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UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

LESLIE NAPPER, JANET FISCHER, JACQUIE EICHHORN-SMITH, TED YANELLO, and LYNDA 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

CLASS ACTION

REPLY MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

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

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I. INTRODUCTION

Defendants' Opposition ("Opp.") is predicated on false factual assertions, wishful thinking and unsupported legal contentions. The County's "anticipation" that funding for its redesigned system will be "equal" to the 2009-10 budgeted amount is inconsistent with its original justification for the redesign, is based on receipt of additional state and federal monies that are far from certain to be approved, and improperly counts money that will fund increased expenses related solely to the transition itself, and not ongoing care. The County's claim that it can provide equivalent services to Plaintiffs ignores both this likely budget shortfall and its own admission that even with equivalent funding, it cannot possibly provide the same services because County employees are more expensive than the contracted workers they would replace.

Claiming that this motion is based entirely on the unfounded fears of class members, Defendants fail to address Plaintiffs' well-founded criticisms of their proposal, which have been advanced by credible experts and administrators with decades of experience in serving people with severe, chronic mental illness. In addition, the recent depositions of the two highest-ranking County mental health officials confirm that the County's transition plans are haphazard and incomplete.

Plaintiffs have convincingly demonstrated that this redesign is unlawful; that it is dangerous and threatens them with immediate and irreparable harm; and that it should be enjoined.

II. DEFENDANTS HAVE FAILED TO REBUT PLAINTIFFS' SHOWING OF IRREPARABLE INJURY IN THE ABSENCE OF PRELIMINARY INJUNCTIVE RELIEF.

As Plaintiffs explained in their opening brief, a crucial element in establishing the right to a preliminary injunction is a likelihood of irreparable injury absent judicial relief. Plaintiffs' Memorandum of Points and Authorities in Support of Preliminary Injunction ("Pl. Br.") at 14, citing *Winter v. Natural Res. Def. Council,* 129 S. Ct. 365, 374 (2008). Throughout its opposition, the County contends that there will be no injury to Plaintiffs because there will be "no closure or reduction of services" and no change in "the menu or level of outpatient services" it provides. Opp. at 2, 3, 8, 10 n.16, 11, 15, 17, 20, 22, 24. Repeating an assertion, however, does

not make it true. The evidence before this Court confirms that the County's proposed "hybrid plan" will result in a reduction in services, as well as a disruption in medically necessary treatment that will inevitably result in harm to vulnerable county patients.

A. The County Will Not Receive Equivalent Funding for Adult Outpatient Services in 2010-11.

The County states that last year's funding for services for these 5,000 clients was $18.6 million, and claims that funding for its new county clinics will be the same. Opp. at 2:21-24, 3:5-6. The claimed 2010-11 amount is illusory, however, because it includes $6.4 million that may not be allocated and/or will not go to ongoing client services. First, the County includes a one-time allocation by the Board of Supervisors of $2.9 million to fund "transition" expenses. Opp. at 2; Bennett Declaration ("Decl.") (Dkt. No. 88) at 10 & Ex. A (Memorandum of Sacramento County Board of Supervisors ("Bd. Memo")). Because these funds are for the transition itself, it is obvious that they are not available for ongoing client services in 2010-11, and even more obvious that they will not be available in coming years. Second, the total includes $2.5 million in funding under the Mental Health Services Act ("MHSA") that may be available "[u]pon approval by the state after a community process," and that could then trigger an "anticipated" $1 million in federal Medicaid funds. Opp. at 3:1-4. The County's receipt of these funds is entirely speculative, as they have not been approved or released. *See id*. Without these two items, the funding for the new County clinics consists only of "$11.3 million for the Sacramento Wellness Centers [and] $.9 million for WRC." Opp. at 2:25-3:1. This $12.2 million total represents a reduction of one third – $6.3 million – below last year's budget.

Even more unsettling is the fact that all State MHSA funding for the County's "TCORE Workplan" – a total of over $7.5 million – depends entirely on State approval of this massive change (Opp. at 2), although it has no assurance that the State will approve this change. The County admits that its planned "redesign" requires "State approval" (Bd. Memo at 2) but plans to "front the funding . . . pending compliance with the MHSA." *Id.* Proceeding with these cuts without first obtaining state approval is simply reckless, since officials with the State Department

of Mental Health ("DMH") have already expressed strong disapproval of the County's redesign,[1] and could well deny the County's request to use MHSA funds for the new County clinics. The County inexplicably failed to initiate the public comment process required before it may submit the required MHSA plan update and amendment request;[2] even after it completes this, the State has 60 days to approve or deny the request. Welf. & Inst. Code §5847(g)(1).

In fact, the State has not indicated that it will approve the County's plan, has expressed concerns about the plan, and has not yet responded back to the County's latest attempts to allay those concerns. Supplemental ("Supp.") Branick-Abilla Decl., Ex. A (Deposition of Mary Ann Bennett-Treadway) ("Bennett Depo.") at 69:22-70:11. In the interim, if the County destroys its cost-effective system of Regional Support Teams ("RSTs") and is then unable to access MHSA funds for its county facilities, Plaintiffs and other needy clients will be left with the worst of all possibilities. The County admits that it does not know what it would do if the State does not approve these funds, and has no alternate plan in place. *Id.* at 71:12-13, 71:25-72:2. It does not even have a plan in place in the event of a delay in the State's approval process. *Id.* at 138:6-9. At a minimum, the County must wait until the State has acted on its request to change its use of MHSA funds before taking irreversible steps to defund the RSTs.

B. Even If the County Could Be Assured of Level Funding, Services Would Be Reduced Due to the Greater Expense of County Workers and Their Lack of Appropriate Training.

Even assuming 2010-11 funding remained level, which it will not, the County's plan will result in a reduced number of staff available to Plaintiffs and other County Medi-Cal patients. County officials have candidly admitted that contracting with private providers is "cost effective" because County employees are far more expensive than the staff of the private non-profits who

[1] Branick-Abilla Decl. (Dkt. No. 19), Ex. J (DMH letter). Eventual State approval is made more unlikely by the fact that the "TCORE workplan" approved by the State in 2006 required caseloads of 1:12, and services offered in the community, including the client's home, 24 hours per day, 7 days per week. Supp. Branick-Abilla Decl., Ex. B (Three-year MHSA Workplan dated Jan. 31, 2006) at 103. Although the County claims that its new wellness centers will follow the TCORE workplan, the services are clinic-based, not community-based, have a far higher caseload and will be open only during traditional 9 to 5 business hours. Bennett Depo. at 130:9-15.

[2] Supp. Branick-Abilla Decl., Ex. C (MHSA Annual Update, 2010-2011) at PRA 001569-1570.

now provide services.[3] As a result, far fewer staff will be available to provide treatment services under the "hybrid plan."[4]

In practical terms, this drastic increase in caseload means equally drastic reductions in the services they receive. With a caseload of 75 to 90, workers cannot provide the former TCORE clients with the case management, follow-up, home visits, and counseling they need. Supp. Franczak Decl., ¶¶ 12-14.[5] The County argues that the higher caseloads reflect different staffing patterns so that a direct comparison is not possible (Opp. at 6; Weaver Decl. (Dkt. No. 91) at 7), but the bottom line is that there will be fewer staff, and thus, fewer client services. Their lack of experience with community-based social rehabilitation services will only compound these problems. The County's belief that licensing is sufficient training is no answer, according to an expert in training and credentialing in psychosocial rehabilitation. Dahlquist Decl., ¶ 16.

C. The County's "Hybrid Plan" Is Not Based On the Recovery Model.

While Defendants claim to be "committed to the recovery model," both the structure and planned implementation of the system redesign show otherwise. While Plaintiffs are not here contending that only a recovery model-based system could ever be appropriate, the fact that the new system lacks critical elements of the model Defendants claim to follow demonstrates both the unreliability of Defendants' blanket statements and the dangers implicit in the transition.

[3] Answer to Class Action Complaint (Dkt. No. 68), ¶ 27; Branick-Abilla Decl. (Dkt. No. 19), Ex. I (8/20/09 Meeting Minutes); Bennett Depo. at 139:7-13.

[4] The County further concedes that the caseloads of 75 to 90 will be higher than those RSTs, which have a staff ratio of 1:70. Bd. Memo at 10. In fact, the deterioration in staffing ratios is far worse than the County lets on. Under the RST model, a case-carrying "personal service coordinator" is supported by a team of clinicians who are not counted in the staffing ratio; in the new County model, however, the clinicians are the "case carrying" workers, meaning that unlike the current system, the County plan "does not provide for clinical staff whose time is devoted only to their clinical specialty." Supp. Franczak Decl., ¶ 13; *see also* Stanton Decl., ¶ 13 (noting her site will see 60% reduction in staffing under County redesign, which "will have a significant effect on staff's ability to provide one-to-one peer support"). For some, the discrepancy in caseloads will be even greater, since TCORE clients have an even lower caseload ratio of 1:25 at present, a fact that the County conveniently omits. When the 2,000 clients currently served through the County's TCORE programs are moved to the new county clinics, they can expect a caseload that is more than 3 times higher than the caseloads of 1:25 they were promised.

[5] Another unacknowledged cut in services is the transfer of staff from the County's Adult Access team to the new county clinics. The Access teams are the hub around which all county mental health services turn, since they handle initial assessments and referrals, crisis referral, involuntary hospitalizations, discharge planning, etc. Branick-Abilla Decl. (Dkt. No. 19), Ex. B (Policy No. 01-03, Access to Services).

Dr. Stoneking notes that the County's claimed dedication to the recovery model is mere "lip service," as the proposed redesign is "totally missing two critical components" of that model: community collaboration in the planning and design of the delivery system, and services that have been planned by, and are directed by, clients and their families. Second Supp. Stoneking Decl., ¶ 4. In contrast to the current, client-centric model, the redesign has been imposed on clients from the top down, with no involvement by clients, family members, community members or other stakeholders; County planning and staff meetings are no substitute for a genuine community-involved process. *Id.*, ¶ 6. To make matters worse, despite repeated assurances that newly transferred County workers would be trained in the recovery model, at a recent public meeting Defendants' declarant Kelli Weaver admitted that such training would not even start until November 2010, three months after the transition of patients begins on August 1. Cecchetini Decl., ¶ 7. Weaver also stated that "all County staff will be expected to be familiar with the clients in the entire work team's caseload because clients will not be assigned to any specific County staff." *Id.* This latter statement makes a mockery of the increased staffing ratios claimed by Defendants, and virtually assures that clients will be unable to develop trusting relationships with individual service providers, as is currently the case.

D. Assuming *Arguendo* No Reduction in Services, Plaintiffs Will Still Suffer Irreparable Injury From the Disruption of Their Current Treatment.

The County argues that "there is absolutely no evidence demonstrating that a provider change will lead to an increased probability of institutionalization or any other type of injury" (Opp. at 9:13-15) and casually dismisses Plaintiffs' showing of harm as "unsubstantiated fears" (Opp. at 16), and "fear of change." Opp. at 23, 25. These claims are incorrect, factually and clinically.

Defendants fail to address or rebut the testimony of Plaintiffs' expert, Dr. Michael Franczak, that mental health providers "are not interchangeable." Franczak Decl. (Dkt. No. 32), ¶ 15. In his supplemental declaration, Dr. Franczak expands on the damaging impact of the loss of provider continuity, citing extensive research on the better outcomes and lower treatment costs when clients have long-term relationships with their mental health providers. Supp. Franczak

Decl., ¶¶ 4-9. The converse is also true: outcomes are worse when there is no therapeutic bond or alliance with the provider, or when this bond is broken. *Id.* Extensive research confirms the importance of continuity of care and long-term treatment relationships. *Id.*

Second, the clients affected by the closure of the RSTs and TCORE are acutely mentally ill and are at great risk of self-harm or harm to others when their fears and anxiety escalate, even if County officials deem these "unsubstantiated." For example, Plaintiff Eichhorn-Smith has had numerous suicide attempts, she views the closure of her treatment program as a major loss, and losing services will result in decompensation and risk of self-harm or institutionalization. Eichhorn-Smith Decl. (Dkt. No. 30), ¶¶ 5, 12; Supp. Cline Decl. ¶ 1.

Defendant Ann Edwards-Buckley, the County's Director of Health and Human Services ("DHHS"), candidly acknowledges that as a result of the transition process, clients may experience "increased acuity," which means that they "may have an increase in their symptoms, whatever those symptoms may be; depressive symptoms, anxiety symptoms, psychotic symptoms"; that "it would be a good idea for the County to plan" for this increase; and that she is unaware of any plans by the County to deal with increased client acuity. Supp. Branick-Abilla Decl., Ex. D (Deposition of Ann Edwards-Buckley) ("Edwards-Buckley Depo."), at 82:18-83:12. Dr. Franczak concludes that the County's failure to plan for increased acuity from the transition is "extremely cavalier and even dangerous to affected clients." Supp. Franczak Decl., ¶ 16.

III. DEFENDANTS HAVE FAILED TO REBUT PLAINTIFFS' STRONG SHOWING OF LIKELIHOOD OF SUCCESS ON THEIR LEGAL CLAIMS.[6]

A. Defendants' Evidence Confirms That Their Planned Reductions Will Violate the ADA.

Plaintiffs' ADA claims arise from the likelihood that the reduction in, and disruption of, essential mental health services will create an extreme risk of institutionalization to clients who

[6] Plaintiffs also raised claims under the Medicaid Act and the Due Process Clause of the U.S. Constitution. Pl. Br. at 18-22. Plaintiffs do not revisit these claims in this brief because of the doctrine of constitutional avoidance, and because they turn on the same factual showing as Plaintiffs' ADA claims. The core element of the Medicaid claims is the denial of medically necessary services, which in turn leads to the risk of institutionalization. Similarly, the validity of the due process claim is premised on the existence of a reduction in services. If Plaintiffs prevail on their ADA claims, they are also likely to prevail on these additional claims.

are able to remain safely in the community only with these services. Pl. Br. at 15-16. Distilled to its essence, Defendants' response is that because their "hybrid plan" differs in minor details from earlier concepts, Plaintiffs have shown "no nexus between the Hybrid Plan and the potential for institutionalization." Opp. at 16:13-14. This ignores the many declarations already in the record regarding fundamental consequences of Defendants' decision to disrupt a well-functioning system that provides cost-effective treatment to thousands of fragile individuals with mental illness. Because the "hybrid plan," like its precursors, will result in 5,000 people losing their trusted mental health providers and facing transfer to a program that is not as well staffed, it is inevitable that many clients will decompensate and require hospitalization and placement in a locked facility. Even with the best transition plan, some clients will go into crisis and needlessly end up in institutions when they could have remained safely in the community with their current providers.[7]

Plaintiffs also argued that, if the County is permitted to proceed with these cuts, the ADA nonetheless requires it to provide an adequate transition plan, and that the transition plan proposed by the County would not ensure that Plaintiffs are able to transfer successfully to the new system. Pl. Br. at 17. The County counters that the transition efforts criticized in the Complaint and opening brief are inapplicable to its new "hybrid plan." Opp. at 16. Other than allowing a slightly longer period of time, transition plan described in the "hybrid plan" still omits all the elements deemed necessary by clients, providers and experts.

According to Plaintiffs' experts, Dr. Franczak and Dr. Stoneking, the County's plan, which is little more than a plan to transfer clinical records and a group appointment with the new team, is inadequate to ensure continuity of care and fails to meet nationally recognized standards for a safe or successful transition for this extremely vulnerable population. Supp. Franczak Decl., ¶¶ 20-23. The County's proposal is silent as to essential components of adequate transition

[7] As Dr. Franczak's supplemental declaration shows, clients with severe mental illness should not be deliberately subjected to the loss of a provider because discontinuity of care has negative effects on clients. *See* Supp. Franczak Decl., ¶¶ 4-9 & Ex. A (Green article) at 15 ("high clinician turnover . . . may negatively affect patients"). Even Defendant Edwards-Buckley admitted that, all other things being equal and assuming a good relationship with one's provider, one would not choose to change providers. Edwards-Buckley Depo. at 94:18-25.

planning, including consideration of all aspects of the individual's needs across service systems, collaboration among service providers, responsiveness to "special populations" such as those with co-occurring disorders, plans to address relapses, and monitoring outcomes. *Id.*, ¶ 22. The plan to transfer hundreds of individuals per week does not allow for the high probability of broken appointments and some individuals' need for a lengthier transition period than the 10 days contemplated by the County. *Id.*, ¶ 21; *see also* Second Supp. Stoneking Decl., ¶ 13. Dr. Stoneking concludes that it is "troubling" that the County "believes it can transfer most patients with simply a phone call from the new provider." Second Supp. Stoneking Decl., ¶ 13. In Dr. Franczak's opinion, a properly-planned transition would require a minimum of six months. Supp. Franczak Decl., ¶ 22. Dr. Stoneking notes that when the RSTs were created in 1993, the transition took place over a period of over 16 months. Second Supp. Stoneking Decl., ¶ 5.

The proposed transition plan is also largely incomplete, even at this late date. Dr. Stoneking observed that "the 'redesigned' system was, at best, half-baked when it was approved by the Board of Supervisors in June 2010, with many critical details totally missing from the proposal document submitted to the Board, and yet to be worked out." *Id.*, ¶ 8.

The deposition testimony of Ms. Edwards-Buckley and Ms. Bennett confirm the shockingly haphazard nature of the County's transition planning, and the continuing lack of plans critical to a successful transition. Neither of the top two County officials responsible for the system redesign appears to know anything about a myriad of planning and process steps that are essential to a successful transition. Ms. Edwards-Buckley repeatedly stated that Ms. Bennett would be the person to ask about such details, but Ms. Bennett repeatedly testified that she was unaware of them. For example, she did not know about what instructions their "phone bank" staff are being given for dealing with client calls (Bennett Depo. at 91:17-92:3); whether clinicians have been trained to follow up on questions raised by those calls (*id.* at 92:12-19); whether the phone bank staff will even attempt to contact all consumers (*id.* at 94:4-6); whether any patient records have yet changed hands (*id.* at 96:25-97:1); what plan, if any, is in place to follow up with

clients who fail to show up for appointments[8] with the new County providers (*id.* at 106:14-18, 107:11-15; *see also* Edwards-Buckley Depo. at 81:3-24); whether the new County clinics will provide for "drop-in" appointments"[9] (Bennett Depo. at 119:18-20); what the plan is for serving consumers who are in crisis[10] (*Id.* at 120:8-14); what will happen at the new clinics when clients need services after regular business hours, i.e. in the evenings or on weekends[11] (*id.* at 130:9-20; *see also* Edwards-Buckley Depo. at 65:1-14); whether any of the County staff coming over from other locations have experience with the "recovery model" (Bennett Depo. at 134:12-14); or whether the training module for incoming staff is even complete (*id.* at 138:13-21). The only conclusion to be drawn from this remarkable testimony is that, at best, the County simply has not thought through many important service issues, and at worst, there simply will be no such services (such as after-hours crisis services).

Moreover, in the opinion of Plaintiffs' expert, Dr. Beth Stoneking, the transition plans that Defendants *have* announced are woefully inadequate. Callers to County phone lines have already received inadequate information leading to stress and anxiety (Zykofsky Dec. (Dkt. No. 89) at 10; Second Supp. Stoneking Decl., ¶ 8); it appears that "only [clients] who complain or visibly decompensate will receive any attention from the County," while many who experience stress less overtly will not be attended to. Second Supp. Stoneking Decl., ¶ 9. Dr. Stoneking opines that the notion that clients can be transitioned without intake appointments "reflects a disregard for appropriate standards of care" because an involuntary transfer creates issues that only an interview can reveal. *Id.*, ¶ 13.

Defendants attempt to trivialize Plaintiffs' concerns regarding transition, claiming that this

[8] In contrast, RSTs have established procedures to ensure that clients attend their appointments, and to follow up with any clients that fail to show. *See, e.g.,* Supp. Buck Decl., ¶ 5

[9] RSTs, on the other hand, offer flexible hours and drop-in groups and clinics. *See, e.g.,* Supp Bolte Decl., ¶ 11.

[10] In contrast, RST staff are prepared to work with clients in crisis, regardless of where they are or what time it is, for as long as it takes to stabilize the clients. *Id.*, ¶ 8.

[11] RST staff understand that their hours are dictated by the needs of their clients. As Alexan Bolte explained, "Providing service under the recovery model means you meet the needs of your client where the client is at the time during the week or weekend." *Id.*, ¶ 8.

merely a veiled attempt to preserve the present system "in perpetuity." Opp. at 18. There is a world of difference between preserving the present system untouched (which Plaintiffs do not seek to do), and blowing up a well-functioning "life support" system on which 5,000 severely ill individuals depend. Plaintiffs would never dispute that the County can make changes in the system, terminate contractors based on poor productivity or quality concerns, or develop new systems based on increased efficiencies and treatment modalities. However, the County fails to acknowledge how drastic and unprecedented a change it is proposing.[12]

New and striking evidence supporting Plaintiffs' ADA claim comes, surprisingly, from the County's own opposition. As part of its "hybrid plan," Sacramento is actually *increasing* its spending on locked, institutional mental health care by 13.6%.[13] Defendants' declarations are also replete with admissions that they have deliberately redirected the entire budget for the regional support teams – $4.5 million – to support salary increases and other costs in the County-run Mental Health Treatment Center ("MHTC"), a locked inpatient facility, and a locked 12 bed psychiatric health facility.[14] Every county in California is facing a fiscal crisis, but only Sacramento has chosen to increase costly institutional care. Dahlquist Decl., ¶ 7. County

[12] County staff point to their past experiences transitioning other clients to new providers and delivery systems. Zykofsky Decl. (Dkt. No. 89) at 5. Neither of the two examples cited are comparable for several reasons. First, the two earlier transitions were necessary to improve client services. Here, the County has no complaint about the quality or efficacy of the services provided by the RSTs and TCORE-HRC. Edwards-Buckley Depo. at 74:8-75:2; Bennett Depo. at 74:8-19. In fact, it hopes to provide the same services through the re-design. Bd. Memo at 9-10. Second, the scale of this proposed transfer is unmanageable, according to national experts familiar with mental health systems. In Arizona, when a mental health managed care plan comparable to that operated by Sacramento went into bankruptcy and collapsed, government officials wisely decided not to disturb any clinical relationships, and changed administrative staff instead. Supp. Franczak Decl., ¶ 3.

[13] Of the County's $75.6 million Adult Mental Health 2010-11 budget, $38.3 million is allocated for institutional or inpatient care – a $4.5 million or 13.6% increase from the previous year. King Decl. (Dkt. No. 85) at 1:27-28; 1:25-26. Contrast this to the budget of $37.3 million for outpatient services, which includes a decrease from last year's allocation of $18.6 million for the Adult Mental Health Outpatient program to $12.1 million this year – an approximately $6.5 million slash, over one-third of the budget. *See id.*

[14] "DHHS decided to utilize the realignment funds for acute, sub-acute, Psychiatric Health Facility (PHF) and SMHTC beds." Bennett Decl. (Dkt. No. 99) at 2:22-23; "[R]ealignment funds, which have historically been used to fund the contractor-operated component of the Adult Outpatient Services, were no longer available for the RSTs"; realignment funds are depleted due to declining revenue, reimbursement of transfer funds and "increased compensation and benefits for County employees" working at the MHTC. Kennedy Decl. (Dkt. No. 92) at 2:23-25; 2:22; *see also* Bennett Depo. at 32:23-33:13 (realignment funds were moved from the RSTs to the MHTC).

officials claimed that this heightened spending was necessitated by increased demand, but one expert observes:

> Many other counties satisfy their obligations under their Medi-Cal managed care without operating a locked inpatient facility of their own, as Sacramento does. In fact, twenty five California counties do not have any inpatient psychiatric services at all. . . . [O]ther counties . . . have developed and utilized crisis residential programs as alternatives to hospital-based acute care.

Id., ¶ 12.

This expert notes that Sacramento also has the second-highest rate of involuntary detentions in the state, an "extremely high rate" that is more than twice the state average and "is associated with the fact that the County lacks capacity in its community-based services so that it can only channel clients to [its locked inpatient facility] rather than use the alternatives that many other counties offer." *Id.*, ¶14. Defendants claim these decisions are discretionary (Opp. at 11, 13), but under the ADA, a public entity "cannot amend optional programs in a way so as to violate the integration mandate." *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1182 (10th Cir. 2003).

Defendants further admit that they have failed to pursue alternatives for funding the current adult outpatient program using MHSA monies (Bennett Decl. (Dkt. No. 88) at 2:15-21) as well as failing to consider reconfiguration of the MHTC into smaller facilities which would draw down millions in federally matched Medicaid dollars. Dahlquist Decl., ¶ 15. Such failure to consider alternatives that preserve community care and conform with the ADA's integration mandate are actionable. *See Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Pub. Welfare*, 402 F. 3d 374, 380 (3d Cir. 2004) (finding that state's budgetary constraints defense alone was inadequate and scrutinizing factors including state efforts to procure funding for community services, evidence that the state responsibly spent its budgetary allocations, and trends showing decreased reliance on institutional beds and increases in community services); *Sanchez v. Johnson*, 416 F.3d 1051, 1067 (9th Cir. 2005) (upholding state fundamental alteration defense where state showed 196% increase in funding for community options, actual increase in community services and decrease in reliance on institutional beds over 10 year period).

B. Plaintiffs' Motion is Not Moot.

Defendants claim that the Court is powerless to grant relief because the motion is "based upon a service delivery model that was never implemented by the County." (Opp. at 11:20-21.)[15] As an initial matter, this assertion is factually incorrect because the County plan is virtually indistinguishable from the "County Proposal" outlined at a public meeting on April 1, 2010.[16] More fundamentally, however, the relief sought is not dependent on the precise contours of the plan adopted by the County. Rather, Plaintiffs seek an order enjoining the Defendants from "terminating or reducing" the funding for the *existing* outpatient programs, or making reductions in medically necessary services, "unless and until the Court has determined" that, among other things, Plaintiffs "will continue to receive these . . . services in the most integrated setting possible . . . ." [Proposed] Order (Dkt. No. 52), ¶ 2(a). As it is uncontested that Defendants are terminating the existing programs (*see, e.g.*, Opp. at 1:6-8), the County must demonstrate that its proposed replacement system complies with the ADA's integration mandate and protects Plaintiffs' other rights.

C. The Court Has Authority to Enjoin Action That Violates Plaintiffs' Fundamental Rights.

Defendants next argue that the Court is powerless to enjoin violations of Plaintiffs' rights where an injunction would require the County to enter into new contracts with existing provider contracts. This frivolous argument simply wishes away the long-established role of the judiciary in evaluating states' resource allocations pursuant to the three-part test set forth in *Olmstead v. L. C. ex rel Zimring*, 527 U.S. 581, 607 (1999) (states are required to provide community-based treatment where, among other things, "the placement can be reasonably accommodated, taking

[15] Defendants also criticize the timing of the motion, but that was necessitated by the timing of the County's actions. The County informed Plaintiffs that it intended to start transitioning clients (patients) to its new system on July 1, 2010, but that the Board would not even consider, much less approve, the new system until mid-June; at the same time, the County opposed Plaintiffs' request to consider this motion at the earliest possible time. *See* Dkt. No. 59. This left Plaintiffs with no choice but to file the motion for preliminary injunction prior to the Board's action.

[16] The County stated at this time that it intended to "[e]xpand the County-operated TCORE-APSS program", "staff the County Clinics with . . . staff identified for termination", and create County clinics "in facilities where the county currently has vacant leased space." *See* Branick-Abilla Decl. (Dkt. No. 19), Ex. F, Attachment B at 2.

into account the resources available to the State . . . ."). Not surprisingly, this argument is not supported by a single case under the ADA or the Rehabilitation Act. Its sole support is a pair of non-ADA municipal contract cases in which California courts rejected challenges by losing bidders, on the basis that courts should ordinarily "declin[e] to inquire into legislative thought processes or motives." *Mike Moore's 24-Hour Towing v. City of San Diego*, 45 Cal. App. 4th 1294, 1305 (1996) (citations omitted). The instant case, however, does not require a re-examination of legislative motivations; the Court can, and should, grant injunctive relief for the simple reason that the County's proposed redesign violates the *Olmstead* mandate.

D. This Controversy is Justiciable.

Plaintiffs have standing to seek the requested injunctive relief. A plaintiff seeking a preliminary injunction must show that "he is under threat of suffering an 'injury in fact' that is concrete and particularized; the threat must be actual and imminent, not conjectural or hypothetical; it must be fairly traceable to the challenged action of the defendant; and it must be likely that a favorable judicial decision will prevent or redress the injury." *Summers v. Earth Island Institute*, 129 S. Ct. 1142, 1149 (2009); *Nelson v. Nat'l Aeronautics & Space Admin.*, 530 F.3d 865, 873 (9th Cir. 2008). A plaintiff can show standing by presenting evidence in the form of verified complaints, declarations, or affidavits that establish the likelihood that he will suffer injury as a result of the conduct sought to be enjoined. *See, e.g. Summers*, 129 S. Ct. at 1149-1150 (affidavits used to decide question of standing for preliminary injunction).

Here, Defendants assert that Plaintiffs lack standing because their complaint and declarations were prepared prior to submission of the so-called "hybrid plan." (Opp. at 14:26-15:8.) In making such an argument, Defendants seek to sweep under the rug all of their prior actions that necessitated the filing of the preliminary injunction motion in the first place. The declarations are accurate and highly relevant evidence of the disorder, confusion and poor planning that have characterized Defendants' actions since they announced in April 2010 that they were closing most of the adult outpatient mental health programs. Those issues did not simply disappear on June 17, 2010 when the Board adopted the County's so-called "hybrid plan." Plaintiffs and other class members faced – and continue to face – real threat of injury due to an

impending reduction in medically necessary mental health services as a result of the County's actions. Defendants' standing argument is therefore baseless.

IV. GIVEN DEFENDANTS' FAILURE TO IDENTIFY A JUSTIFICATION FOR DISRUPTING MEDICALLY NECESSARY TREATMENT TO 5,000 VULNERABLE CLIENTS, THE PUBLIC INTEREST AND THE BALANCE OF EQUITIES TIP SHARPLY IN PLAINTIFFS' FAVOR.

Under *Winter,* plaintiffs must also show that the balance of equities tips sharply in their favor. 129 S. Ct. at 374. Plaintiffs have already made this showing with evidence that preserving the current system will save public funds, since the outpatient services provided by private contractors are far more cost-effective than those provided by county employees or in locked institutions. Pl. Br. at 24.

The County's Opposition is surprising, for it offers no pressing reason for changing its entire delivery system and disrupting medically necessary mental health care to 5,000 people. The County simply asserts its "legislative discretion" to make any change it chooses. Opp. at 14. Initially, the County cited its budget crisis (Opp. at 2), but later claimed that there will be no reduction in funding because it has "found" additional funds.[17] Opp. at 2-3; Bd. Memo at 3. The most consistent justifications cited by County officials for closing the RSTs have been the County Charter provision known as "Section 71-J" that protects public employees from layoffs, and other civil service protections. *See, e.g.,* Branick-Abilla Decl. (Dkt. No. 19), Ex. F at 2-3 & Attachment B (4/1/10 Meeting Minutes). At public meetings, County officials stated that point of the "redesign" was to save the jobs of forty County employees scheduled for layoffs, but who will now be transferred to positions in the new County clinics.[18] Similarly, the County is transferring $4 million from the RSTs to cover increased costs of raises and salary increases for DHHS staff. Bd. Memo at 3. The County could secure inpatient services more cheaply from private contractors but claims it cannot do so because of Section 71-J and civil service protections for the

[17] The County's "new funds" are from the MHSA, and it originally claimed that prohibitions against supplantation of funds prevented the use of MHSA funds to support the RSTs. Bd. Memo at 7. However, in her deposition, the DHHS Director reversed her position, conceding that the County could have requested MHSA funding to maintain the RSTs and TCORE but decided against it. Edwards-Buckley Depo. at 98:7-22. Thus, the DHHS director confirmed that restrictions on the use of MHSA funds are not a justification for defunding the RSTs.

[18] Branick-Abilla Decl. (Dkt. No. 19), Ex. F at 2-3 & Attachment B (4/1/10 Meeting Minutes).

county employees at the MHTC. *See* Edwards-Buckley Depo. at 28:7-14. However, when it comes to arguing its case before this Court, the County's Opposition is silent as to Section 71-J, leaving it with no justification at all.

The County also argues that an injunction preventing termination of funding for the RSTs will require it to reduce services in other, equally essential areas. Opp. at 24. To the contrary, the funds already allocated by the County to fund a transition to the new system ($2.9 million) will largely cover the short-term costs of an injunction. If the County then proceeds to seek MHSA funds to continue the RSTs, as many have suggested, it will be in the same situation as it is now but without the need to pay for a costly transfer process , and no risk of needless harm to clients.

Since the County offers no compelling justification for its decision to terminate funding to the mental health providers on which 5,000 individuals have relied, and since these services are also more cost-effective and less costly than services provided by County employees, especially in the County's inpatient facilities, the balance of equities tips sharply in Plaintiffs' favor, and the public interest favors issuance of an injunction.

V. CONCLUSION

In the words of Dr. Franczak, the County's plan "will reduce available funding by at least 30%, decrease staffing capability, fails to account for the probability of higher acuity and crises of affected participants, and contains wholly inadequate transition planning. The result of this folly will be irreparable harm to individuals in the form of clinical regression, increased hospitalization and institutionalization, injury, illness, and death." Supp. Franczak Decl., ¶ 27. Plaintiffs respectfully request that the proposed preliminary injunction order issue.

Dated: July 14, 2010

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