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IN THE UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LESLIE NAPPPER, JANET FISCHER, JACQUIE EICHHORN-SMITH, TED YANELLO, and LYNN MANGIO, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

COUNTY OF SACRAMENTO; BOARD OF SUPERVISORS OF THE COUNTY OF SACRAMENTO; County Supervisor ROGER DICKINSON; County Supervisor JIMMIE YEE; County Supervisor SUSAN PETERS; County Supervisor ROBERTA MACGLASHAN; County Supervisor DON NOTTOLI; SACRAMENTO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH SERVICES; ANN EDWARDS-BUCKLEY, Director, Department of Behavioral Health Services; MARY ANN BENNETT, Mental Health Director,

Defendants.

Case No. 2:10-cv-1119 JAM-EFB

STATEMENT OF INTEREST OF THE UNITED STATES

Date: July 21, 2010
Time: 9:30 a.m.
Place: Courtroom 6, 14th Floor
Judge: Hon. John A. Mendez

FEDERAL CASES

FEDERAL STATUTES

FEDERAL REGULATIONS

I. INTRODUCTION

The United States files this Statement of Interest, pursuant to 28 U.S.C. § 517, because this litigation implicates the proper interpretation and application of title II of the Americans with Disabilities Act, 42 U.S.C. § 12101 et. seq., ("ADA"). In particular, this case involves title II's integration mandate. *See Olmstead v. L.C.*, 527 U.S. 581 (1999). The Department of Justice has authority to enforce title II, 42 U.S.C. § 12133, and to issue regulations implementing the statute, *id*. § 12134. The United States has a strong interest in the resolution of this matter and urges this Court to grant Plaintiffs' Motion for Preliminary Injunction. The Superior Court of California issued a tentative ruling granting a preliminary injunction that may have an impact on this present motion. (*See* tentative California Superior Court ruling by Judge Steven H. Rodda, Item No. 26, Attached as Ex. A.)

This lawsuit alleges that Sacramento County's redesign of its outpatient mental health service system puts thousands of Medi-Cal recipients with mental illness at substantial risk of institutionalization in violation of the ADA. The County asserts that the redesign is necessary in light of budget shortfalls; however, the County is simultaneously *increasing* funding for costly institutional care. While the County argues that the same array of services will be provided under the new system, the facts make it clear that plaintiffs will experience a significant reduction in services, putting them at risk of entry into unnecessarily segregated settings such as hospitals, psychiatric facilities, and jails.

Beyond the heavy human toll the County's actions will impose on plaintiffs, they will also give rise to significant financial costs for the County. The cost of providing plaintiffs with necessary outpatient services is far less than the costs associated with unnecessary hospitalizations and institutionalizations that will be caused by the inadequate level of outpatient

services. Defendants attempt to frame the injury at the heart of this case as one of "fear of change"; however, this characterization ignores the very real injury recognized by *Olmstead*, the risk of plaintiffs having to enter institutional placements and hospital emergency rooms due to insufficient community care.

II. SUMMARY OF FACTS

A. Sacramento County's Current Outpatient Mental Health Services Are Provided Through County Contracted Regional Support Teams.

Sacramento County provides outpatient mental health services to thousands of Medi-Cal recipients through four regional centers, Regional Support Teams (RSTs), run by non-profit entities. (Declaration of Beth Stoneking, DKT 49, ¶¶13, 19.) Each of the named plaintiffs has received community mental health services under the current system for many years (ranging from 2 to 10 years). (Declaration of Leslie Napper, DKT 41, ¶2; Declaration of Jacquie Eichhorn-Smith Decl., DKT 30, ¶1; Declaration of Jan Fischer, DKT 31,¶2; Declaration of Lynda Mangio, DKT 40, ¶13; Declaration of Ted Yanello, DKT 51, ¶3.) The RSTs currently serve a population of individuals with significant mental health needs, as those with less severe needs were terminated from the County's outpatient mental health programs last year. (Supplemental Declaration of Dr. Michael Franczak, DKT 99-6, ¶15.) Plaintiffs are individuals with a variety of mental illnesses, including Chronic Severe Depression, Post Traumatic Stress Disorder, bipolar disorder, and schizoaffective disorder, among others. (Mangio Decl. ¶2; Fischer Decl. ¶2, Eichhorn-Smith Decl. ¶2; Yanello Decl. ¶2; Declaration of Alan Cummings, DKT 28, ¶4, Declaration of Edraline Powell, DKT 44, ¶4; Declaration of Teresa Johnson, DKT 37, ¶2; Declaration of Channel Kirby, DKT 38, ¶2; Boynton Decl. ¶3; Napper Decl. ¶2; Declaration of Linda Connors, DKT 27, ¶1.)

The RSTs develop individual treatment plans for each client that combine "medication,

psychosocial therapy, group counseling, peer support, and self-help, and many opportunities for learning life skills and developing resources to integrate into their communities." (Stoneking Decl. ¶21.) Additionally, RSTs provide community integration services including assistance with accessing public transportation, locating and maintaining housing, and assisting clients with skills to help build relationships with friends and family. (Kirby Decl. ¶11; T. Johnson Decl. ¶5; Declaration of Rania Haidary, DKT 33, ¶5; Eichhorn-Smith Decl. ¶8; Declaration of John Buck, DKT 25, ¶1; Declaration of Lynn Place, DKT 43, ¶10). In addition to the services available through RSTs, the County provides services through Transitional Community Opportunities for Recovery and Engagement ("TCORE"). (Declaration of Frank Cline, DKT 26, ¶7; Place Decl. ¶26.) TCORE provides "short-term intensive services to people being discharged from hospitals and who are not receiving any mental health services. TCORE tries to reduce or prevent the need for crisis services, hospitalizations, and institutionalization by increasing the linkage to community-based services for the unserved and underserved." (Cline Decl. ¶7.)

B. <u>Sacramento County's Plan to Transition All Clients From the County Contracted Regional Support Teams to County Operated Clinics</u>.

On June 17, 2010, the Sacramento County Board of Supervisors approved a $2.9 million dollar plan to restructure the outpatient mental health system by closing the RSTs and replacing them with new county-run clinics, staffed by county employees. (Declaration of Kelli Weaver, DKT 91, at 6; Declaration of Mary Ann Bennett, DKT 88, at 3 and Ex. B at 3, "Department of Health and Human Services Proposal to Restructure the County's Adult Outpatient Mental Health Services System.") This decision was largely driven by two factors. First, the County created a budget shortfall in the adult outpatient system when it shifted discretionary realignment revenues – approximately $3.2 million – from community-based services to institutional care at its 50-bed locked inpatient facility, the Mental Health Treatment Center. (Bennett Decl. at 2, 5;

Deposition of Mary Ann Bennett, attached as Ex. B, 33:11-13.) Second, the County sought to protect the jobs of 40 County employees – as opposed to maintaining jobs at the RSTs – who were originally given layoff notices for reduction in other County departments. (Bennett Decl. at 5; Bennett Dep. at 60:24-61:18, 132:5-13, Ex. B.)

Many details regarding the transition itself and the level of services that will be provided at the County clinics remain unresolved with transitions slated to begin as early as 10 days from the date of the scheduled preliminary injunction hearing. For instance, defendants have failed to provide any concrete details on central issues, including when the County will get state approval on its plan (and whether MHSA funds will be authorized); whether the facilities can actually begin transitioning clients on August 1; what information will be provided to individuals calling the phone bank; what protocol is in place to deal with consumers who have concerns; what steps have been taken to identify individuals with unusual needs; what tracking will be done for individuals who miss appointments; whether clinical staff will meet language needs (beyond the use of interpreters); whether any medical records have changed hands; what the contingency plan will be if the number of transfers cannot be completed under the current timeline; whether additional staffing is needed to front-load intake time; what steps will be taken for no-shows; whether site visits / in-home visits will occur as follow-ups; what experience (if any) the County staff have with regards to delivering mental health services using the recovery model; what training the County staff will receive. (Bennett Dep. at 69:13-70:18, 78:20-79:2, 92:5-20, 95:15-21; 86:15-17, 88:24-89:3, 96:15-97:1, 98:24-99:5, 101:25-102-5, 103:1-22, 107:11-22, 134:12-14, 138:13-139:6, Ex. B.; Stoneking Second Supp. Decl. ¶8.)

III. ARGUMENT

A. Olmstead and the Integration Mandate.

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities.

> [N]o 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.

As directed by Congress, 42 U.S.C. § 12134, the Attorney General issued regulations implementing title II, which are based on regulations issued under section 504 of the Rehabilitation Act.[1] *See* 42 U.S.C. § 12134(a); 28 C.F.R. § 35.190(a); Executive Order 12250,

[1] Title II was modeled closely on Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, which prohibits discrimination on the basis of disability in federally conducted programs and in all of the operations of public entities that receive federal financial assistance. Title II provides that "[t]he remedies, procedures, and rights" applicable to Section 504 shall be available to any person alleging discrimination in violation of title II. 42 U.S.C. § 12133; *see also* 42 U.S.C. § 12201(a) (ADA must not be construed more narrowly than Rehabilitation Act). The ADA directs the Attorney General to promulgate regulations to implement title II, and requires those regulations to be consistent with preexisting federal regulations that coordinated federal agencies' application of Section 504 to recipients of federal financial assistance, and interpreted certain aspects of Section 504 as applied to the federal government itself. 42 U.S.C. § 12134(a)-(b). Title II thus extended Section 504's pre-existing prohibition against disability-based discrimination in programs and activities (including state and local programs and activities) receiving federal financial assistance or conducted by the federal government itself to all operations of state and local governments, whether or not they receive federal assistance. The ADA and the Rehabilitation Act are generally construed to impose the same requirements. *See*

45 Fed. Reg. 72995 (1980), *reprinted in* 42 U.S.C. § 2000d-1. The title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The preamble discussion of the "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible..." 28 C.F.R. § 35.130(d), App. A. This mandate advances one of the principal purposes of title II of the ADA – ending the isolation and segregation of people with disabilities. *See Arc of Wash. State Inc. v. Braddock*, 427 F.3d 615, 618 (9th Cir. 2005).

Eleven years ago, the Supreme Court applied these authorities and held that title II prohibits the unjustified segregation of individuals with disabilities. *Olmstead*, 527 U.S. at 596. *Olmstead* held that public entities are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when a) treatment professionals reasonably determine that such placement is appropriate; b) the affected persons do not oppose such treatment; and c) the placement can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. *Olmstead*, 527 U.S. at 607.

The Court explained that this holding "reflects two evident judgments." *Id*. at 600. "First, institutional placement of persons who can handle and benefit from community settings

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Sanchez v. Johnson, 416 F.3d 1051, 1062 (9th Cir. 2005); *Zukle v. Regents of Univ. of California*, 166 F.3d 1041, 1045 n. 11 (9th Cir. 1999). This principle follows from the similar language employed in the two acts. It also derives from the Congressional directive that implementation and interpretation of the two acts "be coordinated to prevent[ ] imposition of inconsistent or conflicting standards for the same requirements under the two statutes." *Baird ex rel. Baird v. Rose*, 192 F.3d 462, 468-9 (4th Cir. 1999) (citing 42 U.S.C. § 12117(b)) (alteration in original). *See also Yeskey v. Com. of Penn. Dep't of Corrections*, 118 F.3d 168, 170 (3d Cir. 1997) ("[A]ll the leading cases take up the statutes together, as we will."), *aff'd*, 524 U.S. 206 (1998).

perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id*. "Second, 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 enrichment." *Id*. at 601. *Olmstead* therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization. A state's obligation to provide services in the most integrated setting may be excused only where a state can prove that the relief sought would result in a "fundamental alteration" of the state's service system. *Olmstead*, 527 U.S. at 603-4.

B. Plaintiffs Satisfy the Requirements for a Preliminary Injunction.

To obtain a preliminary injunction, plaintiffs must show (1) likelihood of success on the merits of their ADA Title II claim; (2) likelihood that the disruption in services will cause irreparable harm; (3) balance of hardships weighs in favor of plaintiffs; and (4) granting an injunction is in the public interest.[2] *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. ----,----,129 S. Ct. 365, 374-76 (2008). The decision of whether to grant or deny a motion for preliminary injunction is a matter of the district court's discretion. *Am. Trucking Ass'ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1052 (9th Cir. 2009). District courts are empowered to grant preliminary injunctions "regardless of whether the class has been certified." *Cota v. Maxwell-*

[2] Three preliminary injunctions have recently been granted in *Olmstead* cases in California district courts. In *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161,1164 (N.D. Cal. 2009), the district court granted plaintiffs' motion for a preliminary injunction, filed on August 18, 2009, which sought to enjoin defendants from reducing a particular community-based service from a maximum of five days to three days per week. A second preliminary injunction was granted in the same case in relation to new eligibility criteria that put plaintiffs at risk of institutionalization, *Cota v. Maxwell-Jolly*, 688 F. Supp.2d 980, 985 (N.D. Cal. 2010). And in *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1109 (N.D. Cal. 2009), California was enjoined from reducing or terminating in-home health services thereby putting plaintiffs at risk of institutionalization.

Jolly, 688 F. Supp. 2d 980, 991 (N.D.Cal. 2010) (citations omitted).

1. Plaintiffs Are Likely To Prevail On Their Title II Claims.

Plaintiffs can establish the three key elements of an *Olmstead* claim. *Olmstead*, 527 U.S. at 607. The first two elements – that plaintiffs are appropriate for and do not oppose community placement – do not appear to be in dispute. Regarding the third element, plaintiffs' request that the County not reduce services below the level plaintiffs need in order to avoid institutionalization and that it transition the system in a way that does not place plaintiffs at risk of institutionalization is reasonable given the County's resources and its ability to serve others with disabilities.

a. Maintaining the Level and Quality of Services is Essential Because the Proposed Plan Puts Plaintiffs at Risk of Institutionalization in Violation of the ADA.

The level of services under the new outpatient mental health system will be insufficient to maintain the plaintiffs in community living. First, plaintiffs are particularly vulnerable to reduction in services. Plaintiffs have severe mental health disabilities and many have experienced multiple psychiatric hospitalizations in the past. (Franczak Supp. Decl. ¶15.) Budget cuts implemented last year have already terminated outpatient mental health services for persons with less acute mental health disabilities, thus those who remain in the outpatient system have significant needs. (Id.) For example, Mr. Yanello, an individual with bipolar disorder, was repeatedly institutionalized prior to receiving services through a RST: "I was institutionalized on many occasions. I was suicidal. Specifically, I was hospitalized at the Sacramento Mental Health Treatment Center on at least eight occasions. I also was hospitalized at Sierra Vista at least three times and at the Sutter Psychiatric Hospital at least twice." (Yanello Decl. ¶4) After receiving RST services, Mr. Yanello has stabilized and is "doing much better;"

successfully living in the community, doing yard work, cooking, and working. (Id. at ¶5-8.) Similarly, Ms. Napper, diagnosed with both bipolar disorder and schizoaffective disorder, "bounced back and forth between different mental hospitals and mental facilities" and was hospitalized and placed in crisis residential facilities numerous times prior to receiving community-based mental health services from the county. (Napper Decl. ¶¶ 2,6.) Since receiving services in the community, Ms. Napper's life has changed dramatically; she has stabilized and has not been hospitalized or placed in a crisis program for several years. (Id. ¶ 7.)

Ms. Napper and Mr. Yanello's experiences are similar to the experiences of the other class representatives. For instance, Ms. Fischer, diagnosed with bipolar disorder and major depression, describes a similar history of cycling "in and out of [institutional] facilities" (hospitalized 10+ times at the Sacramento Mental Health Treatment Center and in two other locked facilities) (Fischer Decl. ¶ 4.) While receiving services in the community, Ms. Fischer's hospitalizations have decreased and she is able to remain in the community, building relationships with her sister and her family. (Id. ¶¶4, 6, 9.)

Ms. Eichhorn-Smith has spent the bulk of her adult life – more than 24 years – in and out of psychiatric hospitals due to self-injurious behavior. (Eichhorn-Smith Decl. ¶¶2, 3, 5.) These hospitalizations have decreased due to the treatment she now receives, and she looks forward to going back to school and finding a job now that she has stabilized. (Id. ¶¶1, 6, 11.) Without frequent and close contact with her outpatient mental health staff, Ms. Eichhorn-Smith will almost certainly be re-hospitalized due to the self-harm behavior associated with her mental illness. (Cline Supp. Decl. ¶1 "If these services are disrupted Ms. Eichhorn-Smith will decompensate and be at risk of harming herself or being placed in an institution.")

Reductions in services through the new County clinics is inevitable because the funding

for the new clinics will be between 16% and 30% lower than funding for the RSTs. While the defendants maintain that the funding levels for outpatient mental health services – $18.6 million dollars – will remain the same for fiscal year 2009-10 as fiscal year 2010-11, this is not so. (Opp. 2-3.) Included in the County's $18.6 million budget for fiscal year 2010-11 is $2.9 million dollars for the system transition that will not be spent to continue client services and thus represents an approximately 16% reduction in funding from the previous fiscal year. (Opp. 3.) Further, an additional $3.5 million dollars of funding is purely speculative and questionable as it depends upon State approval. (Bennett Dep. 69:16-70:25, Ex. B.)[3] If the $3.5 million falls through, then the total budget reduction over last year will be approximately 30%. Finally, each County dollar buys more outpatient services through the RST contractors than under the County-operated system due to contractor efficiencies. (Declaration of Margaret Branick-Abilla, DKT 19, Ex. I, "Mental Health Services Act Steering Committee, 8/20/09 Meeting Minutes," at 3; Stoneking Second Supp. Decl. ¶7.)

The staffing levels and other reductions in services under the system redesign are insufficient and will exacerbate plaintiffs' risk of institutionalization. For instance, TCORE caseloads will increase 300% (from 1:25 to 1:75) which will have a devastating effect on TCORE clients. (Franczak Supp. Decl., DKT 99-6, ¶12.) TCORE's current low staffing ratios allow staff to respond quickly to clients' crisis situations to avoid hospitalization and institutionalization. (*Id*. ¶7.) Jacquie Eichhorn-Smith, a TCORE client for over two years, has received intensive services from a Consumer Family Advocate that have minimized

[3] The Mental Health Services Act money that defendants rely on as a central funding stream for the system redesign has not been approved by the State and defendants do not know when – or if – they will get this approval. In fact, the State Department of Mental Health has already expressed concerns about the plan in a letter dated May 5, 2010. (Letter attached as Ex. J of Pls.' Mem. In Supp. of Preliminary Injunction, DKT 17.)

hospitalizations. (Supplemental Declaration of Frank S. Cline, DKT 99-4, ¶¶1,5,6.) If caseloads triple, it will be impossible to maintain this level of responsiveness and the level of care will decline, putting plaintiffs at risk of institutionalization.[4]

With the high client-staff ratio, plaintiffs with more intensive needs will be unable to receive the same level of care that they require to live successfully in the community because each staff member will have less time available for each client. Defendants' proposed plan currently provides for 30 minutes per service per week per client which is insufficient for the vast majority of individuals being served by the program. (*Id*. ¶¶ 17,19.) The effects of increased staffing levels are demonstrated by the plaintiffs' own previous experiences. Ms. Napper previously received reduced outpatient services, but they proved to be insufficient to keep her out of psychiatric facilities:

> Before I started at Northgate, the treatment I was offered at other mental health places at the county was mainly medication. This approach did not work for me and I had trouble staying on my medication. Northgate [RST] does not treat me as someone who just needs medication. They go far beyond that…Without question, since I became a client at Northgate, my condition has improved a lot and I do not end up in mental facilities the way I did before.

(Napper Decl. ¶8.)

Ms. Lynda Mangio, who has Chronic Severe Depression, Post Traumatic Stress Disorder and panic attacks, describes her experiences with County mental health services when low staffing levels resulted in her failure to receive adequate services: "In an attempt to escape my isolation, I went to the Wellness and Recovery Center (Center) in Sacramento County to attend groups four times a week. When I went to the Center, almost all the groups were canceled. It is

[4] Staffing ratios set forth by defendants pose an additional challenge because they account for clinical staff carrying cases (rather than providing for clinical staff whose time is fully devoted to their clinical specialty). As a result, there are substantial decreases in service from the current system, where the staffing ratios include only personal service coordinators and all other clinicians' services are above and beyond that ratio. (Franczak Supp. Dec. ¶ 13.)

my understanding that many groups were canceled because the Center did not have enough staff that day or staff did not show up for groups." (Mangio Decl. ¶¶2,12.) Before receiving services at an RST, Ms. Mangio had "daily suicidal thoughts" and she is concerned that with this transition, she will again have suicidal thoughts and face hospitalization. (Id. at ¶¶11, 17.)

Patricia Boynton, who has attempted suicide on three occasions, previously received insufficient services from the County and was told by her psychiatrist that "they did not have the resources to help me when I went into crisis." (Boynton Decl. ¶¶5,8.) Not surprisingly, Ms. Boynton was hospitalized at the Mental Health Treatment Center "at least 15 times" during the period she received insufficient outpatient services. (Id.) In contrast, Ms. Boynton states that she receives crisis support services at her RST and "a number of times their support prevented a trip to the Treatment Center." (Id. at ¶11.)

In addition to increased staffing ratios, additional service cuts in the new outpatient mental health system place plaintiffs at higher risk of institutionalization. For example, TCORE services under the new system will be reduced from 24 hours per day, 7 days per week to a 9 to 5 business day. (Bennett Dep. at 130:9-15, Ex. B.) Further, the TCORE services under the new system will be clinic-based, whereas under the system set to phase out starting August 1, 2010, TCORE services are community-based with staff often serving clients in their residences. (*Id*.) The new system will also significantly reduce the peer services available to a mere 1 peer to 300 clients. (Stoneking Second Supp. Decl. ¶10.)[5]

Plaintiffs' expert witnesses also state that under the County's Hybrid Plan, the service

[5] In addition to these concerns, plaintiffs raise concerns about the lack of adequate training of staff in the system redesign. Training on recovery model for County staff will not start until November, more than three months after defendants have begun transitioning clients. (Declaration of Paul Cecchettini, DKT 99-3, ¶7, citing comments from Kelli Weaver at meeting with County representatives on July 13, 2010.)

levels will be insufficient to prevent institutionalization. Betty Dahlquist, an expert in the delivery of public mental health services, states that due to insufficient levels of community services, Sacramento County *already* overly relies on institutional settings. (Declaration of Betty Dahlquist, DKT 99-5, ¶11.) Dahlquist bases her conclusions, in part, on her analysis of data regarding the high rates of involuntary psychiatric hospitalizations in Sacramento County: "In my opinion, this extremely high rate of involuntary hospitalizations is associated with the fact that the County lacks capacity in its community-based services so that it can only channel clients to the MHTC rather than use the alternatives that many other counties offer." (Id. at ¶¶13-14.) The California Mental Health Planning Council reached the same conclusion that Sacramento County's lack of community based options forces it to rely on institutional settings. (Id. ¶13.)

Prior service cuts in Sacramento County's outpatient mental health services have resulted in increased hospitalizations:

> [t]he mental health service cuts last year have had a devastating effect. Consumers without adequate supports in place ended up going to the emergency rooms of general hospitals…The hospitals do not understand their conditions and, as a result, may keep a client in psychiatric crisis for days on end because there is nowhere else for them to go.

(Place Decl. ¶¶21, 22; *See also* Declaration of Josephine Balaoro, DKT 21, ¶¶1, 15 ("my residents will be left without the mental health services that they need to be successful in living in homes. Then, for no good reason and through no fault of their own, they will end up back in the locked facilities that they were in before"); Declaration of Jessica Johnson, DKT 36, ¶7; Declaration of Renee Klee, DKT 39, ¶13; Declaration of Ron Risley, M.D., DKT 45, ¶18; Declaration of Janette Steele , DKT 48, ¶9.)

b. Providing Adequate Community Services Will Cost Sacramento County Less Money.

Maintaining services adequate to avoid institutionalization will likely cost the County *less money*. Sacramento County already spends a significant portion of its mental health budget on costly institutional care – namely the Mental Health Treatment Center and acute psychiatric unit. (Dahlquist Decl. ¶¶6,8.) Increasing funding for institutional care at the expense of community services perpetuates Sacramento County's unparalleled reliance on institutional care. (Dahlquist Decl. ¶¶7,8.) No other county is increasing funding for inpatient services. In fact, counties across the State are *decreasing* funding for these services. Sacramento County currently operates the largest Psychiatric Health Facility in the entire state while other counties instead employ smaller, more cost-effective crisis residential beds. (Dahlquist Decl. ¶¶7,8.) The cost for serving an individual at an RST is significantly less than the cost to treat the consumer at the Mental Health Treatment Center. The Treatment Center daily cost to treat each consumer is $1,095, whereas the RST daily cost to treat each consumer is $9.33. (Declaration of Roleda Bates, DKT 22, ¶ 4; Place Decl. ¶ 32.) With adequate community services that plaintiffs request, Sacramento County can reduce its dependence on costly institutional care.

Moreover, that the County is experiencing a budget deficit does not exculpate it from complying with the *Olmstead* integration mandate. *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1183 (10th Cir. 2003) ("that [a state] has a fiscal problem, by itself, does not lead to an automatic conclusion" that providing the community services that plaintiffs seek would be a fundamental alteration.) Further, "[i]f every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed." *Fisher*, 335 F.3d at 1183. *See also Pennsylvania Protection and Advocacy, Inc. v. Pennsylvania Dept. Of Public Welfare*, 402 F.3d 374, 380 (3d Cir. 2005).

Congress was aware that integration "will sometimes involve substantial short-term burdens, both financial and administrative," but the long-term effects of integration "will benefit society as a whole." *Fisher*, 335 F.3d at 1183, *citing*, H.R. Rep. No. 101-485, pt.3, at 50, *reprinted* in 1990 U.S.C.C.A.N. 445,773.

c. The County's Timeframe and Implementation Plan is Insufficient to Ensure Successful Transition in Violation of the ADA.

The request that the implementation of the County's plan occur in a manner that minimizes disruptions in care that put plaintiffs at risk of entry into costly institutional settings is reasonable and does not effect a fundamental alteration.

Defendants plan to transfer an astonishing 90-110 clients per week from each RST, beginning August 1, 2010 even though as of the date of this filing, defendants do not yet have operational clinics. (Weaver Decl. at 9; Declaration of Jack Rodney Kennedy, DKT 92, at 10.) At this rate, defendants anticipate completion of more than 4,000 transitions by September 30, 2010; however, there will be an additional month (October) for any remaining transitions to take place. (Weaver Decl. at 9.)

The window for transitions set forth in defendants' plan is insufficient to properly transition all of the County's current clients: at a minimum, it would take six months "to accomplish a reasonably effective transition process." (Franczak Decl. ¶19; Stoneking Second Supp. Decl. ¶13; *see also* Declaration of Alexan Bolte, DKT 23, ¶18.) The current timeframe, while potentially sufficient for medication appointments and the transfer of clinical records, "will not be possible to ensure continuity of care for this population which … [ensuring successful transitions] takes a considerable amount of time, thought, and care". (Franczak Supp. Decl. ¶21.)

Defendants' current plan presumes that a form letter sent to consumers with a date and

time for a group appointment will be sufficient to ensure transition to the new providers. (Id. ¶23.)[6] This depersonalized protocol is inconsistent with clinical authority on how such transitions should be undertaken. *See* Id. (describing transition process and its essential elements: comprehensiveness, individual engagement, responsiveness to special populations, maximizing resources/wrap-around services, relapse prevention, clear responsibilities, contingency plans and tracking, and monitoring outcomes). Dr. Stoneking reiterated these concerns, noting that "a phone call from a new, unknown service provider in the context of an involuntary transfer is totally unsatisfactory and dooms the transition plan to failure. County personnel would have to be on hand at the RSTs for a significant transition plan in order to accomplish an acceptable hand-off, and there is no indication that the County has any such plans." (Stoneking Second Supp. Decl. ¶ 15.)

The current plan proposes to transfer all clients at least four times faster than the last major transition of Sacramento County outpatient mental health services in 1991-1993. That transition "took over 16 months – four months of planning and over a year for implementation following approval by the Board of Supervisors, as opposed to 2-3 months that the County says will be sufficient to implement its current redesign." (Stoneking Second Supp. Decl., ¶5.) Further, current RST providers, who are the most familiar with plaintiffs' needs and the intake process, do not believe the transition period is sufficient. (Supplemental Declaration of John Buck, DKT 99-2, ¶6 (noting that 24 intakes per week at his RST is the maximum number of intakes that can be handled).)

Failure to appropriately plan for gaps in services violates *Olmstead's* integration

[6] Group appointments, as Dr. Franczak points out, do not provide for "confidentiality, address individual needs, or include current providers" – elements that are essential to continuity of care. (Franczak Supp. Dec. ¶20.)

mandate. *See Ball v. Rodgers*, No. 00-cv-67, 2009 WL 1395423, at *5 (D. Ariz. April 24, 2009) (state defendants violated title II's integration mandate because their "failure to provide adequate services to avoid unnecessary gaps in service and institutionalization was discriminatory.") The primary problem with the County's transition plan stems from poor planning. It is entirely reasonable to request that a county which is undertaking a dramatic redesign of the safety net system for the County's most vulnerable population ensure that the transition satisfies their obligation under the integration mandate. *Brantley,* 656 F. Supp. 2d at 1175 (holding that the "defendants certainly bear the burden of ensuring more than a "theoretical" availability of such services" in order to satisfy the state defendants' obligations under the *Olmstead* integration mandate when reducing Adult Day Health Care services.) Plaintiffs' experts describe in detail the factors and contingencies that would minimize the risk of institutionalization with the transition. (Franczak Supp. Decl. ¶¶20-24; Stoneking Second Supp. Decl. ¶¶13,15.) Pausing implementation of any system redesign until difficult (and important) issues are resolved is consistent with *Olmstead* and the requirement that public entities serve individuals in the most integrated setting.

2. Plaintiffs Will Suffer Irreparable Harm if Defendants Are Not Enjoined.

The reduction of services and the ill-conceived transition plan put plaintiffs at substantial risk of unnecessary institutionalization constituting irreparable harm. Dr. Franczak aptly summarizes the harm that plaintiffs will suffer if the system redesign moves forward as-is: "clinical regression, increased hospitalization and institutionalization, injury, illness, and death." [7] (Franczak Supp. Decl. ¶ 27.)

[7] The nature of serious mental illness as a "chronic, relapsing illness" dictates that without appropriate community services, "frequent re-hospitalizations" will result. (Franczak Dec. ¶14.) Other courts have recognized this phenomenon. *See, e.g. Rosie D. ex rel. John D. v. Swift*, 310

Dr. Franczak, who has worked for almost 40 years with individuals with similar needs to putative class members, states that the proposed service cuts will likely result in unnecessary institutionalization in hospital emergency rooms and psychiatric facilities. (Franczak Decl. ¶10; Franczak Supp. Decl. ¶¶2, 26-27.)[8] Dr. Stoneking similarly states that when clients are deprived of medically necessary services, even temporarily, they will be "placed at risk of institutionalization or acute, more expensive services in crisis facilities, hospital emergency rooms, institutes for mental disease ("IMDs"), jails, and even prisons." (Stoneking Decl. ¶¶5, 39.) These hospitalizations "can worsen the downward spiral … by further destabilizing them, making it extremely difficult for them to move back into the community." (*Id*.)

The likelihood that with the planned reduction in services, plaintiffs will experience an increased risk of institutionalization and associated irreparable harm through loss of community involvement and related problems has been recognized by other courts faced with similar factual circumstances and evidence. For example, in *V.L. v. Wagner*, the State of California planned to reduce the number of individuals eligible for In Home Supportive Services (IHSS) for people with disabilities, including those with mental illness. *Wagner*, 669 F. Supp. at 1112. Based upon similar testimony by "experts, county officials, caregivers and individual recipients," the court enjoined the defendants from implementing the service reductions and found that "individuals

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F.3d 230, 232-33 (1st Cir. 2002) ("These debilitating conditions [of children with psychiatric or behavioral disorders] have led to a wide array of unhappy results, including expulsions from schools, cyclical transfers between treating facilities, repeated hospitalizations, and years spent away from family members at crisis stabilization units.")

[8]Dr. Franczak states that the "significant upheaval" of this transition "will result in harm for many individuals increasing likelihood of adverse outcomes including increased hospitalization, use of emergency rooms, jail, prisons, [and] homeless shelters…" (Id. ¶11.) Dr. Franczak explained further that without effective transitioning, individuals will experience significant deterioration in their mental status, an increase in symptoms, and a reduction in their ability to relate to others and will likely end up in institutions. (Franczak Decl. ¶17.)

with mental disabilities who lose IHSS assistance to remind them to take medication, attend medical appointments and perform tasks essential to their continued health are at a severely increased risk for institutionalization." *Id*. at 1119-20. The court further found that "there is also a serious risk that individuals with mental or cognitive disabilities will become homeless if they lose IHSS services. Once homeless, mentally ill individuals decline rapidly and could end up anywhere from a psychiatric hospital to jail." *Id*. at 1122.

The harm associated with the reduction of services, including hospitalization, institutionalization, loss of housing, loss of employment, isolation, deteriorating mental health, and even death is undeniably severe. Mr. Yannello recounted his hospitalizations at various facilities and flatly states: "I truly hated it when I was hospitalized." (Yannello Decl. ¶4.) If plaintiffs are institutionalized, they will face separation from friends and family, loss of affordable community housing, and loss of jobs in the community. (Yanello Decl. ¶¶6, 8; Fischer Decl. ¶6; Boynton Decl. ¶1.) If the defendants are not enjoined, the injury to plaintiffs with history of suicide attempts or suicidal thoughts, including Channel Kirby, Lynda Mangio, Patricia Boynton, Rania Haidary, Yian Meng Saeteurn, Alan Cummings, Jan Fischer, Ted Yanello, Jacquie Eichhorn-Smith, can never be rectified. (Kirby Decl. ¶3; Napper Decl. ¶2; Mangio Decl. ¶11, , Boynton Decl. ¶8; Haidary Decl. ¶7; Saeteurn Decl. ¶9; Cummings Decl. ¶7; Fischer Decl. ¶10; Yanello Decl. ¶4, Eichhorn-Smith Decl. ¶5.)

Courts have routinely recognized that the harm associated with institutionalization – even on a short term basis – is severe. In *Long v. Benson*, No. 08cv26, 2008 WL 4571903, at *2 (N.D. Fla. Oct. 14, 2008), a Florida court granted a preliminary injunction in an *Olmstead* case and explained that forcing the individual to leave his community placement and enter a nursing home "will inflict an enormous psychological blow." The court further explained that "because of the

very substantial difference in [plaintiff's] perceived quality of life in the apartment as compared to the nursing home, each day he is required to live in the nursing home will be an irreparable harm." Similarly, in *Marlo M.*, 679 F. Supp. 2d at 638, a North Carolina court granted a preliminary injunction in an *Olmstead* case because the plaintiffs had "lived successfully in their community based apartments," and, if they lost community services they would "suffer regressive consequences if moved [to a nursing home], ***even temporarily***." (emphasis added). And in *Crabtree v. Goetz*, No. 08-0939, 2008 WL 5330506 *25 (M.D. Tenn. Dec. 19, 2008) (unpublished), the court granted a preliminary injunction enjoining state defendants from cutting home health care services that would force plaintiffs with disabilities into institutional placements; the court explained that institutionalization "would be detrimental to [plaintiffs'] care, causing, *inter alia*, mental depression, and for some Plaintiffs, a shorter life expectancy or death."[9]

The Court in *Olmstead*, too, recognized these very concerns, describing the adverse effects that occur with unnecessary institutional placements:

> First, institutional placement … perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life ... Second, 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 enrichment.... In order to receive needed medical services, persons … must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.

Olmstead, 527 U.S. at 600-01.

[9] *See also Haddad v. Arnold*, No. 3:10-00414 (M.D. Fla. July 9, 2010) (Opinion granting preliminary injunction in *Olmstead* case after finding that the plaintiff will suffer irreparable injury if forced to enter a nursing home.) (Attached as Ex. C.)

3. The Balance of Hardships Tips in Plaintiffs' Favor.

The hardships that the plaintiffs will endure absent an injunction – including the risk of institutionalization, homelessness, jail and even death – far outweigh any potential hardship to the County. The defendants have not specifically identified the cost, if any, associated with maintaining the same level of services for the plaintiffs, most likely because the County denies that a service reduction will actually occur under its Hybrid Plan. (Opp. 10) Further, the defendants have not identified the costs, if any, associated with preparing and implementing a transition that will reduce the risk of institutionalization. The defendants claim that it will cost the County $4.5 million to "reinstate the mental health system" as it existed in FY 2009 – 2010, although defendants did not explain how they calculated this number. (Declaration of Thomas Burkart, DKT 86, at 2.) Because the plaintiffs are not seeking to reinstate the mental health system as it existed in fiscal year 2009- 2010, this figure is not a reliable measure of cost associated with the plaintiffs' actual modification request. (Pls.' Reply at 10.) Further, because the cost of providing institutional care is so high ($1,095 per day at the Mental Health Treatment Center versus $9.33 per day at the RSTs) (Bates Dec. ¶4) any financial hardships that defendants may incur will likely be offset by the cost savings that accrue from avoiding unnecessary institutionalizations.

Other courts when faced with similar reductions in social services have determined that the harm to the plaintiffs outweigh the defendant's budget considerations. For example, the risk of institutionalization and inability to access necessary medical care as a result of reductions to In Home Supportive Services outweighed the financial burden of the state during a fiscal crisis. *Wagner,* 669 F. Supp. 2d at 1122. *See also Brantley*, 656 F. Supp. 2d at 1177 (state's fiscal crisis does not outweigh harm to indigent seniors and disabled adults who faced a reduction in

the state's Adult Day Health Care program.)

4. Granting a Preliminary Injunction Is In The Public Interest.

The public interest weighs heavily in favor of granting relief. "It would be tragic, not only from the standpoint of the individuals involved but also from the standpoint of society, were poor, elderly, disabled people to be wrongfully deprived of essential benefits for any period of time." *Lopez v. Heckler*, 713 F.2d 1432, 1437 (9th Cir. 1983).

There is a strong public interest in granting a preliminary injunction to allow plaintiffs to remain in community settings. There is a public interest in eliminating the discriminatory effects that arise from segregating persons with disabilities into institutions when they can be appropriately placed in community settings. As *Olmstead* explained, the unjustified segregation of persons with disabilities can stigmatize them as incapable or unworthy of participating in community life.[10] *Olmstead*, 527 U.S. at 600. In *Long*, the court relied on this reasoning to hold that the public interest favored allowing the plaintiff to "remain in the community rather than be isolated in the nursing home":

> If, as it ultimately turns out, treating individuals like Mr. Griffin in the community would require a fundamental alteration of the Medicaid program, so that the Secretary prevails in this litigation, little harm will have been done. To the contrary, [plaintiff's] life will have been better, at least for a time…

Long, 2008 WL 4571903, at *3.

C. Plaintiffs Raise a Justiciable Issue.

Plaintiffs raise a justiciable issue because they will experience a reduction in outpatient mental health services as a result of the defendants' actions. It is well settled that to establish

[10] *See also* U.S. Amicus Brief in *Olmstead* at 16-17, citing to 136 Cong. Rec. H2603 (daily ed. May 22, 1990) (statement of Rep. Collins) ("To be segregated is to be misunderstood, even feared," and "only by breaking down barriers between people can we dispel the negative attitudes and myths that are the main currency of oppression.").

standing, the litigants must show (1) plaintiffs suffered actual or threatened injury; (2) the condition complained of caused the injury or threatened injury, and (3) the requested relief redressed the alleged injury. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). When examining whether plaintiffs suffered actual or threatened injury, the inquiry focuses on whether the injury-in-fact is (1) "concrete and particularized," and (2) actual or imminent, not 'conjectural' or 'hypothetical.'" *Lujan*, 504 U.S. at 560. The injury here – loss of Medicaid outpatient mental health services – is concrete, particularized and imminent. *Cal. Pro-Life Council, Inc. v. Getman*, 328 F.3d 1088, 1095 (9th Cir. 2003); *United States v. Antelope*, 395 F.3d 1128, 1132 (9th Cir. 2005); *Mental Disability Law Clinic v. Hogan*, No. 06-cv-6320, 2008 WL 4104460, at *23-25 (E.D.N.Y. Aug. 26, 2008) ("Due to Mary Jo's illness and the allegation that she continues to refuse to take her medication, the likely harm of another hospitalization and the fact that this harm could be avoided if she were subject to [assisted outpatient treatment] is not too speculative or conjectural to preclude standing."); *Lynch v. Baxley*, 744 F.2d 1452, 1456 (11th Cir. 1984).

Service cuts are inevitable under the funding levels and staffing ratios included in the new plan. The County cannot possibly provide the same level of services while implementing a funding cut of 16% to 30%, especially considering that it costs more to provide services directly through the County rather than through contractors. The defendants repeatedly state the new plan offers the same "menu" or "array" of services. (Opp. 8; Weaver Decl. at 3, 5; Zykofsky Decl. at 5; Kennedy Decl. at 5; Bennett Dep. 58:22-24, Ex. B.) However, as discussed in Section II(A)(1)(a) above, even if the "menu" – i.e. the types of services offered – is comparable (which it is not), the intensity by which the services are offered will be significantly diluted, causing a concrete and actual loss of services. The loss of services itself is sufficient to create standing,

and the risk of institutionalization that directly results from this loss in services provides a secondary injury grounding plaintiffs' standing. These harms are "concrete" and "immediate" and satisfy the Supreme Court's standards for awarding a remedy in this case.

IV. CONCLUSION

For the reasons stated above, the Court should grant Plaintiffs' Motion for Preliminary Injunction. With the Court's permission, counsel for the United States will be present at any upcoming hearings.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on July 19, 2010, a copy of foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's CM/ECF System.

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