbell Aff. ¶ 21 & Ex. O.

2. Adult Home Residents Are Part of The Community

Adult homes are located in the community in residential areas, close to stores, restaurants, religious institutions, libraries, parks and/or beaches and boardwalks, and public transportation.[6] Residents are free to come and go from the home as they please, subject to

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[6] Burstein 9-10; Davis 107-09; Mendel 18-19, 75; Yunger 23, 39-41; P.B. 51-53; P.C. 96-98; L.G. 15, 21, S.B. 19, 130-132; R.H. 34-41, 79-81; C.H. 82-83; L.G. 171-72; L.H. 52-54; G.H. 152-55; C.H. 64-65, 72-73; B.J. 51-53; I.K. 45, 61-63, 68; G.L. 49-56, 68-72; T.M. 30-32; A.M. 56-57, 59, 67-71, 83-84; J.M. 45-47, 55-57, 61-62;

reasonable limitations in some homes, such as nighttime curfews after which doors are locked and residents must be admitted by a staff member at the front desk area.[7] The undisputed evidence in this case shows that residents do in fact take advantage of opportunities to enjoy the benefits of living in New York City. As further described infra, each of the eighteen residents deposed in this case testified that he or she regularly leaves the home and visits shops, parks, restaurants, entertainment facilities, and/or other neighborhood conveniences.[8] Residents also walk around the neighborhoods where they live,[9] attend services at local religious institutions,[10] take GED classes,[11] use public transportation on a regular basis,[12] and visit their families and friends, sometimes staying overnight.[13] Some residents have jobs or volunteer their time,[14] vote

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D.N. 14-19, 32, 36-38, 68-69; S.P. 13-14; D.W. 25.

[7] 18 NYCRR § 487.5(a)(3)(xii); Burstein 18-20; Davis 34-35; Mendel 23-24; Yunger 59; P.B. 64, 66; S.B. 84-85; M.B. 35, 98-99, 166-67; L.G. 90-91; G.H. 164-167; R.H. 113, 151; L.H. 75-76; C.H. 103; I.K. 85; G.L. 100; T.M. 54-55, 104; A.M. 157, 185; D.N. 169-170; S.P. 58-59; D.W. 75; Lockhart 134-35.

[8] P.B. 50-53, 57-58, 148; S.B. 11-25; M.B. 40-50, 103-112; P.C. 38-39, 95-98; L.G. 14-18, 20-26; R.H. 33-41, 66, 80-82, 123-24; L.H. 49-50, 117-118; G.H. 77-83, 97-99, 130-45; C.H. 14, 18-22, 50, 53-54, 57-67, 72-75; I.K. 44-46, 62-67; B.J. 53- 58; G.L. 33-34, 49-56, 68-73; A.M. 56-57, 59-60, 64-73; J.M. 44-51, 54-58, 68-70; T.M. 31, 41, 45-48; D.N. 14-19, 31-38, 73-75; S.P. 8-12; D.W. 30-32, 156-158; see also Burstein 45-46, 56-57, 106; Mendel 51, 97; Yunger 22-23, 39-41; cf. Davis 106-07.

[9] S.B. 11, 16-17; L.H. 49; G.H. 144-45; I.K. 60; A.M. 82; J.M. 57-58, 70-71; T.M. 31; D.N. 14-16; S.P.57-58; D.W. 30.

[10] P.B. 58; R.H. 124-26; C.H. 16-17; A.M. 56-57; J.M. 34-35, 51-52; D.N. 19-23; see also G.H. 115; I.K. 47; D.W. 153; Burstein 85-86; Yunger 91.

[11] B.J. 19-20; Burstein 85-87.

[12] P.B. 56-57; S.B. 15, 18-20; M.B. 35-37; P.C. 98; L.G. 16-17, 135-36; R.H. 81-82; G.H. 97-99,142, 154-55; L.H. 54-55; C.H. 13, 22-24, 83; B.J. 51-52, 72; I.K. 16, 68-69; G.L. 9, 11, 33; T.M. 32-33, 78-79; A.M. 84-86; J.M. 24-25, 61; D.N. 26, 68-69; S.P. 13-16; Burstein 89-90; Mendel 77; cf. D.W. 25-27.

[13] P.B. 108-09, 133-34; S.B.56-57; M.B. 94-95; L.G. 14-15, 25-31, 135-36; G.H. 115-20; L.H. 54-55, 93-94; I.K. 56-58, 71; B.J. 50-52; G.L. 34-35, 48-49, 134-35; T.M. 79-80; A.M. 61, 79-80; J.M. 104-07; D.N. 26-27, 29-31, 61, 254; S.P. 55, 67-68; D.W. 25, 26-28, 153-54, 181; Burstein 51-52; Davis 109-110; see also C.H. 50-54.

[14] S.B. 40; G.L. 78-79; A.M. 144-45; S.P. 15, 16, 29-35; Burstein 45, 77, 82-84; Davis 110; Rosado 166-68.

at polling stations,[15] and/or become acquainted with people who live in the neighborhood.[16]

3. Mental Health Providers Offer Recovery-Oriented Services To Residents

Although the quality or effectiveness of programs is not covered by the ADA, mental health providers offer many recovery-oriented, rehabilitative services for adult home residents who have mental illnesses, including mental health clinics, continuing day treatment programs ("CDTs"), and case management services.[17] These programs aim to assist residents to become more independent, and where appropriate, to move to alternative settings.[18] Many, if not most, adult home residents with mental illness participate in mental health clinics or CDTs, generally several times per week.[19] At Park Inn, for example, a home that has 181 residents, approximately 140 residents attend on-site clinics and an additional 30 residents attend an off-site CDT.[20]

Mental health providers offer programs to teach or reinforce skills that foster independence, such as grooming, medication education, vocational training, money management or budgeting classes, computer skills, cooking, and GED classes.[21] Clinics also provide socialization programs, which aim to remove the obstacles to communicating with others.[22] At New Horizon's CDT, residents learn budgeting, shopping, and work-related skills through an on-

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[15] G.H. 145-46; R.H. 127-28; I.K. 60; G.L. 57.

[16] M.B. 97-102; P.C. 100-03; A.M. 79-80; J.M. 64-67; D.W. 29-30, 32, 172; Davis 198-99; see also L.H. 51.

[17] Myers 38-49; Bienstock Aff. ¶ 7; Bear 49-52; Lockhart 18.

[18] Bienstock Aff. ¶ 3, Ex. B; Levine 162-67; see also Rosado 160-61.

[19] See Bienstock Aff. ¶¶ 3, 5; Burstein 53-55; Bear 23, 31-32, Levine 29-30; see also Davis 73-77; Mendel 53-61; Yunger 99-103, 105-06.

[20] Burstein 8, 53-54.

[21] Bienstock Aff. ¶ 5; Bear 24-29, 34-37, 126-27; Levine 32-34, 162-167.

[22] Levine 29, 170.

site thrift shop that is run and staffed by the residents.[23] New York Psychotherapy's CDT offers similar programs for learning job skills, computers (including the Internet), and cooking; the CDT also offers a group in which clients who have moved from adult homes to various Housing Programs discuss their experiences with adult homes residents.[24]

Mental health providers take residents on organized excursions to libraries, amusement parks, bowling alleys, stores, parks, neighborhood athletic centers, and restaurants.[25] In addition, mental health providers link residents with services in the community, including educational and vocational opportunities, and medical or dental needs.[26] Case managers also assist residents with budgeting and connecting with their families.[27] Residents acknowledge that these services are effective, including C.H., who testified that "they [Federation of Organizations] got the people who don't want to do nothing with themselves come in[to] groups and get involved. That's the only reason why I wouldn't cast judgment at them, because they're very successful too."[28]

Even residents who do not use the services of mental health providers find that adult homes have made them more self-reliant and content with themselves. B.J., a resident at Brooklyn Manor, testified that since living in Brooklyn Manor she "came a long way" because her health has stabilized, she has not been admitted to a psychiatric hospital, she has learned

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[23] Bienstock Aff. ¶ 3.

[24] G.H. 29-60, 70-73; A.M. 11-27; Rosado 108-13, 156-60.

[25] Bienstock Aff. ¶ 5; Bear 40-41; Levine 34-35; Lockhart 88; Mendel 60-61; G.H. 41-46; C.H. 40-41, 43-48; G.L. 44-47; A.M. 24-26; D.N. 39, 49-51; S.B. 25-30, 38; B.J. 43-44; S.P. 22-23.

[26] Lockhart 17-25.

[27] Levine 31-32; Lockhart 18-24.

[28] C.H. 43.

social skills, studies the Bible, and practices the piano.[29] B.J. testified that there is no other place she would rather live now, that living in the home "really has been an asset to me," and that adult homes are the "[b]est thing that can ever happen to mental patients."[30]

4. Mental Health Providers Assist Qualified Adult Home Residents To Move From Adult Homes

If a resident wishes to move, the mental health providers should discuss alternative housing options consistent with the client's needs and desires, including supported housing and other Housing Programs.[31] Residents testified that they discuss any desires to move out of adult homes with their mental health providers.[32] When appropriate, mental health providers (or others) assist residents who are interested in Housing Programs by, among other things, completing HRA 2000 applications.[33] In fact, from 2000 to Jan. 2006 HRA received 807 applications from adult home residents. Ex. Hathaway-R. Some providers also help residents find housing that is not specifically designed for persons with mental illnesses. Federation of Organizations, for example, has assisted residents review classified advertisements, visited potential apartments with residents, provided security deposits, and helped residents furnish their apartments.[34]

5. Residents Move From Adult Homes

The evidence in this case also shows that residents who clearly desire and are qualified to

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[29] B.J. 31-34, 46-48.

[30] B.J. 32-34, 92-93.

[31] Bienstock Aff. ¶ 6; Bear 53-54; Levine 31-32, 181; Lockhart 25-28, 48-50, 181-82.

[32] M.B. 116-21; S.B. 97; P.C. 190-91; L.G. 105-08, 171; B.J. 42-43; G.L. 102-03, 111-20, 124; A.M. 127-28; D.N. 139-40; S.P. 99-101, 106-07; D.W. 142-44.

[33] Levine 72-74; Lockhart 25-26, 190-91; see also G.H. 182; Burstein 127-30; Mendel 64-65.

[34] Lockhart 27, 49; see also B.J. 41.

move from the adult homes do, in fact, move to alternative settings, including Housing For Persons with Mental Illness, private residences, and family members' homes. In fact, since April, 2005, approximately 200 residents state-wide have moved to housing licensed or funded by OMH. Reilly Aff. ¶ 29. Among the eighteen residents deposed in this case (sixteen of whom had been designated by DAI as potential witnesses),[35] four had moved out of the adult homes by January 2006,[36] one additional resident had firm plans to move to a family friend's home in Pennsylvania within two months,[37] and another resident had left the home in 2004 to live with friends in Georgia, but after two years away, returned to the home.[38] Of the four former residents who had moved out of their adult homes by January 2006, two had moved to housing funded by OMH,[39] and two others to private residences.[40] Residents also testified that they knew other residents who had moved from the adult homes.[41] Adult home operators similarly testified that residents move from the adult homes to alternative settings.[42] In addition, mental health providers testified that residents move from adult homes to alternative settings, and that they will

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[35] Nineteen residents were deposed, but during the deposition of D.A., D.A.'s counsel asked to adjourn the proceedings because counsel was concerned that D.A. did not understand the questions being asked. D.A.'s testimony has not been cited in this brief.

[36] M.B. 10-12; P.C. 15; A.M. 6-7; J.M. 7.

[37] D.N. 59-62.

[38] C.H. 9-10, 118-21.

[39] A.M. 6-7; P.C. 15.

[40] M.B. 10-12; J.M. 7.

[41] See, e.g., P.C. 162-63; L.G. 170-71; G.H. 55; R.H. 153-55; L.H. 131; I.K. 153-55; G.L. 107-111; T.M. 119; J.M. 149-51; A.M. 166-67; D.N. 165-68; S.P. 114-15.

[42] Burstein 69-72,74-78; 112-13, 132-33; Davis 88-99; Mendel 68-72; Yunger 120-48.

provide assistance in doing so.[43] Indeed, Francis Lockhart, an Associate Director of Programs at Federation of Organizations, testified that she was unaware of any residents who had submitted HRA applications, been deemed appropriate to move, and did not move because of a lack of spaces available.[44] Finally, the records provided by adult homes and mental health providers showed that some residents identified by DAI's experts as being qualified to move had moved to various locations, including Housing For Persons with Mental Illness.[45]

B. DOH's Inspections and Enforcement Actions Against New York City Adult Homes

DOH has a rigorous program of inspection of adult homes and enforcement activities, and contrary to the allegations of the complaint, the undisputed evidence shows that the Department has not failed to take strong action against the large, impacted adult homes that are the focus of this lawsuit. Homes with the best inspection records are to be surveyed every 18 months, and other homes are to be inspected every 12 months. In recent years, DOH has taken a number of actions to strengthen and improve its inspections and enforcement activities. For example, it has increased its staff in the Metropolitan Area Regional Office ("MARO") by contracting with the New York City Health Services Review Organization ("NYCHSRO"). This has added approximately 20 additional staff who are available to conduct inspections. Hart Aff. ¶ 58. The timeliness of inspections has significantly improved in recent years. Id. In addition, regulations adopted in 2002 permit DOH to assess fines immediately for the more serious violations, those which endanger residents (known as endangerment violations). Affidavit of David V. Wollner

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[43] Bienstock ¶ 6; Bear 20-21, 52-53; Lockhart 26-28.

[44] Lockhart 131-32.

[45] See, e.g., Hathaway Aff. Exs. G-K (attaching records concerning H.J., C.S. (Discharged to Supportive Apartment); P.B. (Moved to Oregon); M.R. (Moved in with family JG2569); J.M. (Discharged to Apartment Program).

¶ 57.

Inspections of the homes at issue in this case have cited a number of violations related to residents' rights and residents' ability to participate in their surrounding community and to learn independent living skills. For example, homes have been cited for failure to follow through on a resident's expressed desire to move, to have a sufficient program of activities, to allow residents to self-administer their own medications, and to ensure that the resident council met on a regular basis and that the issues raised by the council were addressed. Hart Aff. ¶¶ 64-73.

Strong enforcement actions have resulted in the closure and/or re-opening under new operators of a number of the most problematic, large impacted homes, including two of those listed in the complaint. For example, a number of enforcement actions were brought against Brooklyn Manor. Unfortunately, many of the charges were dismissed by the ALJ presiding over the administrative hearings, and the ALJ declined to revoke Brooklyn Manor's operating certificate. Nonetheless, through negotiations facilitated by DOH officials, undoubtedly advanced by the prospect of further enforcement actions, the operator agreed to sell the facility to a new operator, Leon Hofman, who had a history of successfully transforming another problematic home, the Leben Home. An operating certificate was issued for the opening of the new Brooklyn Adult Care Center on August 17, 2006. Hart. Aff. ¶¶ 90-98 & Ex. SS.

Ocean House Center closed as of January 2007 as a result of coordinated efforts by the Office of the Attorney General, the District Attorney of New York County, and DOH. The Leben Home's operating certificate was suspended pursuant to settlement of an enforcement action, and the home was sold and re-opened as the Queens Adult Care Center in 2002. Seaport Manor closed in early 2003 pursuant to a stipulation with DOH. Hart Aff. ¶¶ 74-89.

Thus, the undisputed evidence shows that, contrary to implications in the complaint that DOH has ignored or tolerated violations in large, impacted homes, DOH has devoted more

resources to oversight of those homes, and has conducted rigorous inspections of those homes and taken stronger enforcement actions against those homes than against other homes. In fact, the average number of violations[46] cited by MARO in impacted homes in 2004-2006 was 7.6, 6.31 and 6.34, compared to 5.31, 5.71, and 4.68 in non-impacted homes. Ex. Hart-UU. Most significantly, of all enforcement penalties imposed by MARO from 2000 to 2007, only two have been against non-impacted homes. By contrast, 15 have been imposed against impacted homes. Ex. Hart-VV.

C. The State Has Taken Many Steps to Improve the Oversight of Adult Homes and The Conditions And Services for Residents

While numerous State agencies have long been dedicated to rigorous oversight of adult homes and to improving the conditions, services and quality of life for adult home residents, a number of initiatives in recent years have been specifically designed to enhance residents' opportunities for recovery from their mental illness and to make progress toward their individual goals in any number of areas, including education, employment, socialization, independence, or finding alternative housing. Hart Aff. ¶¶ 46-63; Reilly Aff. ¶¶ 19-31. Residents have acknowledged that these steps have improved conditions and the quality of life for residents. R.H. 130; G.L. 27-29.

1. Inter-Agency Committee on Adult Homes

In or about January of 2001, three agencies involved in oversight of adult homes or mental health programs providing services to adult home residents, OMH, DOH and the Commission on Quality of Care and Advocacy for Persons with Disabilities ("CQC"), formed an inter-agency committee on adult homes to improve coordination and communication among the agencies. A Memorandum of Understanding dated November 2001 formalized this coordination.

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[46] Excluding compliance surveys, those where no violations and no findings were cited.

Ex. Reilly-A. The agencies developed a mechanism for conducting joint inspections, particularly when issues related to mental health services such as case management or assistance with psychiatric medications were involved. The agencies developed improved ways of sharing information such as inspection reports, and took steps to strengthen the Do Not Refer list, which precludes various covered entities from referring individuals to adult homes that have failed to meet applicable standards. Reilly Aff. ¶¶ 10 - 12.

2. OMH Adult Home Team

In approximately September of 2000, OMH also formed the Adult Home Monitoring Team, made up of staff assigned for the first time to work exclusively on adult home issues. This team has enhanced the oversight of mental health programs providing services to residents on-site in adult homes and off-site. Reilly Aff. ¶ 13.

3. Adult Care Facilities Workgroup

In the spring of 2002, an Adult Care Facilities Workgroup was appointed, made up of a number of private individuals, including mental health and health professionals, advocates for persons with disabilities, mental health service providers, and adult home operators, to review ACF policy and make recommendations to State officials. The Workgroup issued a report in October, 2002, making a number of recommendations for improving services for adult homes, including conducting assessments of residents, the use of independent service coordinators and peers, improving the medication system, and making other housing options available to residents. Wollner Aff. ¶¶ 23 - 26 & Ex. A; Reilly Aff. ¶¶ 14 - 18.

4. Assessments of Adult Home Residents

A number of initiatives, many inspired by the Workgroup's recommendations, have been implemented in recent years. DOH contracted with New York Presbyterian Hospital to conduct assessments of adult home residents. These assessments gathered important demographic data

useful for public policy planning purposes. Where specific medical needs were identified, residents were referred to the adult home staff for care and follow up. Wollner Aff. ¶¶ 27 - 31. OMH has used the assessments to identify residents who may be interested in moving to alternative housing, and has referred those residents to their private case managers or mental health treatment providers for follow up. Reilly Aff. ¶ 31.

5. OMH Case Management & Peer Support Program

OMH has instituted a case management and peer support program in adult homes. Through this program, various private non-profit service agencies have been funded to provide case management services and peer support to residents of adult homes. One major goal of this program is to improve the coordination of services. The program is also designed to provide access to a wide variety of services, including housing, and the case managers are expected to and have assisted residents who need or desire alternative housing. To date, this program is operational in 35 adult homes, including 12 of the homes referred to in this action. Reilly Aff. ¶¶ 19 - 24.

6. DOH EnAbLE Program

DOH has also funded the Enhancing Abilities and Life Experience Program, known as EnAbLE. Under this program, adult homes are awarded grants to fund a variety of programs designed to maximize residents' abilities and improve their quality of life. Such programs may include vocational or educational programs such as GED classes, health and wellness education, or training on independent living skills, such as through construction of teaching kitchens and laundry rooms where residents can learn cooking and laundry skills through hands-on experience. Wollner Aff. ¶¶ 36 - 38.

7. Statutory and Regulatory Amendments

Various statutory and regulatory changes have also been enacted to strengthen oversight of adult homes and improve conditions. The Do Not Refer list was created on the DOH website and the list of entities which are given notice and which are prohibited from referring individuals to adult homes on the DNR list was expanded. The ability of DOH to use receivers to operate adult homes was strengthened, and adult homes were required to have at least one common room that is air conditioned. Wollner Aff. ¶¶ 53 - 55. Regulations were enacted that allowed DOH to immediately assess fines for violations that endanger residents, instead of allowing the home 30 days to correct the violation. Wollner Aff. ¶ 57. The SSI payments for adult home residents and their PNA has also been significantly increased, making a very concrete improvement in residents' lives and their ability to afford personal items and to travel and participate in activities in the community. Hart Aff. ¶ 63.

8. Enhanced Access to Alternative Housing

Residents' ability to access alternative housing has been enhanced in a number of ways. Adult home residents have been added as a target population for housing licensed or funded by OMH, and case managers have been enlisted to assist residents who want to move. The undisputed evidence shows that some adult home residents have in fact moved from adult homes. Reilly Aff. ¶ 29.

D. The State's Comprehensive, Effective Olmstead Plan

While New York has not published a single document entitled "Olmstead Plan," and is not required to, defendants have a comprehensive, effective Olmstead plan for individuals with mental illness in New York State, including residents of adult homes in New York City. This plan includes: (a) an array of activities, programs and services that defendants are developing and have developed with the intention of assisting all persons with mental disabilities, to the extent

possible, to live and receive services in the community instead of an institution (i.e., state-operated psychiatric hospitals); (b) all of OMH's planning, program implementation and oversight of the mental health system; (c) DOH's inspection and oversight of adult homes; and (d) the State's Home and Community-Based Waivers program. See, e.g., Myers Aff. ¶¶ 97-149; Affidavit of Keith Simons ¶¶ 26-107; Wollner Aff. ¶¶ 60-65. Through its many components, defendants' Olmstead plan is effective and provides adult homes residents access to a wide range of community based services including, but not limited to, Housing Programs. Myers Aff. ¶¶ 150-86; Simons Aff. ¶¶ 56-79.

Much of defendants' Olmstead planning is reflected in OMH's Statewide Comprehensive 5.07 Plans for Mental Health Services. Simons Aff. ¶¶ 16-111 & Ex. A-F; Myers Aff. ¶¶ 97, 103. These Plans summarize OMH's strategic planning for, commitment to, and allocation of extensive resources to community-based treatment, to assist mentally disabled State residents to live in the most integrated setting appropriate to their needs and reach their personal goals. Simons Aff. ¶¶ 15, 16, 19; Myers Aff ¶¶ 97-98. They also summarize OMH's activities and programs that are designed to help adult home residents recover and access Housing for Persons with Mental Illness through a network of mental health professionals. Simons Aff. ¶¶ 16-19, 27-38, 66-79; Myers Aff ¶¶ 104-05.

1. DeInstitutionalization

In accordance with the true mandate of Olmstead, even before that decision was rendered, and indeed, even before the ADA was passed, OMH had taken extensive efforts to ensure that patients in its state operated psychiatric centers, who were determined by state treatment professionals to be qualified to live in the community, were discharged without undue delay into community residential settings with linkages to appropriate supports and treatment. Campbell Aff. ¶¶ 16-19; Simons Aff. ¶¶ 80-84 ; Myers Aff ¶¶ 38-51. Between 1994 to 2006, the adult

inpatient census at state operated psychiatric centers decreased dramatically, from 10,122 to 5,251. Simons Aff. ¶¶ 82-83; Myers Aff ¶¶ 32, 152. Moreover, OMH has redirected savings from closures of inpatient beds and entire hospitals toward community-based services. Simons Aff. ¶ 59; Myers Aff ¶¶ 32-33; Affidavit of Martha Schaefer Hayes ¶¶ 68-71.

2. Investment in and Vast Network of Community-Based Services

Defendants' Olmstead planning also includes the wide array of community-based services which are funded, licensed and/or supported by OMH and which provide community-based treatment and support through a vast network of primarily not-for-profit providers. Myers Aff. ¶¶ 35-59, 145; Simons Aff. ¶¶ 39-55. OMH's many community-based programs include but are not limited to Housing Programs for adults and children with mental illness, case management, clinic treatment programs, continuing day treatment programs, psychosocial clubhouses, peer bridger programs, ACT teams and other initiatives. Myers Aff. ¶¶ 68-70, 105; Simons Aff. ¶¶ 39-40, 66. These programs are designed to provide individuals with mental illness, including adult home residents, with services and treatment to help them identify personal goals, and to develop the skills necessary to reach those goals. Myers Aff. ¶¶ 109-19, 137-44; Simons Aff. ¶¶ 28, 34-37, 47-48, 66-72. Most importantly, having sufficient community based services allows people to remain in and receive treatment in the community, as opposed to inpatient hospital settings. Myers Aff. ¶¶ 59, 156; Simons Aff. ¶¶ 82-84.

3. OMH's Expansion of and Commitment to Housing for Persons with Mental Illness

OMH's development of as much Housing for Persons with Mental Illness as feasible is another component of defendants' Olmstead plan. While OMH is not a housing agency, it has invested significant funds to develop 29,050 existing units of Housing for Persons with Mental Illness. Myers Aff. ¶¶ 68-95, 109-15; Simons Aff. ¶¶ 57-64; Newman Aff. ¶¶ 14-27, 101; Schaefer Hayes ¶¶ 13-26. Moreover, defendants' commitment to expand the availability of

Housing Programs for all individuals with SPMI, including adult home residents, is evident from OMH's allocation of tens of millions of dollars for the development of additional beds, which will bring the total number of State-government subsidized beds to 38,800. Myers Aff. ¶ 69; Simons Aff. ¶¶ 57-60; Newman Aff. ¶¶ 15-27; Schaefer Hayes ¶¶ 13-26.

4. Adult Home Initiatives and Services

Defendants' Olmstead Plan also includes the various initiatives that defendants have undertaken to improve and enhance the services available to residents of adult homes, further discussed supra at 19-22. These include the assessments conducted under contract with the New York Presbyterian Hospital, the adult home case management and peer support programs funded by OMH, the EnAbLE programs funded by DOH, enhanced inspections, and OMH's designation of adult home residents as a target population for Housing Programs. Reilly Aff. ¶¶ 19-31; Wollner Aff. ¶¶ 27-31; Myers Aff. ¶¶ 128-49.

5. Oversight of System Through Licensing

Defendants' Olmstead plan includes OMH's oversight of the mental health system through its licensing processes and oversight of programs and services, which enables defendants to monitor the Olmstead plan to ensure it is effective. See Myers Aff. ¶¶ 120-24 & Ex. GG; Simons Aff. ¶¶ 98-100. Indeed, OMH has granted over 2,500 licenses to the mostly local and not-for-profit providers which typically provide the vast network of community- based services. OMH monitors and improves the quality of services provided by these not-for-profit entities through a number of mechanisms. See, e.g., Simons ¶¶ 98-100 & Ex. A.

Likewise, defendants' Olmstead plan includes DOH's licensure and enforcement of regulations governing adult homes, including those requiring homes to link residents with many enumerated services, including mental health services, and to facilitate interaction with the community. Myers Aff. ¶ 97 & Exs. EE, FF; Simmons Ex. A at OMH 6136-38.

6. Other Aspects of Defendants' Olmstead Plan

Additional components of defendants' Olmstead plan include utilization of Home and Community Based Waivers; OMH's strategic planning to ensure quality and use of effective evidence-based practices such as medication management and supported employment; OMH's work to advance accountability and encourage best practices and care coordination, including through information technology; OMH's basic and applied research in the mental health field; and OMH's strategic planning to promote general public health as it relates to mental health, wellness, suicide prevention, and the forensic system. Myers Aff. ¶ 30 & Exs. B, D; Simons Aff. ¶¶ 85-88 & Exs. A-F. OMH continually evaluates its programs against developments in the mental health field, with a goal of improving effectiveness. Myers Aff. ¶ 40; Simons Aff. ¶ 15. OMH is committed to making improvements, and fully expects improvements to continue. Myers Aff. ¶ 40; Simons Aff. ¶¶ 36-37, 97.

7. Olmstead Planning Efforts

Finally, defendants' Olmstead plan includes the State's more formal efforts to ensure compliance with the Olmstead decision, such as through committees, including the statutorily created Most Integrated Setting Coordinating Council, and the Coalition to Promote Community Based Care. Wollner Aff. ¶¶ 60-65 & Ex. BB; Myers Aff. ¶¶ 125-27 ; Simons Aff. ¶ 111.

E. Cost Comparison: Transfer Would Cost The State More

Comparing the costs incurred by the State to fund housing for adult home residents and Housing for Persons with Mental Illness (Housing Programs) establishes that the State pays more per bed for Housing for Persons with Mental Illness, including Supported Housing, than it does for adult homes. Ex. Kipper-A; Schaefer Hayes Aff. ¶¶ 87-97; Myers Aff. ¶¶ 188-200; Newman Aff. ¶¶ 90-99. This conclusion follows from consideration of the relevant costs to the State, which include the State share of Supplemental Security Income ("SSI"), direct State funding of

Housing Programs, and the cost of Medicaid services to residents of both types of housing.

1. Adult Home Funding: SSI

The State provides income support to low-income individuals with SPMI through the SSI program. Ex. Kipper-A. The SSI program is managed by the federal Social Security Administration, and is partially federally funded. Ex. Kipper-A. It provides monthly payments to low-income individuals who are 65 or older or disabled. Id. Most of the residents of adult homes at issue in this case rely on SSI funding to cover the cost of their room and board at the adult homes.[47] Ex. Kipper-A; Newman ¶ 92; Schaefer Hayes ¶ 91. In contrast to Housing Programs, OMH provides no direct funding for room and board for adult homes. Ex. Kipper-A.

The State's share of an individual's SSI benefit is dependent on the individual's residential setting and the location of the residence within the State. Ex. Kipper-A. Table A-1 below outlines the five categories of housing and associated payments for individuals residing in New York City as of January 1, 2006. Id. at 4.

Table A-1: New York State Annual SSI Benefit Levels Chart - New York City Region

Living Arrangement	Federal	State	Total
Living Alone	$7,236	$1,044	$8,280
Living With Others	$7,236	$276	$7,512
Congregate Care Level I-Family Care	$7,236	$3,198	$10,434
Congregate Care Level II-Residential Care	$7,236	$5,220	$12,456
Congregate Care Level III-Enhanced Residential Care	$7,236	$6,300	$13,536

Adult homes are classified as Congregate Care Level III housing. Id. In 2006,[48]

[47] As of the end of 2004, 14% of the adult home residents relied on private funding to finance their room and board at the adult home. One percent relied on other funding sources. Id.

[48] The SSI rates increased slightly in 2007, which changed the figures to a small degree, Kipper Aff., Exs. C & D, but not the conclusion as to which cost is significantly higher. Newman Aff. ¶ 91 & Ex. K.

individuals with SPMI residing in adult homes in New York City received Congregate Care Level III funding at an annual rate of $13,536 per year, with $7,236 from federal funds, and $6,300 from the State. Id.; Newman Aff. ¶ 97.

The resident uses most of the SSI benefit to pay the adult home for room, board, three meals a day, housekeeping, personal care and supervision by 24-hour staff onsite. Ex. Kipper-A; Newman ¶ 92; Schaefer Hayes ¶ 91. Residents keep a small portion of the SSI benefit as a Personal Needs Allowance ("PNA"). Ex. Kipper-A. In 2006, in New York City, the standard annual PNA for adult home residents was $1,800, or $150 per month. Id.

2. Funding of Housing For Persons With Mental Illness

In contrast to adult homes, the largest component of funding for Housing Programs is direct State funding from OMH. Ex. Kipper-A; Newman ¶¶ 90-92; Schaefer Hayes ¶¶ 87-89.

a. Supported Housing

Supported Housing, in the form of the scattered-site rental apartments is funded directly by OMH and through the individual's income, which often consists only of SSI. Ex. Kipper-A; Newman ¶¶ 90-91; Schaefer Hayes ¶¶ 87-89. Individuals with SPMI residing in Supported Housing receive the 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 housing provider. Ex. Kipper-A; Newman ¶ 91; Schaefer Hayes ¶ 90. The 2006 annual Living Alone rate was $8,280, the State's share of which was $1,044. Ex. Kipper-A; Newman Aff. ¶ 91.

Additionally, OMH pays the not-for-profit provider a stipend to obtain housing, pay rent for the apartment unit, and provide staffing in the form of minimal case management to residents. Ex. Kipper-A; Newman ¶ 57-58; Schaefer Hayes ¶ 90. For Supported Housing units that existed prior to 2005 in New York City, OMH currently pays a stipend of $12,770 per year which includes recent cost of living adjustments. Ex. Kipper-A; Newman ¶ 71. For new Supported

Housing units that are being developed in New York City pursuant to OMH's May 2005 RFP, OMH was in 2005 paying a stipend of $13,500 per year. Ex. Kipper-A; Newman ¶ 67; Schaefer Hayes ¶ 29. The current rate is $14,197. Newman Aff. ¶ 91.

b. Supportive SRO's and CR-SRO's

Supportive SRO's are similarly funded through a combination of SSI payments to the resident and direct State funding from OMH. Individuals residing in Supported SRO's receive the SSI Living Alone rate and are required to pay 30% of this payment to the housing provider. Ex. Kipper-A. The 2006 annual Living Alone rate was $8,280, the State's share of which was $1,044. Id.

CR-SRO's are funded through a combination of SSI payments and direct State funding from OMH. Ex. Kipper-A; Ex. Newman-H. Individuals residing in CR-SRO's receive the SSI Congregate Care Level II rate and are required to pay 30% of this payment toward housing costs to the provider. Ex. Kipper-A. The 2006 annual Congregate Care Level II rate was $12,456, the State's share of which was $5,220. Id.

3. Medicaid Costs

The Medicaid program provides health care coverage to individuals with low incomes. Ex. Kipper-A. Medicaid is funded jointly by the federal, State and local governments, typically with the federal government providing half of the funding. Id. Medicaid-eligible residents of New York, including residents of adult homes and Supported Housing, receive a variety of services. Id. The need and cost for Medicaid services varies depending on an individual's needs. Id.; Schaefer Hayes ¶¶ 115-18. It is highly speculative to assume that merely moving an individual from one residential setting to another will cause an immediate change in the individual's Medicaid service needs and the State's share of associated Medicaid costs. Id.; Ex. Kipper-B; Myers ¶¶ 207-10; Schaefer Hayes ¶¶ 114-23; Lieberman Dep. at 63, 193-94; Ex.

Saurack-14. While plaintiff contends that the cost analysis should include projected Medicaid savings, such assumptions are speculative, and therefore, properly excluded from the analysis. See Bruggeman v. Blagojevich, 219 F.R.D. 430, 435 (N.D. Ill. 2004)("only the resources available in the [state mental health budget] should be a factor; speculative or potential resources are irrelevant").

4. Plaintiff's Proposed Transfer Would Increase State Costs

If the State were required to move thousands of adult home residents to scattered-site Supported Housing apartments, the State's costs would dramatically increase. Because vacancy rates for Housing Programs are low in New York City, placing a large number of individuals in those programs would require development of additional units. Myers Aff. ¶¶ 209-210; Schaefer Hayes Aff. ¶¶ 126, 129. Table A-2 below reflects the annual housing-related cost to the State, as of 2006, for residents in adult homes and residents in Housing Programs (excluding consideration of any potential development or capital costs), along with the annual increase in per resident cost to the State, assuming an individual were to move from an adult home to one of the types of Mental Health Housing. See Kipper Aff., Ex. A.

Table A-2: Housing-Related Cost to State of Proposed Transfer from Adult Homes

Housing Type	State Share of SSI	Direct State Funding	Total State Cost	Increase in State Cost	Cost as a Percent of Adult Home Cost
Adult Home	$6,300	$0	$6,300	N/A	N/A
Supported Housing	$1,044	$13,500	$14,544	$8,244	231%
Supportive SRO	$1,044	$16,269	$17,313	$11,013	275%
CR SRO	$5,220	$15,419	$20,639	$14,339	328%

Specifically, for each eligible individual who moved from an adult home to scattered-site Supported Housing in 2006 the increased cost to the State would have been $13,500 if only OMH's budget is considered, and $8,244 if the State's contribution to SSI is included. Id.

Newman Aff. ¶¶ 94, 99. This represents a dramatic increase of 231% in cost to the State. Kipper Aff. Ex. A. In 2007, the increase to the State would be $7,549 per bed. Schaefer Hayes ¶ 97.

This analysis includes consideration of expected relevant savings and is based on conservative assumptions, assuming that a given adult home resident with SPMI is qualified for and does not object to transfer to Supported Housing. Id.; Newman Aff. ¶ 94; Myers Aff. ¶ 201. If instead, the individual lacks sufficient independent living skills to maintain the Supported Housing residence with minimal case management, and needs an ACT team (which cost OMH $3,000 to $7,500 per slot previously and has increased), or additional services, then the cost to the State of the transfer would increase even more.[49] Ex. Kipper-A; Schaefer Hayes Aff. ¶ 99; Myers Aff. ¶ 202.

ARGUMENT

I. Introduction - Standards Governing This Motion

A. Basic Principles of The ADA

Title II of the Americans with Disabilities Act ("ADA"), which applies to public services, provides 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. To establish a violation of the ADA, a plaintiff must prove that 1) they are qualified individuals with a disability, 2) that the defendants are subject to the ADA, and 3) that plaintiff was denied the opportunity to participate in or benefit from defendants' services, programs, or activities, or was

[49] While no individualized housing assessments were conducted of any of plaintiff's proposed constituents, the record shows that for the few whose records contain an indication that they might, with further evaluation, be deemed by treatment professionals to be qualified for and not opposed to moving to Supported Housing (Exs. Geller-A & B), it is likely that most would be determined to require an ACT team to maintain a Supported Housing program bed.

otherwise discriminated against by defendants, by reason of the plaintiff's disability. Henrietta D. v. Bloomberg, 331 F.3d 261, 272 (2d Cir. 2003). ADA claims may be brought under any of three theories - intentional discrimination, disparate impact, or failure to make a reasonable accommodation. Tsombanidis v. West Haven Fire Dep't, 352 F.3d 565 (2d Cir. 2003).[50]

Title II, as noted, governs only the activities of public entities, which are defined as, inter alia, any State or local government, any department, agency, special purpose district, or other instrumentality of a State or States or local government. 42 U.S.C. § 12131(1). U.S. Department of Justice ("DOJ") regulations specifically provide, however, that the "programs or activities of entities that are licensed or certified by a public entity [such as adult homes] are not, themselves, covered by this part." 28 CFR § 35.130(b)(6). See also DOJ Technical Assistance Manual ("TAM"), II-3.7200 ("The State is not accountable for discrimination in the employment or other practices of XYZ company, if those practices are not the result of requirements or policies established by the State.").

Under the ADA, a State must "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination ...," but it need not do so if it "can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." 28 CFR § 35.130(b)(7).

While the ADA prohibits discrimination on the basis of disability, it does not guarantee equal results from public programs. Alexander v. Choate, 469 U.S. 287, 304 (1985) ("The Act does not, however, guarantee the handicapped equal results from the provision of state Medicaid"); DOJ TAM, II-3.3000 ("The ADA provides for equality of opportunity, but does not guarantee equality of results."). The ADA does not set standards for the quality or efficacy of

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[50] Because, with the exception of "subtle differences" not relevant here, the standards under the ADA and the Rehabilitation Act are the same, the Rehabilitation Act will not be discussed separately. Henrietta D., 331 F.3d at 272.

programs, or guarantee that a particular program will be tailored for the needs of a specific individual. See Olmstead v. L.C., 527 U.S. 581, 603 n. 14 (1999) ("We do not ... hold that the ADA imposes on the States a 'standard of care' for whatever medical services they render, or that the ADA requires States to 'provide a certain level of benefits to individuals with disabilities.'"); Doe v. Pfrommer, 148 F.3d 73 (2d Cir. 1998) (rejecting challenge to VESID services, where plaintiff's "challenge is not illegal discrimination against the disabled, but the substance of the services provided to him through VESID"); Flight v. Gloeckler, 68 F.3d 61 (2d Cir. 1995); P.C. v. McLaughlin, 913 F.2d 1033, 1041 (2d Cir. 1990) (The [Rehabilitation] Act does not require all handicapped persons to be provided with identical benefits."); Black v. Dep't of Mental Health, 100 Cal. Rptr. 2d 39 (Ct. App. 2000) (rejecting ADA claim based on an inappropriate placement and the poor quality of treatment). Moreover, the ADA does not require that States provide a new service, program or benefit to the disabled that it currently does not provide to anyone else. Rodriguez v. City of New York, 197 F.3d 611 (2d Cir. 1999); Leocata v. Wilson-Coker, 343 F. Supp. 2d 144 (D. Conn. 2004), aff'd mem., 2005 U.S.App. LEXIS 19730 (2d Cir. Sept. 13, 2005).

B. Integration

In Olmstead, 527 U.S. 581, the plaintiffs, patients in a state hospital, challenged the failure to discharge them to the community. The Court held that "States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." See also 28 CFR § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.") DOJ has

defined the "most integrated setting" as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible..." 28 CFR Pt. 35, App. A.

A plurality of the Olmstead Court explained that the State may raise a fundamental alteration defense where it can "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." 527 U.S. at 604. Because the State must consider the needs of all of its disabled citizens in allocating scarce resources, the Court made it clear that courts could not give special preference to individuals simply because they brought a lawsuit. 527 U.S. at 607 ("a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.") The Court further stated that a court could not look solely at the cost of providing relief to just one plaintiff as against the entire State budget, since such a small expense would virtually never provide a defense. Rather, a court must consider the cost of providing community-based care to everyone eligible for and desirous of it.

Plaintiff's attempt to apply Olmstead to this case distorts the Court's decision as well as the ADA itself beyond recognition. The plaintiffs in Olmstead were in the State's custody in a State hospital, where State treatment professionals were responsible for their care and discharge planning. As further discussed in Point II, infra, to hold the State responsible for seeing that persons residing in privately owned and operated adult homes are assessed and moved to different settings when appropriate, expands Title II's coverage of public services far beyond Congressional intent. Moreover, because the State does not currently offer such assessment and housing referral services in adult homes (concepts which, in any event, do not apply to these residences), the relief sought here would fundamentally alter State programs and/or require the

State to create a new program that it currently does not provide, contrary to fundamental ADA principles. As the DOJ TAM makes clear, the State should be held responsible for disability discrimination only when it engages in discrimination itself or when discrimination by its licensees is the result of requirements or policies established by the State. In the context of an integration claim, this should be limited to situations where an individual is in the State's custody, as in Olmstead, or when a State policy requires that individuals receive services in a non-integrated setting. Neither is true with respect to adult homes.

POINT I

PLAINTIFF LACKS STANDING TO ASSERT ITS CLAIMS AGAINST DEFENDANTS

To establish standing, a plaintiff must meet the "'irreducible constitutional minimum'" requirement of showing that it has suffered an injury-in-fact that is fairly traceable to defendants' allegedly unlawful action, and which is likely to be redressed by a favorable decision. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560-61 (1992). Even if this minimum showing is made, a plaintiff may still lack standing under certain judicially imposed prudential limitations, Allen v. Wright, 468 U.S. 737, 751 (1984), although Congress may remove these prudential barriers when enacting legislation. See Havens Realty Corp. v. Coleman, 455 U.S. 363, 372 (1982).

An association has standing to bring claims on behalf of its members if it can show: "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." Hunt v. Wash. State Apple Advert. Comm'n, 432 U.S. 333, 343 (1977)). The first two elements of this test are constitutionally required, while the third element is a prudential consideration. See United Food & Commercial Workers Union Local 751 v. Brown Group, Inc., 517 U.S. 544, 555 (1996).

A protection and advocacy organization ("PAIMI organization"), such as DAI, may either

bring claims in its own capacity or on behalf of its constituents, but it must establish standing like any other litigant.[51] Doe v. Stincer, 175 F.3d 879, 884, 886-87 (11th Cir. 1999); Aiken v. Nixon, 236 F. Supp. 2d 211, 224 (N.D.N.Y.), aff'd, 80 Fed.Appx. 146 (2d Cir. 2003); Monaco v. Stone, 2002 WL 32984617, at *21 (E.D.N.Y. Dec. 20, 2002). At a minimum, to establish associational standing, a PAIMI organization must show that ***at least a single one of its constituents*** would have standing to bring a claim in his own right and that the interests the PAIMI group seeks to protect are germane to its purpose. Monaco, 2002 WL 32984617, at *21; Aiken, 236 F. Supp. 2d at 224; Pa.. Protection and Advocacy, Inc., 136 F. Supp. 2d at 365.

DAI does not have standing to bring this action because it cannot establish that a single one of its constituents has standing. Moreover, even if DAI could make these showings, it cannot establish standing to obtain systemic injunctive relief because it cannot prove widespread violations, giving standing to thousands of residents. Finally, DAI does not have statutory authority to bring this case on behalf of many, if not all, of its constituents.[52]

A. DAI Fails the Associational Standing Test

1. None of DAI's Constituents Have Suffered an Injury-In-Fact

To constitute an injury-in-fact, an injury must be "concrete and particularized," "actual or imminent," and "not conjectural or hypothetical." Lujan, 504 U.S. at 560 (citations omitted).

DAI has failed to establish injury-in-fact. Even if Olmstead were found to apply to privately-owned adult homes, DAI has failed to come forward with reliable proof that any of its constituents have suffered an actual injury by some action of the State. DAI has not identified even a single resident who meets the elements of an Olmstead claim. Significantly, as discussed

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[51] DAI brings this case only on behalf of its constituents; DAI has not alleged injury to itself. See Compl. ¶¶ 8-12, 34.

[52] Defendants do not contest that the interests DAI seeks to protect are germane to its purpose.

in Point IV, DAI has not established that any constituent is ***qualified*** to move to housing options it seeks by, among other things, meeting the minimum admission criteria of the third-party housing providers that operate the housing DAI seeks. See Warth v. Seldin, 422 U.S. 490, 503-06 (1975) (plaintiffs lacked standing because they were unable to show that absent allegedly restrictive zoning practices they would have been able to afford to live in defendant town). If DAI's constituents are not qualified for the housing they seek, by definition they have not been injured by any alleged action of defendants.

Nor can DAI establish injury-in-fact with respect to any residents who have not filed HRA 2000 applications to move to alternative housing programs. Any claim that these residents have been injured because they lack access to supported housing or other programs funded by OMH is speculative, conjectural and clearly not imminent because the filing of an HRA 2000 application is a necessary pre-requisite to being accepted into Housing For Persons with Mental Illness. See, e.g., Shotz v. Cates, 256 F.3d 1077, 1081-82 (11th Cir 2001) (ADA Title II claim dismissed for lack of standing where plaintiffs failed to allege that the threat of future discrimination was imminent); cf. Small v. Gen. Nutrition Cos., Inc., 388 F. Supp. 2d 83, 89-90 (E.D.N.Y. 2005) (plaintiff lacked standing to bring ADA Title III claim against several stores where he failed to allege, among other things, that he would visit the stores in the imminent future); McInnis-Misenor v. Me. Med. Ctr., 211 F. Supp. 2d 256, 260 (D. Me. 2002) (plaintiff lacked standing to bring ADA claim concerning a maternity ward because she was not pregnant and any injury was not imminent), aff'd, 319 F.3d 63 (1st Cir. 2003). A "some day" intention to file an HRA 2000 form, without any concrete plans, is insufficient to confer standing. Lujan, 504 U.S. at 564. In fact, many of the 1536 residents identified by DAI as being qualified and not opposed to moving have not filed HRA 2000 applications; only 18 of the 206 residents included in defendants' random sample of the 1536 residents filed the application. DAI cannot claim that

submitting an application would be futile, where residents have submitted these forms, been approved for alternative housing, and moved from the adult homes to these other settings.[53]

2. Defendants Have Not Caused DAI's Constituents Any Injury

DAI also cannot establish that any injury its constituents may have suffered is fairly traceable to the defendants. See Lujan, 504 U.S. at 560. The State has not caused any injury here because it does not operate adult homes, does not require that any resident live in an adult home, and is not responsible for assisting residents to move from these homes. Instead, independent third parties bear this responsibility. If a resident seriously wants to move from an adult home, social workers, psychiatrists, and adult home staff members are available to work with that resident to determine whether he or she is qualified to live in a different setting and to assist the resident in applying. Finally, third-party housing providers decide whether to accept the resident into the housing program after reviewing applications and interviewing the resident. Any injury to DAI's constituents, therefore is highly indirect and "'results from the independent action of some third party not before the Court." Allen, 468 U.S. at 757 (1984); Simon v. E. Ky. Welfare Rights Org., 426 U.S. 26, 42-43 (1976).

3. Any Injury Suffered By DAI's Constituents is Not Redressible

Similarly, DAI cannot establish that any injury they might suffer is "'likely,' as opposed to merely 'speculative,' to be 'redressed by a favorable decision.'" Lujan, 504 U.S. at 561 (quoting Simon, 426 U.S. at 38). DAI seeks an order to move its constituents into allegedly more integrated housing, but DAI has failed to establish that any action by the ***defendants*** would result in the residents moving. As discussed in the above paragraph, the defendants cannot redress the alleged injury of any residents who are not approved by HRA or accepted by the third-parties who operate this housing. Thus, an order directed at defendants alone would not redress the

[53] See, e.g., P.C. 15-16, 154-57; A.M. 6-7, 134-137.

alleged violation. See Warth, 422 U.S. at 503.

B. DAI Does Not Have Standing To Obtain Systemic Relief

Even if DAI were able to show that any of its constituents has standing, DAI does not have standing to seek the systemwide, yet highly individualized, relief it seeks on behalf of thousands of residents. The scope of DAI's standing, and the corresponding remedy it may seek, is limited by the number of DAI's constituents who meet the Olmstead-required elements of being qualified and having a desire to move to alternate housing. In other words, the scope of DAI's standing is coextensive to the number of constituents who have individual standing to bring Olmstead claims. Small v. Gen. Nutrition Cos., Inc., 388 F. Supp. 2d 83, 98 (E.D.N.Y. 2005); Clark v. Burger King Corp., 255 F. Supp. 2d 334, 345 (D. N.J. 2003); Clark v. McDonald's Corp., 213 F.R.D. 198, 215-16 (D. N.J. 2003). DAI has not established that any residents, let alone the thousands necessary to obtain system-wide relief, meet this standard.

In Small v. General Nutrition Cos., Inc., 388 F. Supp. 2d 83, Judge Ross confirmed that the breadth of an association's standing is limited to the standing of its individual members. Small, 388 F. Supp. 2d at 98. In Small, a disabled individual and an advocacy association brought a putative class action, claiming that a chain of stores was inaccessible to wheel-chair users in violation of the ADA. Id. at 85. In addressing the defendant's motion to dismiss for lack of standing, the Court found that the association did not adequately plead standing because it failed to allege that a single one of its members met the standing requirements. The Court noted, however, that even if the association were to allege that a single member did have standing, the association's standing would be limited to the standing of that single member:

> The court emphasizes that at the very least, if [plaintiff association] can establish the standing of one of its members in an amended complaint, [plaintiff association] will have established associational standing. *Its standing would only be coextensive with the standing that member would enjoy, however. Put differently, because associational standing exists only insofar as organization members*

> *have standing, associational standing may not be broader or more extensive than the standing of the organization's members.*

Id. at 97-98 (emphasis added); see also Clark v. Burger King Corp., 255 F. Supp. 2d at 345 (concluding that organization's standing to bring an ADA claim was coextensive with a single member's claim because the association failed to identify other members who had claims); Clark v. McDonald's Corp., 213 F.R.D. at 215-16 (finding that association had adequately plead associational standing, but cautioning that the organization would have to prove that its claims were greater than those of a single member).

Thus, DAI's associational standing must be limited to that of the individual constituents who DAI proves have suffered an injury-in-fact and otherwise have standing. To permit DAI to seek relief any broader than the standing of its constituents would essentially permit DAI to evade the requirements of Rule 23 of the Federal Rules of Civil Procedure, from which Congress certainly did not exempt PAIMI organizations. Indeed, PAIMI groups, including DAI, have in many cases sought systemic relief by joining actions with putative class representatives. See, e.g., Monaco v. Stone, 2002 WL 32984617; Risinger v. Fitzpatrick, 117 F. Supp. 2d 61 (D. Me. 2000); Mich. Protection & Advocacy Serv. v. Kirkendall, 841 F. Supp. 796 (E.D. Mich. 1993); Rubenstein v. Benedictine Hosp., 790 F. Supp. 396 (N.D.N.Y. 1992). Here, DAI has not certified a class, and defendants would therefore be deprived of the protections and safeguards provided in Rule 23. In fact, to prohibit PAIMI groups from expanding the scope of associational standing to the extent DAI seeks here, some courts have required PAIMI groups to name the specific individuals on whose behalf they bring an action at early stages of the litigation. See Tenn. Protection & Advocacy, Inc. v. Bd. of Educ., 24 F. Supp. 2d 808, 816 (M.D. Tenn. 1998); Penn. Protection & Advocacy, Inc., 136 F. Supp. 2d at 355-56; see also

Autism Soc'y of Mich. v. Fuller, 2006 WL 1519966, at **6, 10 (W.D. Mich. May 26, 2006).[54]

The defendants' and the Court's interest in the finality of judgment also favors requiring DAI to establish standing for each of its constituents for whom it seeks relief as well. DAI's unnamed constituents may not be bound by any judgment here because they are neither represented nor in privity with DAI. In contrast to cases where "members" were bound by a judgment, these residents may not even be aware that DAI is prosecuting claims on their behalf. Cf. Nash v. Bowen, 869 F.2d 675, 679 (2d Cir. 1989) (res judicata barred a member from bringing claims identical to association's earlier claims, where individual plaintiff was a member of the association, consulted the association's counsel about the earlier litigation, and shared documents with the association for use in its case); El-Bey v. The City of New York, 151 F. Supp. 2d 285, 295 (S.D.N.Y.) (res judicata barred claims of a member because he was in privity with president of a union who settled identical claims on behalf of union), aff'd, 33 Fed.Appx. 10 (2d Cir. 2002).

Even if DAI could establish standing to bring a claim for systemwide injunctive relief, DAI has certainly not proven that it is entitled to this massive, broad relief. It is well-settled that "the nature of the violation determines the scope of the remedy" and that "the principles of equity . . . militate heavily against the grant of an injunction except in the most extraordinary circumstances." Rizzo v. Goode, 423 U.S. 362, 379 (1976). Where an injunction is sought against State officials, the Supreme Court admonished that "federal courts must be constantly mindful of the 'special delicacy of the adjustment to be preserved between federal equitable

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[54] Some courts have found that PAIMI groups need not name individual constituents at an early stage of the litigation, but those cases differed in terms of the nature of the claims brought and the scope of the relief sought. See Brown v. Stone, 66 F. Supp. 2d 412 (E.D.N.Y. 1999) (standing found at early stage of case asserting challenge to particular state policy regarding commencement of counterclaims by State against mentally ill patients of state facilities because PAIMI identified a particular group of allegedly injured individuals), aff'd sub nom. Mental Disability Law Clinic, Touro Law Ctr. v. Carpinello, 2006 WL 1527117 (2d Cir. May 31, 2006).

power and State administration of its own law." Id. at 378 (1976) (quoting Stefanelli v. Minard, 342 U.S. 117, 120 (1951)).

DAI clearly cannot obtain systemwide relief by merely showing that a few individuals meet the Olmstead requirements, an inherently individualized inquiry. To obtain this type of relief, DAI would have to prove that thousands of individuals meet these elements. See Lewis v. Casey, 518 U.S. 343, 359 (1996) (holding that two instances of unlawful conduct was a "patently inadequate basis" for systemwide relief); Rizzo, 423 U.S. at 367- 69, 380-81 (concluding that broad relief was not warranted where only nineteen incidents involved the deprivation of a federal rights); see also City of Los Angeles v. Lyons, 461 U.S. 95, 97-100, 105-06 (1983) (finding that a city-wide injunction was not justified by a single plaintiff's allegations that he was illegally choked by police). Moreover, systemwide relief is inappropriate because it would be "wildly intrusive." Casey, 518 U.S. at 361. In effect, DAI asks the Court to assume the roles of the Commissioners of OMH and DOH, make policy decisions about developing additional housing units, and determine who should move into that housing. As Justice Thomas explained, the federal courts are ill-equipped to serve such a function:

> Principles of federalism and separation of powers impose stringent limitations on the equitable power of federal courts. . . . Article III cannot be understood to authorize the Federal Judiciary to take control of core state institutions like prisons, schools, and hospitals, and assume responsibility for making the difficult policy judgments that state officials are both constitutionally entitled and uniquely qualified to make. . . .

Lewis, 518 U.S. at 385-86 (Thomas, J., concurring) (internal quotations and citations omitted).

C. DAI Is Not Authorized to Bring These Claims

DAI is not authorized to bring claims on behalf of many if not all of its constituents, and therefore is not entitled to seek systemwide relief. The Protection and Advocacy for Individuals with Mental Illness Act ("PAIMI"), 42 U.S.C. § 10805, authorizes a PAIMI organization to

pursue legal remedies either on its own or on behalf of its constituents. See 42 U.S.C. § 10805 (1)(B),(C). The statute, however, explicitly limits PAIMI organizations' authority to bring cases *on behalf* of individuals by requiring that such individuals meet specific criteria. Specifically, the PAIMI statute authorizes PAIMI organizations to:

> (b) pursue administrative, legal, and other appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in the State; and
>
> (c) pursue administrative, legal, and other remedies ***on behalf of*** an individual who--
>
> (i) was a individual with mental illness; and
>
> (ii) is a resident of the State,
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> but only with respect to matters which occur within 90 days after the date of the discharge of such individual from a facility providing care or treatment.

42 U.S.C. § 10805 (emphasis added). DAI has not established the elements of subsection (c), which is the only provision that authorizes PAIMI groups to bring actions "on behalf" of its constituents. Doe, 175 F.3d at 887 (finding PAIMI organization had not established standing because it did not show that allegedly injured persons were currently receiving treatment or had been discharged within ninety days); Autism Soc'y of Mich., 2006 WL 1519966, at *10 (questioning whether PAIMI organization was entitled to bring action, where it did not allege that matters had occurred within ninety days of the date the constituent was discharged from a facility); but see Brown, 66 F. Supp. 2d at 425 (noting that constituents did not meet the requirements of subsection (c) but PAIMI had standing under subsection (b)). Although some courts have found that PAIMI groups have standing to bring cases on behalf of residents without discussing the requirements of subsection (c), and may have assumed that PAIMI organizations

had authority to bring claims, none have sought relief of the scope sought by DAI here.[55] Because DAI cannot establish that it has authority to bring claims on behalf of many, if not all, of its constituents, it cannot pursue systemwide relief.

POINT II

NO STATE SERVICE, PROGRAM OR ACTIVITY SUBJECT TO THE ADA IS AT ISSUE, WHERE NO STATE POLICY REQUIRES OR CAUSES DISCRIMINATION, AND THE STATE CANNOT BE HELD RESPONSIBLE FOR THE ACTIONS OF ITS LICENSEES, THE ADULT HOMES.

Title II of the ADA, entitled "Public Services," governs the services, programs and activities of public entities. In this case, plaintiff's claim is without merit because plaintiff is unable to identify any State service, program or activity that is subject to the ADA or that is causing discrimination, in the form of non-integration or otherwise. See also Point I, A. 3. The State's primary role with respect to adult homes, licensure and inspection, is not a "service, program or activity" under the ADA and, in any event, is not being administered in a discriminatory fashion or causing discrimination. Rather, plaintiff's complaint lies with the adult homes themselves and, specifically, with the manner in which they are operated and the nature and quality of the services residents receive. However, government licensing agencies cannot be held liable for discriminatory conduct on the part of their licensees.

U.S. Department of Justice regulations specifically provide that, although a licensing program itself is subject to the ADA, the government agency does not thereby become responsible for alleged disability discrimination perpetrated by the licensee. See 28 C.F.R. §

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[55] See Trautz v. Weisman, 846 F. Supp. 1160 (S.D.N.Y. 1994) (standing found for claims against single private adult home and operator); Rubenstein v. Benedictine Hosp., 790 F. Supp. 396, 409 (N.D.N.Y. 1992) (standing found to assert claims against private hospital for injuries on allegations of harm to two individuals); Brown, 66 F. Supp. 2d at 425 (standing found at early stage of case asserting challenge to particular state policy regarding commencement of counterclaims by State against mentally ill patients of state facilities).

35.130(b)(6) ("The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part."). DOJ has reiterated this position in its Technical Assistance Manual ("TAM"). See ADA TAM II-3.7200, annexed to the Affidavit of Barbara K. Hathaway as Exhibit Hathaway-A ("The State is not accountable for discrimination in the ... practices of [a licensee] if those practices are not the result of requirements or policies established by the State. Although licensing standards are covered by title II, the licensee's activities themselves are not covered. An activity does not become a 'program or activity' of a public entity merely because it is licensed by the public entity."). See also Green v. City of New York, 465 F.3d 65 (2d Cir. 2006) (holding that a private hospital is not a public entity simply because it has a contract with the City and operates pursuant to City rules).

Here, plaintiff cannot show either that New York is directly discriminating in any of its own actions or that any alleged ADA violations by the licensed adult homes are "the result of requirements or policies" of the State. There is no State service, program or activity related to plaintiff's claims that is subject to the ADA, and, even if there were, none is *causing* disability discrimination. Defendants cannot be held responsible for the actions of the adult homes themselves. Thus, plaintiff cannot prove this threshold element of its claim, and summary judgment should be granted to defendants.

First, one must identify the State conduct at issue, which plaintiff has failed to do in its complaint. While "services, programs and activities" has been interpreted broadly, see Innovative Health Systems, Inc. v. City of White Plains, 117 F.3d 37 (2d Cir. 1997) (holding that zoning decisions are subject to the ADA), the conduct must still be properly attributable to the public entity, either because the government engages in it directly or because its policies require the conduct. It is indisputable that the State does not provide the housing to these adult home residents. The only direct responsibility the State has with respect to adult homes is its licensing

and inspection of adult homes and the enforcement of governing rules and regulations against adult homes. However, this regulatory role is not subject to the ADA because no individual adult home resident has the right to have these actions undertaken in any particular manner. Any incidental benefit or impact of the State's regulation of adult homes is far too indirect to be enforceable on behalf of specific residents in litigation. Accordingly, a number of courts have rejected ADA claims based on similar regulatory, licensing, or law enforcement activities.

Thus, in Amirault v. City of Roswell, 1996 U.S. Dist. LEXIS 9887, at *14 (D.N.M. March 28, 1996), aff'd mem., 1997 U.S. App. LEXIS 19902 (10th Cir. July 31, 1997), the court found that the mentally disabled plaintiff had "failed to identify any service, program, benefit, or activity to which he was entitled under the ADA and which was denied to him solely because of his disability." After receiving a call from plaintiff's girlfriend warning that the plaintiff was suicidal, local police officers came upon plaintiff in his car. Plaintiff had a gasoline can, and told the officers that he had planned to ignite himself, but had changed his mind. The officers did not detain him. Later, plaintiff in fact set himself on fire. He claimed that the officers' failure to detain him and to involuntarily commit him for mental health treatment deprived him of police assistance, in violation of the ADA. The district court reasoned that since the police owe no duty to protect any individual citizen or to provide for his general welfare, "protection of a particular person or the protection of members of a particular class of persons is not considered to be a municipal service, benefit, or program." Rather, the duty is to the public at large. Accordingly, the court concluded that the police "had no duty to protect Plaintiff from himself as he asserts, nor was Plaintiff denied a municipal or police service, benefit, or program to which he or any other individual or class of individuals was entitled." Id. at *16 - 17. The court further concluded that plaintiff's claim was without merit because, in any event, he had not shown that the police failed to arrest him because of his disability. The Tenth Circuit, stating that it was "in

accord with the district court's reasoning," affirmed. 1997 U.S. App. LEXIS 19902, * 6.[56]

In Tyler v. City of Manhattan, 849 F. Supp. 1429 (D. Kan. 1994), the court likewise rejected a claim based on the public entity's licensing and inspection of allegedly non-compliant restaurants and stores. Rejecting plaintiff's argument that "the City provides a service to the non-disabled public by physically inspecting licensed facilities," the court stated that:

> while that may be true, individuals with disabilities are not denied access to such licensed facilities, or to the claimed benefits flowing from the City's inspection of them, by virtue of any act of the City in the manner it conducts those activities. Rather, they are excluded from the benefits of the City's inspection and licensing services solely because the licensed structure itself happens to be inaccessible. Title II of the ADA and its implementing regulations prohibit discrimination against qualified individuals only *by public entities*. ... It simply does not go so far as to require public entities to impose on private establishments, as a condition of licensure, a requirement that they make their facilities physically accessible to persons with disabilities.

849 F. Supp. at 1442. See also Reeves v. Queen City Transp., Inc., 10 F. Supp. 2d 1181 (D. Colo. 1998) (Public Utilities Commission that issued certificate to bus company not liable for disability discrimination by bus company).

Similarly, in Alford v. City of Cannon Beach, 2000 U.S. Dist. LEXIS 20730, at *56-73 (D. Or. Jan. 17, 2000), the plaintiffs claimed that the city violated Title II by issuing permits, providing police coverage, and distributing information about non-ADA compliant social events held by private entities, and by issuing building permits to restaurants and stores that were not accessible. The court held that the city could not be held liable under the ADA based on any of its own direct actions, such as issuing building permits. The court rejected the argument that the

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[56] The court drew upon cases holding that under the Constitution the government owes no duty to protect or care for individuals who are not in its custody. Town of Castle Rock v. Gonzales, 545 U.S. 748 (2005); DeShaney v. Winnebago Co. Dep't of Social Services, 489 U.S. 189 (1989). It is also well settled that no individual has the right to bring suit based upon a failure of the government to enforce laws in a particular manner. Heckler v. Chaney, 470 U.S. 821, 831 (1985); O'Bannon v. Town Court Nursing Ctr., 447 U.S. 773 (1980); Gagliardi v. Village of Pawling, 18 F.3d 188, 192 (2d Cir. 1994); Mullen v. Axelrod, 74 N.Y.2d 580 (1989).

City's promotion of and other involvement in the social events rendered them public activities. Rather, the plaintiffs were improperly attempting to hold the City liable for the actions of private third parties. The court also reasoned that even issuing building permits to buildings which did not comply with the ADA could not support liability. Relying on the DOJ regulations providing that the activities of licensees could not be attributed to the public licensor, the Court found that the City had no duty to "force third party licensees or permittees to build compliant structures." Therefore, in this case, the licensure and inspection of adult homes cannot render defendants responsible for the alleged non-integration of adult home residents, even assuming (without conceding) that the residents are not in the most integrated setting.

The only other obvious potential State role to which plaintiff alludes in its complaint is the discharge planning required under N.Y. Mental Hyg. Law § 29.15 for patients discharged from State hospitals. While the complaint implies that large numbers of adult home residents were placed in adult homes from State psychiatric hospitals by State discharge planners, the undisputed evidence reveals that in recent years only a small percentage of patients discharged from State hospitals have moved to adult homes. Campbell Aff. ¶ 21 & Ex.O. Moreover, even for those small number of residents discharged to adult homes by the State, the State has discharged these patients to a residence which is legally obligated to assist the residents to become involved in the community. Furthermore, all discharge placements are voluntary. Therefore, a discharge to an adult home cannot be considered a requirement imposed by the State that a patient move to a non-integrated setting. Of course, even if a discharge from a State psychiatric center was deemed to be the conduct subject to the ADA, a claim based on this act would be subject to a three-year statute of limitations. Scaggs v. New York State Dep't of Educ., 2007 U.S. Dist. LEXIS 35860, at *33-35 (E.D.N.Y. May 16, 2007). Thus, at the most, those who have been discharged within three years of the complaint being filed may have a viable claim, but

plaintiff has made no effort to identify those individuals.

In any event, even assuming that at a future date an adult home resident who had been discharged from a State hospital wanted to move from the adult home, it is not the State's responsibility to ensure that the resident moves, or to assist the resident in moving. Any obligation to follow-up on a patient discharged from a State hospital exists for only a brief period. Indeed, a New York court found no basis to impose this duty for even 90 days. Koskinas v. Carrillo, 214 A.D.2d 512 (1st Dep't 1995). Thus, there is no existing State program, service or activity which provides housing referral services or placement in alternative housing to adult home residents, whether they were discharged from a State psychiatric hospital or not, and the ADA does not require that the State create such a new program.

Moreover, even assuming *arguendo* that adult homes are not integrated settings, the State does not require that anyone live in an adult home or receive services in adult homes. Thus, it cannot be said that the State is "administering" services, programs or activities in the adult homes, and the defendants are therefore not in violation of 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."). Adult home residents receive a number of services, some through the Medicaid program. However, their eligibility for services is not in any way dependent upon their living in an adult home or receiving those services in the adult home. They could move out of the adult home or remain and choose to receive services elsewhere. Thus, this case is distinguishable from cases challenging State policies that provide different services in an institution than are available in the community, essentially requiring that an individual enter an institution in order to receive certain services. See, e.g., Fisher v. OK Health Care Authority, 335 F.3d 1175 (10th Cir. 2003). Thus, the State is

not discriminating in any of its own actions.[57]

Nor can plaintiff show that the State is liable based on the actions of the adult homes, since no State policy requires that the adult homes function as non-integrated settings. The alleged non-integration of adult home settings is, therefore, not the "result of requirements or policies established by the State." ADA TAM II-3.7200. In fact, precisely the opposite is true. The regulations require that adult homes provide activities in the surrounding community and encourage residents to maintain ties with family and others in the community. The regulations give residents the right to come and go freely from the homes. Even assuming that these requirements are not being followed by the adult homes, and that the State agencies have done nothing to correct this situation (which is not the case, see Point VI), the State could still not be held liable. To do so would hold the State responsible for the conduct of the licensed adult homes, contrary to case law, DOJ regulations and DOJ guidance in the TAM. Moreover, since the State does not designate certain homes as "homes for individuals with mental disabilities," or dictate the number of individuals with mental disabilities any adult home may accept as residents, plaintiff cannot prove its claim simply by showing that any particular home has a large percentage of residents with mental disabilities. Not only is this not determinative of integration (because the residents remain free to come and go and participate in the life of the community and to interact with non-disabled persons), but the State is not responsible for the number of mentally disabled residents in any particular home.

The conclusion that the State cannot be held accountable for the actions of the adult homes under the ADA is fully consistent with other civil rights statutes and civil rights principles. For example, the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, et seq., covers persons residing in or confined to an institution. Institution is defined as any facility

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[57] The same analysis applies to plaintiff's causes of action alleging that defendants are discriminating in their methods of administration. While such "methods of administration" are not clearly specified in the complaint, nothing the State has done has the cause or effect of discriminating against adult home residents.

"which is owned, operated, or managed by, or provides services on behalf of any State...." The statute expressly excludes privately owned and operated facilities if the sole nexus between the State and the facility is licensing and/or receipt by the facility of payments under programs such as SSI on behalf of residents. Adult homes would fall squarely within this exclusion. Moreover, the doctrine of State action under the Constitution, applicable in actions pursuant to 42 U.S.C. § 1983, would similarly preclude holding the State liable for the actions of adult homes. See, e.g., Blum v. Yaretsky, 457 U.S. 991 (1982) (nursing home's decision to transfer residents did not constitute State action); Sybalski v. Independent Group Home Living Program, Inc., 2007 U.S. Dist. LEXIS 30097 (E.D.N.Y. April 24, 2007). Congress was fully aware of the scope of Title II's provisions when it entitled the Title "Public Services," and knew well how to draft a statute that covered private conduct, as it did in Title I, involving employment. However, Congress chose not to expand Title II to cover private entities. Plaintiff's attempt to apply Title II to problems which are essentially issues of the quality of conditions and services in private facilities tortures Title II beyond recognition.

Thus, Plaintiff's theory, if accepted, would constitute an extraordinary broadening of the scope of the ADA, far beyond Congressional intent and any interpretation of the ADA by the DOJ. It would leave governmental entities open to complaints and liability for any number of actions taken by private entities, simply because they are licensed or regulated by the State.

POINT III

ADULT HOME RESIDENTS RESIDE IN INTEGRATED SETTINGS WHERE THEY MAY COME AND GO FREELY AND INTERACT WITH NON-DISABLED PERSONS

In Olmstead, the Supreme Court held that, in certain limited circumstances the ADA requires that qualified individuals with mental illnesses be moved from institutional settings to more integrated settings. Olmstead, 527 U.S. at 587, 591-92. Even if Title II of the ADA were found to apply to privately operated adult homes that are merely regulated by the State, nothing

in that statute or its governing regulations would require that adult home residents be moved to other settings, because adult homes are "integrated," community-based settings.

As defined by the governing regulations, integrated settings are those that permit opportunities for contact with nondisabled persons. The undisputed evidence in this case shows that adult home residents have virtually unlimited opportunities to interact with nondisabled persons and that many, if not most, adult home residents choose to take advantage of these opportunities. As required by State regulations, adult homes facilitate these interactions through community-based programs, and mental health providers conduct similar activities. Moreover, the undisputed evidence shows that adult homes vary significantly from the psychiatric institutions at issue in Olmstead precisely because, unlike State-run psychiatric hospitals, adult homes do not limit interaction with nondisabled persons in the community.

A. Integration Is Defined As Opportunity for Contact with Nondisabled Persons

Title II prohibits public entities from subjecting qualified individuals to discrimination. 42 U.S. C. § 12132. The ADA identifies isolation and segregation of individuals with disabilities as forms of discrimination. 42 U.S.C. § 12101(a)(2). The Attorney General has promulgated regulations interpreting this prohibition against discrimination, see 28 C.F.R. Pt. 35 (2006), which in relevant part provide: "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) (2006). The regulations further define "most integrated setting" as "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . . ." 28 C.F.R Pt. 35, App. A at 551-552 (2006). The Olmstead Court tacitly endorsed this definition of integration. 527 U.S. at 597-98.

Under the regulatory definition of integration, the key is whether persons with disabilities have opportunities for contact with nondisabled persons, rather than the number of actual

contacts. As discussed further below, the Supreme Court and DOJ regulations make plain that disabled persons must have the opportunity to reject contact with nondisabled persons if they do not want to have those contacts. See Olmstead, 527 U.S. at 602; 28 C.F.R. pt. 25, App. A at 552 (2006). DAI's experts agree that the definition of "integration" turns on the opportunities available to persons with mental illnesses to have contact with nondisabled persons.[58]

B. Adult Home Residents Have Nearly Unlimited Opportunities For Contact With Nondisabled Persons

The undisputed evidence shows that adult home residents have nearly unlimited opportunities for contact with nondisabled persons, and deposition testimony from adult home residents, including many listed by DAI as potential witnesses, shows that residents frequently avail themselves of these opportunities and take full advantage of the other benefits afforded by living in New York City.

Adult homes are located in the community in residential areas, close to stores, restaurants, religious institutions, libraries, parks and/or beaches and boardwalks.[59] All are located near public transportation that provides access to rest of the City.[60] State regulations require that adult home residents be permitted to come and go from the facility at reasonable hours, 18 NYCRR § 487.5(a)(3)(xii), and deposition testimony from residents shows that homes abide by these rules, many permitting residents to come and go as they please,[61] while others have established

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[58] Duckworth Dep. 121-22; Jones Dep. 43-44.

[59] Burstein 9-10; Davis 107-09; Mendel 18, 75; Yunger 23, 39-40; P.B. 51-53; P.C. 96-98; L.G. 15, 21; S.B. 130-132; R.H. 34-41, 79-80; L.H. 52-53; G.H. 152-53; C.H. 64-65, 72-73; B.J. 53; I.K. 45, 61-63; G.L. 49-56, 68-72; T.M. 30-32; A.M. 56-57, 59, 67-71; J.M. 45-47, 55-57; D.N. 14-19, 32, 36-38.

[60] Burstein 10; Davis 108-09; Mendel 18-19; Yunger 41; S.B. 19; L.G. 171-72; L.H. 54; G.H. 152, 154-55; R.H. 80-81; C.H. 82-83; B.J. 51-52; I.K. 68; G.L. 56; T.M. 32; A.M. 83-84; J.M. 61-62; D.N. 68-69; S.P. 13-14; D.W. 25; cf. P.C. 222.

[61] Davis 23-24; Mendel 23-24; Yunger 59; P.B. 64, 66; M.B. 35, 98-99, 166-69; L.G. 90-91; G.H. 164-167; R.H. 113, 151; L.H. 75-76; C.H. 103; I.K. 85; G.L. 100; T.M. 54-55, 104; A.M. 157, 185; D.N. 169-170; S.P.

reasonable nighttime hours during which doors are locked and residents must be admitted by a staff member (like many apartment buildings in New York City).[62] R.H., a resident at Sanford Home, summed up residents' access to the surrounding neighborhood as "Nobody's locked in there. It's open. You can go in and out, where you want to go, whatever time you want to go."[63] B.J., a resident at Brooklyn Manor, similarly testified: "[Y]ou have options. You can go and come when you want to, nobody to tell you don't come and things like that."[64]

Each of the eighteen residents deposed in this case testified that he or she regularly leaves the home and visits shops, parks, restaurants, entertainment facilities, and/or other neighborhood conveniences.[65] For example, G.H., a resident at Surf Manor, testified that every resident living in his adult home eats outside the home at least twice per week, every resident walks around the neighborhood, almost every resident goes out of the home to go shopping approximately ten to fifteen times a year, and although he personally does not, all of the other residents go to the beach or the boardwalk "on a consistent basis."[66] DAI's expert, Dr. Kenneth Duckworth, admitted that residents he spoke with reported leaving the adult homes.[67]

58-59; D.W. 75; Lockhart 134-35.

[62] Burstein 18-20; S.B. 84-85; B.J. 69; M.B. 169.

[63] R.H. 151.

[64] B.J. 57.

[65] P.B. 50-53, 57-58, 148; S.B. 11-25; M.B. 40-50, 103-112; P.C. 38-39, 95-98; L.G. 14-18, 20-26; R.H. 33-41, 66, 80-82, 123-24; L.H. 49-50, 117-118; G.H. 77-83, 97-99, 130-45; C.H. 14, 18-22, 50, 53-54, 57-67, 72-75; I.K. 44-46, 62-67; B.J. 53-58; G.L. 33-34, 49-56, 68-73; A.M. 56-57, 59-60, 64-73; J.M. 44-51, 54-58, 68-70; T.M. 31, 41, 45-48; D.N. 14-19, 31-38, 73-75; S.P. 8-12; D.W. 30-32, 156-158; see also Burstein 45-46, 56-57, 106; Mendel 51, 97; Yunger 22-23, 39-41; cf. Davis 106-07.

[66] G.H. 136-45, see also I.K. 46-47.

[67] Duckworth 122-23.

Residents walk around the neighborhoods where they live.[68] Some attend services held at local religious institutions outside of the adult home, socialize with nondisabled congregants,[69] and even spend time at the houses of religious leaders.[70] Some residents take advantage of educational opportunities, including classes for GEDs at local schools.[71] Residents vote at polling stations.[72] Some residents attend 12-step meetings across the City.[73] Although homes generally provide laundry services for residents, some residents choose to do their own laundry at local laundromats.[74] Residents also lobby state government, engage in rallies, and participate in advocacy organizations for persons with mental illnesses.[75]

Residents take public transportation on a regular basis,[76] and many have reduced fare MetroCards.[77] Some residents who live in outer boroughs use buses and subways to see friends, and go to shops, movies, concerts, and museums in Manhattan.[78] For example, A.M., a former

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[68] S.B. 11, 16-17; L.H. 49; G.H. 144-45; I.K. 60; A.M. 82; J.M. 57-58, 70-71; T.M. 31; D.N. 14-16; S.P.57-58; D.W. 30.

[69] P.B. 58; R.H. 124-26; C.H. 16-17; A.M. 56-57; J.M. 34-35, 51-52; D.N. 19-23; see also G.H. 115; I.K. 47; D.W. 153; Burstein 85-86; Yunger 91.

[70] M.B. 43-45; see also S.B. 57-59.

[71] B.J. 19-20; Burstein 85-87.

[72] G.H. 145-46; R.H. 127-28; I.K. 60; G.L. 57.

[73] C.H. 11-13.

[74] S.B. 82; L.G. 88-89; A.M. 103-04; J.M. 101-02.

[75] L.G. 158-59; R.H. 16-18, 27-33; G.H. 11-16, 19-20, 22-29; I.K. 10-30; G.L. 7-16, 18-19; J.M. 21-25; T.M. 69-71; D.W. 130, 134.

[76] P.B. 56-57; S.B. 15, 18-20; M.B. 35-37; P.C. 98; L.G. 16-17, 135-36; R.H. 81-82; G.H. 97-99,142, 154-55; L.H. 54-55; C.H. 13, 22-24, 83; B.J. 51-52, 72; I.K. 16, 68-69; G.L. 9, 11, 33; T.M. 32-33, 78-79; A.M. 84-86; J.M. 24-25, 61; D.N. 26, 68-70; S.P. 13-16; Burstein 89-90; Mendel 77; cf. D.W. 25-27.

[77] M.B. 35-36; P.C. 105-07; L.G. 175-76; G.H. 155; C.H. 23; B.J. 71-72; I.K. 58-59; G.L. 33, 53; J.M. 62; D.N. 68-69; S.P. 59-60; Burstein 89-90; Yunger 25.

[78] S.B. 18-19; G.H. 97-99; 130-31; T.M. 78.

resident of Sanford Home, who now lives in supported housing, testified that while living in the adult home, he traveled to Manhattan monthly to play chess with a friend.[79]

Residents regularly visit their families and friends, sometimes staying overnight, and family, friends, and others visit residents at the homes.[80] Aside from visits, residents keep in touch with family and friends on the phone.[81] Some residents form friendships with people who live in their neighborhoods.[82] J.M., a former resident of Brooklyn Manor, testified that he talked with people from the neighborhood "all the time,"[83] noting that he spoke with a woman from the neighborhood on the phone regularly and visited her home.[84] A.M. similarly indicated that, while walking through a park, he met a woman who was walking her dog and began to see her or speak with her on the phone nearly daily.[85] D.W., a resident of Queens Adult Care Center, testified that he speaks with women in the neighborhood, that he jokes with an employee of a local bodega, and that he feels like he is part of the community.[86]

Some residents have jobs.[87] For example, S.P., a resident at Parkview Adult Home, testified that he works three days a week doing housekeeping/porter work at Bronx Psychiatric

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[79] A.M. 60-61.

[80] P.B. 108-09, 133-34; S.B.56-57; M.B. 94-95; L.G. 14-15, 25-31, 135-36; G.H. 115-20; L.H. 54-55, 93-94; I.K. 56-58, 71; B.J. 50-52, 111; G.L. 34-35, 48-49, 134-35; T.M. 79-80; A.M. 61, 79-80; J.M. 104-07; D.N. 26-27, 29-31, 61, 254; S.P. 55, 67-68; D.W. 25-28, 153-54, 181; Burstein 51-52; Davis 109-110; see also C.H. 51-54.

[81] M.B. 94-97; C.H. 51-52, 88-90; G.H. 115-116, 126; T.M. 39, 52; A.M. 74-75, 77-78, 80-81; J.M. 52-53, 73; D.N. 61-64; S.P. 62, 68; D.W. 64-65.

[82] M.B. 97-102; A.M. 79-80; J.M. 64-67, 71; D.W. 29-30, 32, 172; Davis 198-99; see also L.H. 51.

[83] J.M. 65-67, 71.

[84] J.M. 72-73.

[85] A.M. 80-81.

[86] D.W. 32, 172.

[87] S.B. 40-42; G.L. 78-79; A.M. 144-45; S.P. 15, 16, 29-36; G.H. 102-06; Burstein 45, 77, 82-84.

Center, participates in a vocational training program, and knows two other Parkview Adult Home residents who have jobs outside of the home - one as a seamstress, the other as a peddler.[88] Some residents engage in volunteer work at local hospitals or other charities.[89] B.J., a resident of Brooklyn Manor, testified that, once per week, she visits residents at local nursing homes and shares gospel tracts with them; at times she is accompanied by another Brooklyn Manor resident.[90]

The testimony of two residents is particularly illustrative.[91] G.H., a resident at Surf Manor HFA in Brooklyn for 19 years, has worked at a local outdoor newsstand every year he has lived in the home. For many years, he worked every day from 4:30 a.m. to 10:00 a.m., although, more recently, he has worked two days a week. He takes two buses to get to the newsstand. From 1996-2000, he and other residents volunteered at a skilled nursing facility, spending time with patients and escorting them to events in the facility. G.H. visits his family twice a month. Until costs became prohibitive, he traveled to different cities across the country with his family to watch professional basketball games, staying at hotels and eating at various restaurants. Several times per year, he spends time with three long-time friends, one of whom lives in Manhattan, another who lives in supported housing in Queens. G.H. regularly keeps in touch with his family and friends on the phone. G.H. eats at local restaurants in the neighborhood, shops for clothes in Manhattan and Brooklyn, and buys periodicals in the neighborhood. For several years, G.H. traveled weekly to the World Trade Center to listen to live country music concerts and spoke

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[88] S.P. 31-33.

[89] M.B. 28-35, 38-40; G.H. 107-10; B.J. 25-29; Davis 110, 202-04; Rosado 166-67.

[90] B.J. 25-28.

[91] For additional examples see Ex. Geller-A at 28-33.

with radio personalities who were present.[92]

C.H., a resident at Queens Adult Care Center, testified that he attends professional basketball and baseball games regularly with other residents. He also goes to rock concerts every other month with his girlfriend at the Beacon, Madison Square Garden, the Shadow, and other venues. C.H. uses public transportation every other day and has a reduced fare MetroCard. He walks around the neighborhood daily for exercise, regularly shops at the local 99-cent store and smoke shop, and occasionally frequents Rite-Aid with his girlfriend. He attends a 12-step program at different venues around the City. On occasion, he meets friends from this program at billiards halls or other locations and speaks with them on the phone. He also eats at fast food restaurants or a diner biweekly with his girlfriend and/or his roommate. Until last year, C.H. attended a local church, and, in the winter, shoveled snow for the church for pay. Several years ago, while living at Queens Adult Care Center, C.H. worked as a parking garage attendant, but, after about 10 months on the job, apparently was asked to stop working by the SSI program.[93]

C. Adult Homes Facilitate Integration

State regulations require adult homes to provide and encourage participation in community-based activities and to assist residents to maintain family and community ties. 18 NYCRR § 487.7(g) & (h). DOH inspectors monitor homes to ensure these regulations are followed.[94] Evidence shows that adult homes follow these regulations and provide community-based activities that facilitate contact with nondisabled persons. Several homes work with Hospital Audiences International (HAI) or other organizations to arrange trips for residents to

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[92] G.H. 77-84, 97-99, 102- 128, 130-36.

[93] C.H. 11-23, 57-73, 78-79, 83, 88-91.

[94] Burstein 96-97; Hart Aff. ¶¶ 64-105.

movies, shows, clubs, museums, and sporting events.[95] Adult homes also coordinate their own trips to stores, restaurants, libraries, museums, boardwalks, and/or movies,[96] and encourage residents to participate in these activities.[97] New Central Manor, for example, regularly has staff accompany residents to thrift shops.[98] In addition, many residents go on trips organized by their mental health providers to libraries, amusement parks, bowling alleys, stores, parks, neighborhood athletic centers, and restaurants.[99] Several homes also arrange for community members to come into the homes to lead religious services, job fairs, and musical shows.[100] Adult homes also encourage residents to maintain contact with family members.[101] In this regard, Queens Adult Care Center hosts family days, in which hundreds of family members visit the facility for entertainment and meals.[102]

Moreover, although not required by the ADA, the State has also taken steps to assist residents to become further integrated in their communities by improving and enhancing services through the case management program and other initiatives.[103]

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[95] Burstein 35-36, 40-41, 55-56; Mendel 44-45, 47-49; Yunger 27-28, 96; see also L.G. 49, 51, 53; G.L. 37-39; A.M. 34-36.

[96] Burstein 34-35, 39-45, 56; Davis 60-65; Mendel 50-51, 95-97; Yunger 23-25, 88-90; see also P.B. 130-31, 135-36; S.B. 53-54; L.G. 36-54; R.H. 41; C.H. 41-42.

[97] Burstein 43, 45-46; Mendel 90-91; Yunger 26-27.

[98] Mendel 95.

[99] Bienstock Aff. ¶ 5; Bear 40-41; Levine 34-35; Lockhart 88; Mendel 60-61; G.H. 41-46; C.H. 40-41, 43-48; G.L. 44-47; A.M. 24-26; D.N. 39, 49-50; S.B. 25-30, 38; B.J. 43-44; S.P. 22-23.

[100] Burstein 36; Davis 62, 67; Mendel 45-47; Yunger 23, 25, 90, 92-93; see also S.B. 11-13, 54-55; M.B. 46-48; L.G. 48-49; G.H. 91; I.K. 47-48; B.J. 49; A.M. 39-40; J.M. 51-52; S.P. 60-61; D.W. 150, 152-153.

[101] Burstein 16-17; Davis 13-14; Mendel 93-94.

[102] Yunger 21-22.

[103] Reilly Aff. ¶¶ 19-24.

D. DAI's Various Claims that Residents Are Not Integrated Are Meritless

DAI suggests that adult homes are not integrated because they are institutions, residents have few contacts with community members, and adult home residents are not independent. Compl. ¶¶ 44-52. These considerations are irrelevant to an analysis of integration, which turns on opportunities for contact with nondisabled persons.

DAI suggests that adult homes are not integrated because they are institutions, claiming that they are large congregate facilities, that have large dining rooms with set times for meals, shared rooms and bathrooms, and generally foster a lack of privacy. See, e.g., Compl. ¶¶ 44-52. DAI misreads Title II's discrimination provisions as interpreted in Olmstead. Title II's discrimination prohibition is not focused on either the type of home or size of the home where a person with a disability lives. The focus of those provisions is, rather, to preclude the isolation and segregation of people with disabilities and to foster their access to the community. See Olmstead, 527 U.S. at 597, 600 ("Unjustified isolation, we hold, is properly regarded as discrimination based on disability."); ("Congress explicitly identified unjustified 'segregation' of persons with disabilities as a 'for[m] of discrimination.'"). The discrimination provisions, therefore, apply to State-run residences that - unlike adult homes - segregate persons with mental illnesses through rules and policies that limit opportunities for interaction with nondisabled persons. Adult home residents are neither isolated nor segregated because they have virtually unlimited opportunity to interact with nondisabled persons.

The Court did not define "institution," as there was no issue in Olmstead about whether the State psychiatric facilities where plaintiffs lived were institutions because presumably, as in New York State, the State psychiatric facilities there had strict rules limiting patients' access to the community.[104] The Court, however, indicated that the discriminatory harm caused by these

[104] Campbell Aff. ¶¶ 11-15.

institutions was the lack of opportunities for contact with nondisabled persons, relying heavily on the Attorney General's definition of integration, which focuses on such contacts. Id. at 592. The Court also emphasized that the unjustified placement or retention of disabled persons in an institution is discriminatory because living in an institution "severely limit[s] their exposure to the outside community." Id. at 596 (citing 28 C.F.R. § 35.130(d) (1998)). Finally, the Court noted that institutional living reinforces stereotypes that disabled persons are "unworthy" of participating in community life and that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural advancement." Id. at 600-601.

Residents in State psychiatric facilities - like those at issue in Olmstead - are subject to explicit rules and policies that limit their time outside of the facility and visitors' time in the facility, including formalized privilege systems. While adult homes have some institution-like qualities, such as scheduled meal times, public address system announcements, and shared rooms and bathrooms,[105] these features do not significantly limit opportunities for interaction with nondisabled persons. Indeed, adult homes are required to permit residents to leave the home at reasonable hours. 18 NYCRR § 487.5(a)(3)(xii). Residents are free to come and go from the Adult Home as they please, shop, sit in the park, use the library, or use any of the other public accommodations available to people who live in New York City. Contrary to the allegations in the Complaint, the residents' undisputed testimony makes plain that residents do indeed take advantage these opportunities.

DAI also suggests that adult homes are not integrated because residents are isolated and do not have contact with nondisabled persons, preferring instead to stay inside the adult homes. See Compl. ¶ 47. A resident's level of integration, however, is a matter of choice for that

[105] Some adult homes have a few rooms where only a single resident resides. See Burstein 11; Yunger 43; Mendel 20-21.

individual or, at most, a function of the quality or effectiveness of the services offered by the adult home or mental health provider, both of which are outside of the scope of the enforcement provisions of the ADA and Rehabilitation Act.

Nothing in the ADA or the governing regulations compels any individual to have more contact with nondisabled persons than he or she desires. See Olmstead, 527 U.S. at 602 ("Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it.") (quoting 28 C.F.R. § 35.130(e)(1) (1998) ("Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . which such individual chooses not to accept.") & 28 C.R.F. pt. 35 App. A, at 450 (1998) ("[P]ersons with disabilities must be provided the option of declining to accept a particular accommodation."). Moreover, as discussed above, the ADA guarantees access to services, but no particular quality of services. In other words, the State may not be held responsible under the ADA if privately-run adult homes or mental health providers violate State regulations and fail to provide adequate services to facilitate and encourage community involvement (or, even, as the Complaint alleges, discourage residents from participating in community-based activities). Thus, even if lack of contact were due not to choice but rather to treatment providers and activities coordinators who do not sufficiently encourage involvement and teach skills necessary for community contact - that is an issue of quality and effectiveness, for which the State cannot be held responsible under the ADA.

Because it is indisputable that residents have the right to, and opportunities are available for, contact with many people and participation in the surrounding community, DAI appears to argue that adult home residents are not integrated because some do not actually take advantage of these opportunities. However, even assuming that some residents have little contact with nondisabled persons, this is not dispositive. The actual number of contacts with nondisabled persons cannot be used as the measure for whether a setting is integrated - both because residents

should have the choice of interacting with as many or as few nondisabled people as they desire, and this standard is entirely unworkable. Under such a standard, the Court would have to evaluate each resident individually to determine whether he or she is integrated. Those residents at an adult home who have many interactions with nondisabled persons would be deemed to live in an integrated setting, while residents in the same home who had fewer interactions would not. Neither a court nor a State agency could administer such a standard. Moreover, such a definition of integration would have truly radical implications for all types of services and housing. It is undisputed that even persons living in scattered-site supported apartments can and do become isolated. Would they then be living in non-integrated settings and the State subject to an Olmstead claim on their behalf? The test for integration, therefore, must rest upon the opportunities for interaction that are available, not on whether residents take advantage of them. Adult homes are integrated settings because residents have these opportunities.

DAI also appears to suggest that adult home residents are not integrated because they are less independent or autonomous than persons who live in supported housing. As discussed above, the legal definition of integration does not turn on independence, but rather on opportunities for contact with nondisabled persons. Dr. Jeffrey L. Geller, defendant's expert, who has more than thirty years experience in the mental health field as a treating psychiatrist, notes that even individuals who live in supported housing face significant limitations on their independence: "[L]iving in one's apartment does not free one from leverage or coercion effectuated by the organized mental health system. It should be clear that it is possible for many to live in an adult home less encumbered by mandatory requirements such as performance attached to housing, or coercion for treatment adherence, than would one in one's own apartment, i.e., supported housing."[106] In some respects, adult homes offer greater autonomy

[106] Ex. Geller-A at 16.

than supported housing because residents may face less pressure to attend day treatment programs or otherwise participate in programs.[107] On the other hand, many types of Housing For Persons With Mental Illness have many rules, including curfews and limitations on visiting hours.[108]

DAI further suggests that adult homes are not integrated simply because some of the homes are populated largely, or even entirely, by persons with mental illnesses. Being in a large home, however, does not minimize the opportunities residents have to leave the home and interact with nondisabled persons. Licensed CR-SROs may have as many as 100 persons with mental illness living together in one building. Moreover, as noted, even plaintiff's experts and other witnesses listed by them admit that it is possible for someone living in a scattered-site apartment to become isolated and have very little contact with nondisabled persons.[109]

Moreover, the State does not designate certain adult homes as being for persons with mental illnesses or in any way control whom the home accepts as residents. Nor does the State place a quota on the number of persons with mental illnesses that a home may accept. The State, therefore, cannot be held responsible for private homes' decisions about whom to admit or the fact that some residents live in a home with a large percentage of persons with mental illnesses.

In sum, the undisputed evidence shows that adult home residents live in integrated settings because they have multiple opportunities for contact with nondisabled persons.

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[107] Id. at 11, 14.

[108] Madan Aff. ¶¶ 12-13 & Exs. A-B; Bear 90-91, 96-98.

[109] Duckworth 285; Lockhart 85-87; Tsemberis 112.

POINT IV

DAI HAS NOT ESTABLISHED THAT RESIDENTS ARE QUALIFIED TO MOVE

Olmstead requires that the State move a person who is in State custody (unlike adult home residents) to a more integrated setting only if, among other requirements, the person is qualified to move into that setting. See Olmstead, 527 U.S. at 602. As in any ADA claim, establishing that the individual with a disability is "qualified" for the program or benefit at issue is an essential element of the claim. Here, the Complaint alleges that at least half of the 4,000 residents on whose behalf DAI has brought this case are qualified to move to more integrated settings, Compl. ¶ 114, but fails to identify a single such resident. After a significant amount of motion practice, in response to defendants' interrogatory seeking the identity of those residents DAI claimed were qualified to more integrated housing, DAI produced a list of 1536 residents who they claim are qualified to move to purportedly more integrated settings.[110] As discussed in defendants' contemporaneous Daubert motion, however, DAI has failed to establish that ***any*** of these individuals are qualified to live in allegedly more integrated settings because, among other reasons, none of these residents has been clinically examined by treatment providers to determine whether he or she meets the minimum requirements for acceptance into these housing programs.

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[110] In response to defendants' interrogatory seeking the names of such residents, DAI initially identified only two residents: one who has now moved to OMH-funded housing, and the other who has declined several opportunities to attend required interviews for supported housing apartments and otherwise rejected opportunities to live outside of the adult home. P.C. 15; I.K. 95, 103, 109-10, 113-14. After repeated requests and motion practice, and after Magistrate Judge Go directed DAI to promptly supplement their response, on September 30, 2005, near the close of fact discovery, DAI disclosed a list of approximately 1250 residents whom it claimed were qualified and not opposed to moving to alternative settings. Relying on this list, defendants developed a sample of these residents, subpoenaed records for them, and had those records reviewed by defendants' expert. In April 2006, however, DAI's expert, Dr. Groves, substantially increased the size of the list of residents, opining that 1536 residents are willing and qualified to move, which required defendants to develop an entirely new random sample and subpoena and review records for numerous additional residents, at considerable expense in staff time and tens of thousands of dollars in expert fees. See Aff. of Barbara K. Hathaway, Exs. B-F.

A. Residents Must Be Deemed "Qualified" By Treatment Providers

In Olmstead, the Supreme Court held that the State has an obligation to move a patient from State psychiatric facilities only if the patient "'meets the essential eligibility requirements' for habilitation in a community-based program." Olmstead, 527 U.S. at 602 (citing 28 C.F.R. § 35.130(d)). The Court emphasized that the State has no obligation to move a patient unless he or she is qualified: ["a]bsent such qualification, it would be inappropriate to remove a patient from the more restrictive setting." Id. Moreover, the State "generally may rely on the reasonable assessments of its own professionals . . . ." Id.

Here, State treatment professionals are not under any legal obligation under the ADA to assess the capacity and desire of residents in private adult homes to move to alternative settings because such an assessment would constitute a new state program. Hart Aff. ¶ 38. This, however, does not relieve DAI of its burden of assessing each of the residents it claims are qualified to move and establishing that each resident, in fact, is qualified to move. Olmstead, 527 U.S. at 602. DAI has utterly failed to meet that burden.

The Complaint fails to identify the precise type of housing DAI seeks for its constituents, but DAI's expert disclosures appear to indicate that DAI primarily seeks to move residents into scattered-site supported housing apartments.[111] As discussed, supported housing is designed for people with mental illness "who are able to live independently with minimal support services."[112] Residents who live in supported housing should be able to take their medication independently and "meet their own daily needs and manage their household with minimal assistance from staff."[113]

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[111] See, e.g., Duckworth at 5-8; Ex. E. Jones-1 at 3, 11.

[112] Ex. Tacoronti-A at 7; Myers Aff. ¶¶ 82, 83, 86-87.

[113] Ex. Tacoronti-A at 7; Exs. Newman-I, J.

B. DAI Failed to Prove That Any Residents Are Qualified for Supported Housing

DAI's experts acknowledge that an in-person clinical examination is necessary to determine the supports that would be required for a person who moved to supported housing.[114] Nonetheless, DAI's experts failed to conduct any clinical evaluation of any of the 1536 residents identified as being qualified to move. Moreover, none of plaintiff's experts even reviewed the residents' mental health records before rendering an opinion. DAI, therefore, has failed to establish that any of these residents meet the eligibility requirements of supported housing.

An assessment of the type and scope of supports each resident would need in supported housing is a critical component of an analysis of whether these residents are qualified to live in supported housing. Clearly any person with mental illness is capable of living in an apartment if unlimited supports are provided; but to meet the minimum criteria for acceptance into supported housing an applicant must need only a bare minimum level of support. DAI's experts have failed to show, using acceptable data and methodology, that ***any*** of the 1536 residents it identified require only this minimal level of support, not more. If any of these residents were to need further supports, DAI would in effect be requesting a fundamental alteration of the supported housing program as currently defined, which is not required by Olmstead. Adding substantial supports would also obviously increase the costs significantly, further supporting defendants' fundamental alteration defense.

Although DAI failed to examine the 1536 residents it identified, the record reflects that the mental health providers who actually treat some of these residents have concluded they are ***not*** qualified to move from their adult homes. It is well-accepted that the Court should defer to

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[114] Ex. Duckworth-7 at 3; Duckworth Dep. 173-175, 191, 204, 282-83; E. Jones Dep. 18-20, 26; Ex. E. Jones-1 at 11.

the opinion of these treatment providers.[115] Olmstead, 527 U.S. at 602; Youngberg v. Romeo, 457 U.S. 307, 322-23 (1982). For example, treatment providers noted the following in residents' records:

- "Recipient will be more appropriate for discharge when he stops drinking beer, copes better with symptoms of his illness, gains insight into his illness, develops sound peer relationships and interpersonal skills. He is not ready for discharge at this time."[116]

- "The recipient lacks insight with regards to his mental health and continues to display a guarded and paranoid disposition. He is not yet ready for discharge at this time. * * * Recipient is not eligible for discharge as he is not yet able to function independently and has not accepted rehab or OT referral. * * * Recipient will become eligible for discharge when he has reduced symptoms and is able to live independently in the community."[117]

- He [Recipient] has persistent severe mental illness requiring the structure of an adult residence. * * * * [R. ___] has a significant psychiatric illness that requires intensive support and structure. He is not capable of living in the community."[118]

- "Recipient is not ready for discharge as her coping skills need improvement, lacks insight into her illness, lacks skills for independent living."[119]

- "Recipient has not developed the skill necessary for independent living and is not ready to be considered for discharge."[120]

Moreover, even New York Presbyterian "assessors" on whom DAI's expert Dr. Groves

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[115] The Court should defer to the mental health providers' judgments here because they serve the same function as the State professionals who treated plaintiffs in Olmstead and Youngberg, who were committed to State-operated psychiatric facilities. In those cases, the Court emphasized that deference should be given to judgments of the professionals who were actually treating the individuals at issue. Olmstead, 527 U.S. at 602; Youngberg, 457 U.S. at 322-23.

[116] Ex. Hathaway-L.

[117] Ex. Hathaway-M.

[118] Ex. Hathaway-N.

[119] Ex. Hathaway-O.

[120] Ex. Hathaway-P.

relies indicated that some of the 1536 residents DAI identified should not be moved from adult homes. For example, one resident's assessment included the following notation: "Based on this assessment resident doesn't seem appropriate for more independent living. The adult home setting seems more appropriate, & hospitalization may be imminent if she doesn't stabilize."[121] Thus, even if the assessments were complete enough to support a determination of housing and support needs (which they are not), the Court should obviously defer to the clinician conducting the in-person interviews, rather than DAI's expert's review of the data.

Defendants' expert, Dr. Jeffrey Geller, also found that supported housing was not likely an appropriate placement for the vast majority of the residents identified by DAI. Dr. Geller analyzed adult home, mental health and Columbia Presbyterian "assessment" records of a random sample of the 1536 adult home residents identified by DAI. Of the 206 residents in the random sample only 134 were eligible for OMH-funded housing and were currently living in the adult homes (many of the residents identified by DAI had moved to nursing homes or psychiatric hospitals or had died). Dr. Geller concluded that if he were to assign these 134 residents to the most appropriate residential settings, only 32 residents or 25% would be assigned to supported housing. In other words, 75% of the residents listed in the random sample would likely not be appropriate for supported housing.[122] Importantly, although his data was more complete than that used by DAI's experts, Dr. Geller did not conduct clinical interviews of these residents or consider whether they desired to move to supported housing, and clearly testified that he would need additional information before recommending placement in supported housing.[123] Nor did he have the benefit of a treatment team to analyze the supports these residents would need.

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[121] Ex. Hathaway-Q.

[122] Ex. Geller-B at 15.

[123] See Geller Dep. at 139-41, 213-215.

Rather, Dr. Geller was simply responding to DAI's experts' conclusions, and his opinion does not establish that any residents are qualified for supported housing. Instead, Dr. Geller's findings establish that DAI's experts' analysis is woefully inadequate to prove this critical element of their case.

POINT V
PLAINTIFF'S CLAIMS ARE BARRED BY THE FUNDAMENTAL ALTERATION DEFENSE

Assuming arguendo that the ADA, as interpreted in Olmstead, applies here, plaintiff's claims must fail under defendants' fundamental alteration defense. In Olmstead, the Court recognized that "the integration mandate is not boundless" and states must have sufficient latitude "to administer services with an even hand." 527 U.S. at 603, 605. States retain the right not to "take any action that [they] can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens." 28 C.F.R. § 35.150(a). The "fundamental alteration" defense defined in Olmstead allows 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 (interpreting 28 C.F.R. § 35.130(b)(7)). See, e.g., Sanchez v. Johnson, 416 F.3d 1061, 1068 (9th Cir. 2005); Bryson v. Shepardson, 2006 U.S. Dist. LEXIS 71775, at *22 (D.N.H. Sept. 29, 2006); Williams v. Wasserman, 164 F. Supp. 2d 591, 638 (D. Md. 2001).

The courts will not disturb a State's scheme when, in light of existing budgetary constraints and the competing demands of other needy populations, "the State has developed a comprehensive, effective plan to move eligible patients into community care settings."

Here, unlike the plaintiffs in Olmstead, plaintiff's constituents are not patients in State hospitals. Nonetheless, even if the Court finds that ADA compels the State defendants to move

the adult home residents to "supported housing" with whatever services they need, the transfer would constitute a fundamental alteration of the State's services and programs.

First, the State's available resources within its mental health budget are limited and the transfer would increase the State's costs. Schaefer Hayes Aff. ¶¶ 38-59, 87-104, 125-30; Kipper Ex. A; Myers Aff. ¶¶ 196-211, 214-19; Simons Aff. ¶ 12. Second, requiring the State to earmark its resources to conduct housing assessments of, and to develop and set aside Supported Housing beds and wrap around services for New York City adult home residents would unfairly impact the State's ability to provide services to other needy State residents with mental illness. Schaefer Hayes Aff. ¶¶ 130-37; Myers Aff. ¶¶ 214-23; Newman Aff. ¶¶ 106-08. Third, plaintiff's remedy would alter many of the State's programs, activities and policies. Schaefer Hayes Aff. ¶ 138; Myers Aff. ¶¶ 224-50; Newman Aff. 104-10. Fourth, the State has a comprehensive, effective Olmstead plan to enable disabled persons who participate in State programs and services to obtain those services in the most integrated setting possible. Myers Aff. ¶¶ 97-186; Wollner Aff. ¶¶ 60-65; Simons Aff. ¶¶ 15-111.

A. The State's Resources Are Limited

In evaluating a State's fundamental alteration defense, the Court should use "the 'available resources' test" which properly focuses on the State's mental health budget, not the overall [welfare] budget or the State's general budget." Bryson v. Shepardson, 2006 U.S. Dist. LEXIS 71775 *22 (D.N.H. Sept. 29, 2006)(quoting Olmstead, 527 U.S. at 597)); Bruggeman v. Blagojevich, 219 F.R.D. 430, 435 (N.D. Ill. 2004)("Olmstead and its progeny limit the scope of available resources to the state's mental health budget"). See also Olmstead, 527 U.S. at 603-604. Against the available resources of the mental health budget, the Court must also consider the range of services that the State provides to others with mental disabilities. Olmstead, 527 U.S. at 597, 603; Bruggeman, 219 F.R.D. at 434.

Hence, in this case, the relevant State budget is the portion of the enacted State budget allocated to OMH,[124] because that is the budget that would be required to fund – if plaintiff were to prevail – housing assessments for all adult home residents, and additional Supported Housing beds and wrap around services for those who were qualified and did not object to moving. Schaefer Hayes Aff. ¶¶ 42-47, 87, 92-94; Ex. Kipper-A; Myers Aff. ¶¶ 68, 213.

Each year OMH receives authorization, through the final budget, for limited funding, and all of OMH's budget is allocated to support its existing programs and services. Schaefer Hayes Aff. ¶¶ 33, 42, 126, 139; Simons Aff. ¶ 24. As did the state officials in Sanchez, Bryson, and Williams, OMH officials must make difficult choices as to how to allocate OMH's limited resources among the competing needs of various populations Statewide. Schaefer Hayes Aff. ¶¶ 125-27; Myers Aff. ¶ 225. No additional resources are available to fund plaintiff's relief because OMH regularly, in its budget process, works diligently to identify potential savings, i.e., from closings of State hospitals, and reinvests them in community programs and services. Schaefer Hayes Aff. ¶¶ 67-71, 106, 126.

B. Transfer Would Cost The State More

Contrary to plaintiff's contention, requiring defendants to assess and move thousands of adult home residents to Supported Housing with whatever services they would need to live there safely, would dramatically increase the State's costs. Schaefer Hayes Aff. ¶¶ 87-124; Ex. Kipper-A; Myers Aff. ¶¶ 187-206.

Because vacancy rates for Housing for Persons with Mental Illness are low in New York City, placing a large number of individuals in those programs would of necessity require

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[124] OMH's budget is the relevant budget because that budget would be required to fund plaintiff's requested relief of assessments and set aside beds and services. However, the cost comparison below factors in the State share of Supplemental Security Income ("SSI"), which residents of adult homes and Housing for Persons with Mental Illness, including Supported Housing, receive.

development of additional beds. Schaefer Hayes Aff. ¶¶ 129-30; Ex. Kipper-A; Myers Aff. ¶¶ 213-15. Specifically, in 2006 for each eligible individual that would transfer from an adult home to scatter site Supported Housing, the increased cost to the State would be $13,500 if only OMH's budget is considered, and $8,244 if the State's contribution to SSI is included. Ex. Kipper-A; Myers ¶¶ 190, 200. This represents a dramatic increase of 231% in cost to the State. This analysis includes consideration of expected relevant savings and is based on conservative assumptions, assuming that a given adult home resident is qualified for and does not object to transfer to the Supported Housing scatter site apartment program. Schaefer Hayes Aff. ¶¶ 87-104; Ex. Kipper-A; Myers Aff. ¶¶ 202-03 . If instead, the individual lacks sufficient independent living skills to maintain the Supported Housing bed with the minimal case management embedded in that model, and needs an ACT[125] team (which previously cost OMH $3,000 to $7,500 per slot), then the cost to the State of the transfer would increase even more.[126] Schaefer Hayes Aff. ¶ 99; Ex. Kipper-A; Myers Aff. ¶ 202-03.

While plaintiff contends that the cost analysis should include "projected Medicaid savings," such assumptions are wholly speculative, and therefore, properly excluded from the analysis. See Bruggeman, 219 F.R.D. at 435 ("[O]nly the resources available in the budget should be a factor; speculative or potential resources are irrelevant."). See Ex. Kipper-A; Myers Aff. ¶¶ 207-10.

Likewise, it would be highly speculative to assume savings to the State of any other sort. Schaefer Hayes Aff. ¶¶ 105-24 & Exs. K, L; Ex. Kipper-A; Myers Aff. ¶¶ 207-10. Given the

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[125] The Pathways to Housing program, which is designed to serve the homeless and which plaintiff holds as a model, is even more expensive. Tsembaris 138, 271-74, 304-08; Myers Aff. ¶ 96 & Ex. DD.

[126] While no individualized housing assessments were conducted of any of plaintiff's proposed constituents, the record shows that for the few whose records contain an indication that they might, with appropriate follow up, later be deemed by treatment professionals to be qualified for and not opposed to moving to Supported Housing (Exs. Geller A & B), it is likely that most would be determined to require an ACT team and possibly additional significant services, such as a home health aide, to maintain a Supported Housing program bed.

conditions of the New York City real estate market and its lack of affordable housing for low income, Schaefer Hayes Aff. ¶ 109, it is reasonable to expect that, in the unlikely event that large numbers of adult home residents were found qualified for, and actually moved to Supported Housing, vacancies in adult homes would be filled with new residents coming from other settings. Schaefer Hayes Aff. ¶ 109; Ex. Kipper -A; Myers Aff. ¶ 209. Therefore, the State would still need to expend resources licensing and monitoring adult homes, and subsidizing the State portion of payments for their residents receiving SSI and choosing to reside there. See Olmstead, 527 U.S. at 604 n.14 (holding cost analysis must account for state's fixed cost of administration).[127] Therefore, it would be unduly speculative to assume any savings based on projected decreases in State SSI contributions.[128] Schaefer Hayes Aff. ¶¶ 108, 110; Myers Aff. ¶¶ 207-10.

C. Other Needy Individuals Would Be Adversely Affected

Courts have recognized the fundamental alteration defense where the State's mental health "budget admits of no easily redirected funds – at least without imposing disadvantages upon other equally deserving persons with disabilities," and "the State is, by and large, doing what it can with limited resources that have been provided by the legislature." See, e.g., Bryson, at *22-23. While OMH is committed to developing Housing for Persons with Mental Illness throughout New York State, OMH is not a housing agency. Schaefer Hayes ¶ 36; Simons Aff. ¶¶ 24-25, 65. Its primary mission is providing and overseeing mental health treatment and

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[127] Myers Aff. ¶¶ 209-10. Furthermore, adult homes are among the range of housing options owned and operated by non-State entities in the community for both nondisabled and disabled adults. Myers Aff. ¶ 61 & Ex. S. The State cannot simply close the privately owned homes in the absence of significant regulatory violations.

[128] Despite defendants' repeated requests, including a motion to compel, plaintiff never produced a list of individuals who had been determined by any clinical professional to be qualified to move to Supported Housing, or what supports specific individuals would need. Plaintiff's utter default on this issue prevents defendants from calculating more comprehensively the cost of such supports and thus the difference in cost to the State on an individual and aggregate basis.

services to all residents of the State. Myers Aff. ¶¶ 19, 21; Simons Aff. ¶¶ 12-18 & Exs. A-F. OMH expends extensive resources to support, among other things, a broad array of community services, programs and activities that assist and enable State residents with mental illness – including adult home residents – to receive treatment in, and reside in, the community. Schaefer Hayes Aff. ¶¶ 33-35; Myers Aff. ¶¶ 24-29, 68-96, 150-59. Since all of OMH's budget is allocated to support existing programs, OMH could not, without adversely impacting other adults and children with mental illness Statewide, devote its limited resources to conduct a housing assessment of, and to develop thousands of additional Supported Housing beds with wrap-around services for the adult home residents allegedly at issue. Myers Aff. ¶¶ 213-23; Simons Aff. ¶¶ 11, 23-24, 65 & Exs. A-F; Schaefer Hayes Aff ¶¶ 125-38.

Therefore, requiring OMH to expend its resources to provide the services to adult home residents that plaintiff seeks would be inequitable, and constitute a fundamental alteration. Myers Aff. ¶¶ 213-28; Simons Aff. ¶¶ 11, 23-24 & Ex. A-F; Schaefer Hayes Aff ¶ 125-37. Specifically, such a directive would force OMH to cut funding for existing community based services and programs serving other adults and children with mental illness. Myers Aff. ¶¶ 219-22; Simons Aff. ¶¶ 11, 23-24, 65 & Ex. A-F; Schaefer Hayes Aff ¶¶ 130-37. In particular, such a directive would require all other adults with mental illness who wanted and were eligible for Supported Housing, including persons being discharged from State psychiatric centers and the other five priority populations designated by OMH,[129] to unfairly wait behind adult home residents for Supported Housing beds. Myers Aff. ¶¶ 217-18; Schaefer Hayes Aff ¶¶ 131-32, 37.

D. Plaintiff's Demand Alters The Nature of the State's Programs

Plaintiff contends that the State should assess and move thousands of plaintiff's alleged constituents to Supported Housing even if they require substantial supports to maintain an

[129] These are populations which, unlike adult home residents, are actually in institutions or lack any housing.

apartment. If compelled, this result would alter the substance of OMH's policies, programs and services. First, to the extent it required OMH to assess and place adult home residents, it would create a new program that does not exist, along with an obligation to staff and fund it. Myers Aff. ¶¶ 238-42. Second, it would change the nature of the Supported Housing program, which by design offers only minimal case management, and was designed for those who have sufficient skills and abilities to maintain their apartment with minimal support. Myers Aff. ¶¶ 243-44; Schaefer Hayes Aff ¶¶ 28-29. Third, plaintiff's demand that its constituents receive "Supported Housing" with whatever supports they need to maintain the apartment is a fundamental alteration because it seeks entitlement[130] to one particular type of State subsidized housing for all individuals with mental illness who desire it, along with a tailored package of any community supports that would permit the individual to maintain the apartment. Myers Aff. ¶¶ 245-50; Simons Aff. ¶ 65. Fourth, setting aside Supported Housing beds for adult home residents would be contrary to OMH policies, which consider the needs of ***all*** State residents with mental illness in allocating its limited resources and which consider adult home residents to be one of seven high need, priority populations. Myers Aff. ¶¶ 229-37; Simons Aff. ¶¶ 73-74; Schaefer Hayes Aff ¶¶ 33-35, 125-28, 131-32. It would also violate Olmstead's admonishment that "a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions." 527 U.S. at 606.

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[130] This "entitlement" does not exist in New York, nor, to the parties' knowledge, anywhere in the U.S., and Olmstead does not require its creation. See Rodriguez v. City of New York, 197 F.3d 611, 615-16 (2d Cir. 1999) (state is not obligated to create new program); cf. Olmstead, 527 U.S. at 603 n.14 (ADA does not guarantee that each recipient of benefits will get care precisely tailored to his needs).

E. Defendants' "Olmstead Plan" Is Sufficient

Simply put, in Olmstead, a plurality of the Supreme Court held that for patients of State hospitals whose treating physicians had determined were qualified to move into community settings, states had a duty to transfer those who did not oppose the transfer within a reasonable amount of time, using a system that had a waiting list that moved at a reasonable pace. Olmstead, 527 U.S. at 593-94 and 607. Long a nationwide leader in its commitment to meeting its residents' mental health needs, New York State was in compliance with Olmstead's mandate even before that case was decided. Myers Aff. ¶¶ 100-02, 152-56; Simons Aff. ¶¶ 16-20, 26-111 & Exs. A-F; Campbell Aff. ¶ 16. The record establishes that New York had significantly reduced the census of state psychiatric centers, closed beds where feasible and invested savings into community based services. Myers Aff. ¶¶ 99-104, 155-56; Simons Aff. ¶¶ 16-20, 26-111 & Exs. A-F. OMH has also worked diligently to allocate increased funding where available from the budget to develop almost thirty thousand units of Housing for Persons with Mental Illness, as well as to develop and support many types of community based services and treatment that enable mentally ill individuals to receive treatment in the community. Myers Aff. ¶¶ 67-69, 153-55; Simons Aff. ¶¶ 57-81 & Exs. A-F; Schaefer Hayes ¶¶ 15, 34, 49-50. Furthermore, New York State's Most Integrated Settings Coordinated Council ("MISCC") has recently issued its comprehensive report on the State's Olmstead plan as it relates to all relevant disabled populations within New York. Ex. Wollner-BB; Myers Aff. ¶ 127.

While OMH has no obligation to publish a single document entitled "Olmstead plan" – much less such a plan tailored to each subpopulation of adults with mental illness living in a particular type of residential setting – OMH has a comprehensive existing system and plan in place to provide mentally ill individuals, including adult home residents, with access to a vast array of community based services and programs, including Housing for Persons with Mental

Illness, should such individuals be interested in and eligible for them.[131] Myers Aff. ¶¶ 97-98, 103-68 & Exs. B-HH; Simons Aff. ¶¶ 15-111 & Exs. A-F. Moreover, the process by which Housing for Persons with Mental Illness is made available by not-for-profit providers to eligible applicants, including adult home residents, functions reasonably in the context of the State's demonstrated past and renewed commitment to expanding community based services, including Housing for Persons with Mental Illness. Myers Aff. ¶¶ 88-94 & Exs. K-Q, S-CC; Simons Aff. ¶¶ 39-41, 46-79, 108-09 & Ex. A-F.

Plaintiff's radical interpretation of Olmstead would impose upon the State – with respect to adult home residents who receive treatment from community based providers and live in private proprietary homes in the community – the same responsibilities the State has for mentally ill patients of State hospitals under the care of State professionals. Assuming arguendo that Olmstead were to be expanded to require a "plan" for adult home residents, the fundamental alteration defense would logically need to be modified to apply to privately operated facilities, in which the State does not control an individual's treatment. As a practical matter, it is not feasible for OMH to maintain a waiting list comprised of applicants residing in private residences Statewide for Housing Programs that are operated by numerous not-for-profit housing providers. Myers Aff. ¶¶ 178-80 & Ex. II. Therefore, the component of a State maintained waiting list as

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[131] The highlights of the system include: OMH's discharge planning policies and practices at its State hospitals; OMH vast network of more than 27,000 community housing beds; OMH's commitment to developing even more OMH Housing beds over the next several years; OMH's designation of adult home residents as a priority population for OMH Housing beds; OMH's oversight through licensure of mental health providers who are required to develop appropriate individual treatment plans for adult home residents; DOH's oversight through inspection and licensure of adult home case managers who are required by applicable regulation to assist residents in moving where appropriate; a not-for-profit SPOA entity which maintains vacancy lists for each not-for-profit housing provider in New York City; a centralized processing City agency, HRA, which accepts HRA 2000 applications for OMH Housing and arranges for interviews with applicants with available not-for-profit housing providers; OMH's Adult Home Case Management Initiative which assists adult home residents in developing and achieving individualized treatment plans; DOH's EnAbLE program; and OMH's research into mental health issues, ensuring the State's mental health policies are informed by state of the art knowledge. Myers Aff. ¶¶ 97-168 & Exs. B-HH; Simons Aff. ¶¶ 26-111 & Ex. A-F; Reilly Aff. ¶¶ 19-31.

discussed by courts applying Olmstead in the context of State hospitals should either be deemed inapplicable, or satisfied by OMH's current comprehensive plan, which includes a system of designating target populations for Housing Program beds and a requirement that mental health professionals providing services to residents of adult homes develop individualized treatment plans, which include, if the individual is interested in such a goal, applying for and moving to an alternate settings of his or her choice, including Supported Housing, and assisting the individual to acquire any needed independent living skills. Myers Aff. ¶¶ 109-13, 116-19, 128-29, 133-44, 181-85 & Exs. G, H, J, K, M, U-W; Simons Aff. ¶¶ 40-41, 47. The application process is available to adult home residents, adult home residents have recently been designated as a priority population to increase their access to such beds, and the record demonstrates that adult home residents have been successful in applying for Housing for Persons with Mental Illness and moving from adult homes when they want to. Myers Aff. ¶¶ 94, 146-149, 174 & Exs. V & W; Simons Aff. ¶¶ 15, 28, 40-41, 43-45, 47; Reilly Aff. ¶ 29.

As demonstrated above, because granting plaintiff's requested relief would fundamentally alter the nature of OMH's policies, services, programs, and activities, defendants' motion for summary judgment should be granted.

POINT VI

DEFENDANTS HAVE NOT DISCRIMINATED IN THEIR INSPECTIONS AND ENFORCEMENT OR TOLERATED POOR CONDITIONS IN IMPACTED ADULT HOMES

Plaintiff's third and sixth causes of action, based on DOH's alleged failure to use its oversight and regulatory authority to redress poor conditions in large, impacted adult homes, must be dismissed, first, because DOH's oversight and law enforcement actions are not a program, service or activity subject to the ADA, and, second, because the undisputed evidence shows that DOH has not used its enforcement powers selectively. Rather, it has taken stronger actions against impacted homes than against non-impacted homes.

In its third and sixth claims, akin to discriminatory or selective enforcement claims, plaintiff alleges that defendants have discriminated "by failing to take adequate measures to redress continued poor conditions in impacted adult homes that, upon information and belief, they do not tolerate in adult homes that primarily serve individuals with physical disabilities." However, the undisputed evidence reveals that defendants have, if anything, devoted more staff and resources to oversight of impacted adult homes than to non-impacted homes, and have not failed to inspect and cite impacted adult homes for violations. Most significantly, the evidence reveals that over the past 6 years, of the enforcement penalties imposed on New York City adult homes, 15 have been assessed against impacted homes, and only two against non-impacted homes. Ex. Hart-VV. Moreover, four of the most problematic, large impacted homes in New York City have closed and/or re-opened under new operators as a result of DOH actions. Thus, plaintiff's third and sixth claims are baseless and must be dismissed.

As shown in Point III, supra, a governmental entity's use of its authority to regulate or to enforce the law does not give a private right of action to any particular individual. No person has the right to have such authority exercised in a particular manner, and no person may individually seek to compel the State to take any particular law enforcement action. Rather, such regulatory authority is of only indirect benefit to the individual, and its exercise is solely within the discretion of the governmental agency. See generally Town of Castle Rock v. Gonzales, 545 U.S. 748 ; Heckler v. Chaney, 470 U.S. 821; O'Bannon v. Town Court Nursing Center, 447 U.S. 773. Accordingly, the exercise or non-exercise of such power is not subject to review by a Court under the ADA. Amirault v. City of Roswell, 1996 U.S. Dist. LEXIS 9887. Any other result would essentially transform the federal Court into a Super-Department of Health, monitoring adult homes' compliance with State Codes and directing administrative enforcement decisions.

However, even if the Court finds that such law enforcement activities are reviewable under the ADA, in order to prevail plaintiff must establish that the laws governing adult homes

essentially go unenforced, or that DOH enforces laws in other venues but denies the benefit of its law enforcement activities to adult home residents with mental disabilities. This plaintiff cannot prove.

In Independent Living Resource Center, Inc. v. City of Wichita, 2002 U.S. Dist. LEXIS 6324 (D. Kansas March 15, 2002), plaintiffs claimed they were denied the benefits of a handicapped parking space program due to the lack of enforcement of parking laws. As a result, non-disabled private citizens parked in the spaces, depriving the disabled of the use of the spaces. The court denied a motion to dismiss, finding that "the ADA applies to all activities of the City of Wichita, including its policies and practices relating to enforcement of handicap parking ordinances." However, the court said that in order to ultimately prevail, plaintiff would have to prove that the objectives of the program were substantially impaired "by showing that the City's handicap parking ordinances go essentially unenforced, or that the City enforces other ordinances but regularly ignores enforcement of handicap parking ordinances, thereby denying individuals with disabilities the benefits of enforcement that other individuals receive."

This Court, unlike the Wichita court, has the benefit of a full record of the defendants' enforcement activities. This record demonstrates that plaintiff cannot show that defendants have discriminated in how they have enforced standards in adult homes. With respect to inspections, in all inspection reports issued by DOH's MARO office, excluding "compliance" surveys (those where homes were found to have no violations and no findings) MARO cited an average of 7.6, 6.31 and 6.34 violations in impacted adult homes in 2004, 2005 and 2006, respectively. It cited 5.31, 5.71 and 4.68 in non-impacted homes during the same period. Ex. Hart-UU. Thus, DOH is simply not ignoring violations in impacted adult homes.

DOH has also imposed penalties against impacted adult homes at a much greater rate than against non-impacted homes. In fact, from 2000 to 2006, penalties have been imposed against 15 impacted homes, and only two non-impacted homes. Ex. Hart-VV. Moreover, DOH actions

resulted in the closure of Seaport Manor, Ocean House Center and Leben Home, three large impacted homes, and DOH assisted in negotiating the sale of Brooklyn Manor after prolonged enforcement activity. In the face of this evidence, it is impossible to maintain that DOH is denying the benefit of its enforcement actions to residents with mental disabilities, or otherwise discriminating against residents with mental disabilities.

POINT VII

GOVERNOR SPITZER SHOULD BE DISMISSED AS A PARTY TO THIS LITIGATION

Pursuant to Rule 21 of the Federal Rules of Civil Procedure, Governor Spitzer should be dropped as a party to this litigation because his presence would not be necessary to afford DAI the full relief it seeks in the event it were to prevail in this litigation.

Under Rule 21, the Court has discretion to drop a party from an action in the interests of justice. The Rule provides in relevant part: "Parties may be dropped or added by order of the court on motion of any party or of its own initiative at any stage of the action and on such terms as are just. Any claim against a party may be severed and proceeded with separately." Fed. R. Civ. P. 21. Thus, the Court may drop a party as a defendant where its presence is unnecessary for the full relief requested by the plaintiff. Comm. For Pub. Ed. & Religious Liberty v. Rockefeller, 322 F. Supp. 678, 686 (S.D.N.Y. 1971).

In Committee for Public Education and Religious Liberty v. Rockefeller, 322 F. Supp. 678 (S.D.N.Y. 1971), the Court dropped the Governor as a party to an action because full relief could be afforded by the other named defendants. Id. at 686. There, the plaintiff named the Governor, the Comptroller, and the Commissioner of Education as defendants in an action challenging the constitutionality of an appropriation of funds for the examination and inspection of students in nonpublic schools. Id. at 679-80. The Court granted defendant's motion to drop the Governor as a party, holding "[i]t is clear that, should the plaintiffs prevail, the full relief they

seek can be afforded by the issuance of an injunction against the Commissioner of Education and the State Comptroller, who between them have the sole power and responsibility for the execution of [the challenged statute's] provisions." Id. at 686; cf. Romeu v. Cohen, 121 F. Supp. 2d 264, 272 (S.D.N.Y. 2000) (Governor is not a proper defendant in actions challenging constitutionality of state statute despite his general duty to enforce the laws), aff'd, 265 F.3d 118 (2d Cir. 2001); Warden v. Pataki, 35 F. Supp. 2d 354, 359 (S.D.N.Y. 1999) (same), aff'd sub nom. Chan v. Pataki, 201 F.3d 430 (2d Cir. 1999).

Here, if DAI were to prevail, full relief could be provided by the four other named defendants. These defendants, the Commissioners of OMH and DOH and the agencies themselves, have plenary authority to regulate the certified mental health care and treatment services received by adult home residents and to regulate the physical plant of adult homes. See generally SSL §§ 460, 460-a. The Governor's presence, therefore, confers no further advantage on DAI. Because full relief could be afforded by the remaining defendants, DAI will not prejudiced by the Governor's dismissal. Comm. for Pub. Educ., 322 F. Supp. at 686. To conserve the limited resources of his important office, Governor Spitzer should be dropped as a party in the interests of justice.

CONCLUSION

FOR THE FOREGOING REASONS, SUMMARY JUDGMENT SHOULD BE GRANTED FOR THE DEFENDANTS AND THE COMPLAINT SHOULD BE DISMISSED.

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Respectfully submitted,

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