ATTACHMENT A

SAMANTHA CHOE (SBN: 252002)
schoe@cov.com
ADDISON THOMPSON* (SBN:330251)
athompson@cov.com
SYLVIA HUANG* (SBN: 313358)
syhuang@cov.com
ANNIE SHI (SBN: 327381)
ashi@cov.com
Covington & Burling LLP
415 Mission St., Ste. 5400
San Francisco, CA 94105
Telephone: (415) 591-6000

[Additional counsel listed on next page]

** C.D. California admission application forthcoming*

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

EASTERN DIVISION

RICHARD HART, ERVIN LONGSTREET, ALDO HERNANDEZ, CHARLES GLUCK, AND GRAHAM WALDROP, individually and on behalf of all others similarly situated,

Plaintiffs,

v.

STEPHANIE CLENDENIN, Director of California Department of State Hospitals, in her official capacity; JANINE WALLACE, Executive Director of Patton State Hospital, in her official capacity,

Defendants.

Case No. 5:20-cv-1559

CLASS ACTION

COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

JENNIFER STARK (SBN: 267062)
Jennifer.Stark@disabilityrightsca.org
AARON FISCHER (SBN: 247391)
Aaron.Fischer@disabilityrightsca.org
ANNE HADREAS (SBN: 253377)
Anne.Hadreas@disabilityrightsca.org
SARAH GREGORY (SBN: 303973)
Sarah.Gregory@disabilityrightsca.org
KIM PEDERSON (SBN: 234785)
Kim.Pederson@disabilityrightsca.org
Disability Rights California
1330 Broadway, Suite 500
Oakland, CA 94612
Telephone: (510) 267-1200
Facsimile: (510) 267-1201

INTRODUCTION

1. Plaintiffs Richard Hart, Ervin Longstreet, Aldo Hernandez, Charles Gluck, and Graham Waldrop (collectively, "Plaintiffs") bring this class action lawsuit because they and others who are similarly situated are at risk of becoming severely ill or dying from COVID-19 while being held at Patton State Hospital, one of the largest psychiatric hospitals in the country. Stephanie Clendenin, Director of the California Department of State Hospitals ("DSH") and Janine Wallace, Director of Patton State Hospital ("DSH-Patton") (collectively, "Defendants") are holding Plaintiffs at this locked facility pursuant to involuntary psychiatric commitments. As of the date of this filing, at least 112 patients and 147 facility staff at DSH-Patton have tested positive for COVID-19. At least two patients have died from complications after contracting the virus. In light of the life-threatening dangers posed by the growing COVID-19 outbreak, Plaintiffs seek immediate action to protect the health and well-being of DSH-Patton patients, including through discharge or transfer to safer, non-congregate settings.

2. With each passing day, the grave threat of SARS-CoV-2, the coronavirus responsible for the COVID-19 pandemic, increases at DSH-Patton. The facility is in the midst of an outbreak. There is no vaccine for the virus. There is no effective treatment. Although DSH-Patton provides psychiatric treatment to patients, it is not equipped to provide essential medical care. Mounting evidence indicates that transmission of COVID-19 is airborne and is particularly dangerous in congregate settings, like DSH-Patton, with close contact and poor ventilation. The Centers for Disease Control and Prevention ("CDC") advises that the only effective means of limiting transmission of the novel coronavirus is through "social distancing" and rigorous personal hygiene. This is impossible for Plaintiffs and other patients of DSH-Patton, given their conditions of confinement.

3. DSH-Patton resembles a jail or prison facility more closely than a community-based medical hospital or treatment center. The facility holds more than

1,500 patients overall and employs over 2,000 staff members. Defendants confine patients to locked units that consist of approximately fifty (50) people, all of whom share one bathroom, one eating area, one communal lounge area, and a few telephones. Patients report that, contrary to DSH protocols, Defendants do not routinely sanitize high-touch common surfaces, including tables, chairs, and telephones, between use by different patients. Staff rotate through the units constantly, and do not wear masks consistently when interacting with patients.

4. Defendants' failure to take steps to limit the spread of COVID-19 at DSH-Patton poses a serious threat to Plaintiffs' lives and well-being. Plaintiffs all have conditions and factors that, according to the CDC, make them highly vulnerable to severe illness or death if they contract COVID-19. For example, Plaintiff Hart is a 66-year-old lung cancer survivor with Chronic Obstructive Pulmonary Disease ("COPD"). Plaintiffs Longstreet, Hernandez, Gluck and Waldrop have a range of serious medical conditions that include coronary artery disease, kidney and liver conditions, hypertension, diabetes, and obesity. According to the CDC, these conditions and factors make Plaintiffs and others with similar conditions vulnerable to severe medical complications and death from COVID-19. Plaintiffs and many other patients at DSH-Patton also have other risk factors, such as those related to age and race, that increase the likelihood of severe complications from COVID-19.

5. By this class action, Plaintiffs seek to represent all individuals confined at DSH-Patton during the COVID-19 pandemic who, pursuant to CDC guidelines, are or might be at high risk for becoming severely ill or dying from COVID-19 (the "Class"). A substantial number of patients held at DSH-Patton—almost certainly several hundred people, who are identifiable through review of basic medical and other records—qualify as "high risk" based on the CDC's guidelines.

6. In response to this pandemic, courts and custodial authorities across the country have prioritized releasing high-risk detainees to protect both the detainees' health

and the public's health. Doing so not only protects the detained individuals with the greatest vulnerability to severe illness and death from contracting the virus, but also contributes to risk mitigation for the other people in detention as well as the facility staff who live among the public.

7. In contrast, Defendants have taken no meaningful steps to modify their policies and procedures to facilitate the release or transfer of Plaintiffs and others similarly situated to safer settings, despite the serious threat that the COVID-19 outbreak poses to their lives. On information and belief, Defendants have denied every request made by Plaintiffs and other high-risk patients to be moved to a safer, non-congregate setting. Among those Defendants have refused to move are patients who have completed or are close to completing their treatment goals at DSH, and patients who have identified community placements where they can safely shelter in place and receive treatment in a non-congregate setting. Even for patients who do not meet the current criteria for discharge to the community, it is inhumane and unconscionable to keep them in a setting where they are unable to protect themselves from infection.

8. Defendants are putting the lives of DSH-Patton[1] patients in danger by

[1] Alarming outbreaks are also occurring in other DSH facilities. For example, at DSH-Metropolitan located in Norwalk, California, at least 66 patients and at least 58 staff members and onsite personnel have tested positive for COVID-19. At DSH-Coalinga, at least 28 patients and at least 32 staff members and onsite personnel have tested positive for COVID-19; at least one DSH-Coalinga patient has died after contracting COVID-19. In the last several days, there have been reports that DSH has begun abruptly moving some DSH-Coalinga patients to DSH-Napa, another crowded, congregate state hospital that has to-date had a small number of patients test positive for COVID-19. This sudden transfer process, done without any transparency as to the process, raises grave concerns that DSH may be moving down the same catastrophic path that the California Department of Corrections and Rehabilitation ("CDCR") went down in conducting hasty transfers of COVID-19-infected patients to San Quentin State Prison. *See* Jason Pohl, *'Horribly botched.' Lawmakers slam California prisons for 'out-of-control' COVID-19 infections*, SACRAMENTO BEE Jul. 1, 2020, https://www.sacbee.com/news/coronavirus/article243935832.html; Rong-Gong Lin II & Sean Greene, *San Quentin prison coronavirus outbreak 'tragic, predictable and*

holding them in crowded, congregate living spaces in the midst of a COVID-19 outbreak. Defendants' continued confinement of Plaintiffs and other high-risk patients at DSH-Patton violates the Due Process Clause of the Fourteenth Amendment and Title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§ 12131-12134. Plaintiffs bring this action on behalf of themselves and others similarly situated in order to remedy these violations.

9. Unless this Court intervenes to order Defendants to take immediate steps to protect DSH-Patton patients, including by effectuating the discharge or transfer of Plaintiffs to safer, non-congregate settings, Plaintiffs and the class of people they seek to represent are at grave risk of irreparable harm, including contracting COVID-19, becoming severely ill, and dying.

JURISDICTION

10. Plaintiffs bring this putative class action pursuant to 42 U.S.C. § 1983 for relief from both detention and conditions of confinement that violate their Fourteenth Amendment right under the U.S. Constitution and pursuant to 42 U.S.C. § 12131 *et seq*. for relief from disability discrimination.

11. This Court has jurisdiction pursuant to 42 U.S.C. § 1983; 28 U.S.C. § 1331; 28 U.S.C. § 2201; and 28 U.S.C. § 2202. A substantial, actual, and continuing controversy exists between the parties.

VENUE & INTRADISTRICT ASSIGNMENT

12. Venue is proper in the Central District of California pursuant to 28 U.S.C. §§ 1391(b)(2).

13. Defendants operate DSH-Patton, which is located in the Central District of California, and the events or omissions giving rise to this action arose in San Bernardino

---

unacceptable,' L.A. TIMES, Jun. 26, 2020, https://www.latimes.com/california/story/2020-06-26/san-quentin-state-prison-coronavirus-cases-soar.

County, which is located within the Central District of California. Plaintiffs also reside at DSH-Patton in San Bernardino County.

14. This action should be assigned to the Eastern Division of the Central District of California pursuant to General Order No. 19-03 § I.B.1.a(1)(c). All Plaintiffs reside in in the Eastern Division, and Defendants operate DSH-Patton, which is located in the Eastern Division.

PARTIES

Plaintiff Richard Hart

15. Plaintiff Richard Hart ("Mr. Hart") is a 66-year-old lung cancer survivor who lost part of his left lung when receiving cancer treatment last year. Mr. Hart also has Chronic Obstructive Pulmonary Disease ("COPD") and hypertension, and is obese with a body mass index of 33.

16. According to CDC guidance, Mr. Hart's age and medical conditions place him at a heightened risk of severe illness or death due to COVID-19. In addition, Mr. Hart is an individual with a disability as defined by the ADA. *See* 42 U.S.C. § 12102(2)(b).

17. Defendants are holding Mr. Hart because a court found him to be not guilty by reason of insanity under Penal Code section 1026 for criminal acts that occurred twenty-two years ago. Mr. Hart's actions did not result in any bodily harm. According to recent reports, his risk of future violence is "low" based on Mr. Hart's improved insight and coping skills, and he is close to completing his treatment goals.

18. The primary purpose of Mr. Hart's continued confinement at DSH-Patton is to receive treatment for his mental health disability. However, managing his condition requires only minimal psychiatric treatment at DSH-Patton, and this treatment could be replicated in another setting without difficulty. In particular, Mr. Hart takes medication and sees a therapist two times per month. Prior to the COVID-19 outbreak, Mr. Hart also attended group programming sessions, which Defendants have cancelled due to the

outbreak.

19. On July 17, 2020, Plaintiffs' counsel sent a formal request to Defendants to evaluate Mr. Hart, on an expedited basis, for transfer or discharge from DSH-Patton to a safer setting in light of Mr. Hart's high risk for becoming severely ill or dying from COVID-19. To date, Defendants have continued to hold him at the facility under the same conditions as existed before the outbreak—with the exception of the indefinite suspension of his group programming. Defendants have refused to transfer or discharge Mr. Hart despite the fact that his own treatment team at DSH-Patton already recommended him for community outpatient treatment on February 4, 2020.

20. If Defendants were to discharge Mr. Hart from DSH-Patton, he could continue therapy and medication in a safer, non-congregate community setting that would not jeopardize his life. Mr. Hart has a supportive family who have offered to assist him in his reentry into the community. He also has income to pay for a place to live independently, and would continue to receive medical and psychiatric services and follow any appropriate conditions for ongoing supervision.

21. Mr. Hart fears for his well-being because of the COVID-19 outbreak at DSH-Patton and is experiencing stress and anxiety. He believes that, if he were to contract COVID-19, he "would have a slim chance of survival."

Plaintiff Ervin Longstreet

22. Plaintiff Ervin Longstreet ("Mr. Longstreet") is a Navy veteran and cancer survivor with multiple medical conditions, including hypertension and kidney and liver conditions that require medication. He has been told by his doctors that he likely will require dialysis in the near future and may need an organ transplant.

23. According to CDC guidance, Mr. Longstreet's medical conditions place him at heightened risk of severe illness or death due to COVID-19. In addition, Mr. Longstreet is an individual with a disability as defined by the ADA. *See* 42 U.S.C. § 12102(2)(b).

24. Defendants are holding Mr. Longstreet at DSH-Patton because a court found him to be not guilty by reason of insanity under Penal Code section 1026 for criminal acts that occurred in 2007. According to recent reports, his risk for future violence is "low," and he is stable on his medications.

25. Mr. Longstreet is currently receiving extremely minimal psychiatric treatment at DSH-Patton. In particular, Mr. Longstreet takes medication and sees a therapist approximately two times per month. Prior to the COVID-19 outbreak, Mr. Longstreet also attended group programming sessions, which Defendants have cancelled due to the outbreak.

26. On June 18, 2020, Plaintiffs' counsel sent a formal request to DSH to evaluate Mr. Longstreet, on an expedited basis, for transfer or discharge from DSH-Patton to a safer setting in light of the COVID-19 risks at the facility. In addition to Mr. Longstreet's risk of becoming severely ill or dying from COVID-19, there are a number of factors that indicate he can be discharged safely. For example, Mr. Longstreet has extensive family support, including a brother, a daughter, and the mother of his children. Mr. Longstreet's family members have expressed their willingness to assist with his reentry into the community, including providing him housing in a non-congregate setting. Mr. Longstreet works in the DSH-Patton barber shop and has been told he could find work in the field after discharge.

27. On July 3, 2020, Defendants informed Plaintiffs' counsel that "Mr. Longstreet has demonstrated progress towards several of the areas identified in his discharge plan, including increased engagement in treatment." DSH evaluators concluded that he was appropriate for immediate transfer to Sylmar Health & Rehabilitation Center, another facility that is smaller than DSH-Patton though is still a congregate setting that has had COVID-19 cases. On July 15, 2020, Sylmar notified DSH that Mr. Longstreet would not be admitted to Sylmar at the present time, to allow for "additional time at DSH-P[atton] to develop a more detailed timeline of events related

to his mental illness" and for DSH to complete a "medication evaluation."

28. To date, Defendants have not taken any action to complete these recommendations, and have not taken any other steps to facilitate Mr. Longstreet's transfer to a more appropriate non-congregate setting that does not pose the same COVID-19 risks. Instead, Defendants continue to hold Mr. Longstreet at DSH-Patton. In addition, Mr. Longstreet has had other medical problems for which he has not been able to see necessary medical specialists due to COVID-19-related restrictions in place at DSH-Patton.

29. Mr. Longstreet experiences extreme stress and anxiety due to the outbreak at DSH-Patton, and he fears for his well-being. In Mr. Longstreet's words, "this is turning into a life sentence, and I wasn't even sentenced to life."

Plaintiff Aldo Hernandez

30. Plaintiff Aldo Hernandez ("Mr. Hernandez") has been diagnosed with coronary artery disease and type 2 diabetes. He is also obese, with a body mass index of 38.1.

31. According to CDC guidance, Mr. Hernandez's medical conditions place him at heightened risk of severe illness or death due to COVID-19. In addition, Mr. Hernandez is an individual with a disability as defined by the ADA. *See* 42 U.S.C. § 12102(2)(b).

32. Defendants are holding Mr. Hernandez at DSH-Patton because a court found him to be not guilty by reason of insanity under Penal Code section 1026 for criminal acts that occurred twenty-five years ago.

33. The primary purpose of Mr. Hernandez's continued confinement at DSH-Patton is to receive treatment for his mental health disability. However, managing his condition requires only minimal psychiatric treatment at DSH-Patton, and this treatment could be replicated in another setting without difficulty. Specifically, Mr. Hernandez takes medication and sees a social worker four times per month. Prior to the COVID-19

outbreak, Mr. Hernandez also attended group programming sessions, which Defendants have cancelled due to the outbreak.

34. Upon information and belief, since the onset of the pandemic, Defendants have failed to assess Mr. Hernandez for discharge or transfer despite his high risk of becoming severely ill or dying if he contracts COVID-19.

35. If DSH were to conduct such an evaluation, it would be apparent that Mr. Hernandez could continue effective therapy and medication in a non-congregate community setting outside of DSH-Patton, where he would not face the heightened risk of contracting the virus. Mr. Hernandez has a supportive family, with whom he is in regular contact by phone and mail, who could also assist with his reentry and participation in ongoing treatment. A recent report noted that he is "psychiatrically stable" and that his symptoms are controlled on medications.

36. Mr. Hernandez is very afraid. He notes: "It is very scary to be stuck in a place where you don't know the outcome and can't see your family. All you can do is hope and pray that you don't catch it."

Plaintiff Charles Gluck

37. Plaintiff Charles Gluck ("Mr. Gluck") has diagnoses of type 2 diabetes and hypertension. He is also obese, with a body mass index of 32.

38. According to CDC guidance, Mr. Gluck's medical conditions place him at heightened risk of severe illness or death due to COVID-19. In addition, Mr. Gluck is an individual with a disability as defined by the ADA. *See* 42 U.S.C. § 12102(2)(b).

39. Defendants are holding Mr. Gluck at DSH-Patton because a court found him to be not guilty by reason of insanity under Penal Code section 1026 for criminal acts that occurred in 1985.

40. The primary purpose of Mr. Gluck's continued confinement at DSH-Patton is to receive treatment for his mental health disability. However, managing his condition requires only minimal psychiatric treatment at DSH-Patton, and this treatment could be

replicated in another setting without difficulty. Specifically, Mr. Gluck takes medication and sees a therapist two times per month. Prior to the COVID-19 outbreak, Mr. Gluck also attended group programming sessions, which Defendants have cancelled due to the outbreak.

41. Upon information and belief, since the onset of the pandemic, Defendants have failed to assess Mr. Gluck for discharge or transfer despite his high risk of becoming severely ill or dying if he contracts COVID-19.

42. If Defendants were to conduct such an evaluation, it would be apparent that, as noted in his most recent court report, Mr. Gluck's risk of serious harm or imminent violence is "low." Mr. Gluck's primary behavioral health needs include substance abuse treatment. If he were released or transferred to a safer setting, Mr. Gluck would be willing to participate in such treatment. If discharged from DSH, Mr. Gluck would also be eligible to receive SSDI benefits.

43. In Mr. Gluck's words: "I feel very uncomfortable because we don't know where we stand. I feel so bottled up, like a rat trapped in a cage."

Plaintiff Graham Waldrop

44. Plaintiff Graham Waldrop ("Mr. Waldrop") has type 2 diabetes and is severely obese, with a body mass index of 57.8. He also has a diagnosis of obstructive sleep apnea, for which he needs to use a continuous positive airway pressure ("CPAP") machine, which requires daily cleaning.

45. According to CDC guidance, Mr. Waldrop's medical and physical conditions place him at greatly heightened risk of severe illness or death due to COVID-19. In addition, Mr. Waldrop is an individual with a disability as defined by the ADA. *See* 42 U.S.C. § 12102(2)(b).

46. Defendants are holding Mr. Waldrop at DSH-Patton because a court found him to be not guilty by reason of insanity under Penal Code section 1026 for criminal acts that occurred in 2007.

47. The primary reason for Mr. Waldrop's continued confinement at DSH-Patton is to receive treatment for his mental health disability. However, managing his condition requires only minimal psychiatric treatment at DSH-Patton, and this treatment could be replicated in another setting without difficulty. Specifically, he takes medication and does not receive any individual therapy. Before being cancelled as a result of the COVID-19 pandemic, Mr. Waldrop participated in group programming at DSH-Patton.

48. Upon information and belief, since the onset of the pandemic, Defendants have failed to assess Mr. Waldrop for discharge or transfer despite his high risk of becoming severely ill or dying if he contracts COVID-19.

49. If Defendants were to conduct such an assessment, it would be apparent that Mr. Waldrop is able to continue medication in a non-congregate community setting outside of DSH, where he would not face a heightened risk of contracting the virus. Mr. Waldrop has a supportive family, with whom he is in regular contact by phone, who can provide him housing and assist with his reentry and participate in ongoing treatment if he is released from DSH-Patton.

50. Mr. Waldrop is afraid to stay at DSH-Patton because he knows that his health conditions put him at high risk if he contracts COVID-19. He is constantly worried about his health and states that he is "afraid to die here."

Defendants

51. Defendant Stephanie Clendenin ("Clendenin") is the Director of the California Department of State Hospitals ("DSH"). She is sued herein in her official capacity only. As DSH Director, Defendant Clendenin oversees the management of California's state hospital system, including California's five state hospitals: DSH-Atascadero, DSH-Coalinga, DSH-Metropolitan, DSH-Napa, and DSH-Patton.

52. Defendant Janine Wallace ("Wallace") is the Executive Director of DSH-Patton. She is sued herein in her official capacity only. Defendant Wallace oversees the

management of DSH-Patton and exercises the day-to-day control over its residents' custody.

53. Defendants are responsible for the health and safety of DSH-Patton patients and with ensuring that they are served in accordance with federal and state law.

FACTUAL BACKGROUND

A. COVID-19 Poses a Grave Risk of Harm.

54. COVID-19 is a novel communicable virus that has proved unusually fatal. As of August 4, 2020, more than 4.7 million people in the United States have contracted the coronavirus and at least 155,000 have died.[2] In recent days, the number of reported cases of infection in many parts of the country, including in California, have shown a frightening increase, and numerous media outlets and public officials expect that the reported number of deaths will increase significantly as well. Far from being over, many epidemiologists are predicting that the pandemic will only worsen in the fall.

55. Some individuals have a higher risk of severe illness from COVID-19, according to the CDC. In particular, the risk of severe illness or death from COVID-19 increases with age, with a large increase in risk starting at age 50.[3]

56. According to the CDC, individuals of any age with the following underlying conditions are also at increased risk of severe illness from COVID-19: cancer; chronic kidney disease; COPD; serious heart conditions such as heart failure, coronary artery disease, or cardiomyopathies; type 2 diabetes; sickle cell disease; immunocompromised state from a solid organ transplant; and obesity (body mass index of 30 or higher).[4]

---

[2] *Cases and Deaths in the U.S.*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last updated Aug. 4, 2020).

[3] *People at Increased Risk of Severe Illness - Older Adults*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html (last updated July 30, 2020).

[4] *People at Increased Risk of Severe Illness - People with Certain Medical Conditions*, CENTERS FOR DISEASE CONTROL AND PREVENTION,

57. In addition, the CDC states that individuals of any age with the following underlying conditions might be at an increased risk for severe illness from COVID-19: asthma; cerebrovascular diseases; cystic fibrosis; hypertension or high blood pressure; immunocompromised state from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines; neurologic conditions such as dementia; liver diseases; pregnancy; pulmonary fibrosis; thalassemia; type 1 diabetes; and individuals who are smokers.[5]

58. For people in the highest risk populations, such as Plaintiffs and the class of people they seek to represent, the United States fatality rate of COVID-19 infection is staggering: almost 20%.[6] Further, although the long-term effects of COVID-19 are not yet well-known, people who contract but do not die from COVID-19 may still have serious lifelong consequences, including lung damage, blood clots, and heart problems.

59. Many people in higher risk categories will develop severe symptoms and will need advanced medical care. This level of supportive care requires highly specialized equipment that is in limited supply, like ventilators, and an entire team of care providers, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians.

B. COVID-19 Poses a Heightened Risk of Harm to Individuals Detained in Locked Psychiatric Facilities such as DSH-Patton.

60. DSH-Patton is a locked psychiatric facility that provides treatment to patients with an objective of preparing them for safe discharge and reintegration into the community. Since the onset of the pandemic, locked facilities have been an epicenter of coronavirus transmission, and psychiatric facilities such as DSH-Patton are uniquely

---

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (last updated July 30, 2020).

[5] *Id.*

[6] Erin K. Stokes, et al., *Coronavirus Disease 2019 Case Surveillance – United States, January 22-May 30, 2020*, MORBIDITY AND MORTALITY WEEKLY REPORT, https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm (last updated June 18, 2020).

vulnerable to COVID-19 outbreaks.

61. Over the past few months, COVID-19 has spread through psychiatric hospitals across the country.[7] By April 17, 2020, there were already more than 1,450 COVID-19 cases reported at state mental health facilities in twenty-three states and Washington, D.C. At the Eastern Louisiana Mental Health System, a locked psychiatric facility, more than 20% of patients tested positive and six died by May 13, 2020. At Tewksbury Hospital, a psychiatric hospital in Massachusetts, 55% of the more 300 patients tested positive for the virus by June 22, 2020. In New York, at least thirty COVID-related deaths have occurred in state psychiatric facilities.

62. According to the CDC and other public health experts, the only known effective measures to reduce the risk for vulnerable people like Plaintiffs and the class they seek to represent are to prevent them from being infected in the first place and to limit community spread. The CDC recommends maintaining a minimum of six feet

[7] *See* Danny Hakim, *'They Want to Forget Us': Psychiatric Hospital Workers Feel Exposed*, N.Y. TIMES, April 27, 2020, https://www.nytimes.com/2020/04/24/nyregion/coronavirus-new-york-psychiatric-hospitals.html; Terrence T. McDonald, *Coronavirus cases at NJ psych hospitals climb to 563, with 9 deaths*, BURLINGTON COUNTY TIMES, May 1, 2020, https://www.burlingtoncountytimes.com/news/20200501/coronavirus-cases-at-nj-psych-hospitals-climb-to-563-with-9-deaths; Elly Belle, *We Can't Forget About Psychiatric Hospitals During the COVID-19 Outbreak*, HEALTHLINE, June 30, 2020, https://www.healthline.com/health/mental-health/psychiatric-hospitals-during-covid-19; Nada Hassanein, *'I don't want to die': Almost Three Dozen Coronavirus Cases Now at Florida State Hospital*, TALLAHASSEE DEMOCRAT, July 22, 2020, https://www.tallahassee.com/story/news/2020/07/22/almost-three-dozen-coronavirus-cases-now-florida-state-hospital/5485504002/; Kristine de Leon, *Montana State Hospital Reports Two Patients Tested Positive for COVID-19*, MONTANA STANDARD, July 22, 2020, https://mtstandard.com/news/local/montana-state-hospital-reports-two-patients-tested-positive-for-covid-19/article_170a86e3-80c1-5ce0-99a5-8edeb1b82a79.html; Luanne Rife, *COVID Outbreaks at Virginia's Psychiatric Hospitals Kill 5, Infect Dozens*, THE ROANOKE TIMES, July 29, 2020, https://roanoke.com/news/local/covid-outbreaks-at-virginias-psychiatric-hospitals-kill-5-infect-dozens/article_0b71b8dd-c440-5005-b467-d60ba388b0cf.html.

between people at all times, reducing frequency of contact, and maintaining rigorous personal hygiene, including frequently and thoroughly washing hands with soap and water.

63. Infection control and social distancing is particularly difficult in psychiatric facilities, however, because such facilities are designed to *encourage* social interaction through shared living spaces, providing meals in communal settings, and group programming. Unlike traditional medical hospitals, psychiatric hospitals are simply not designed to resist the spread of viral infection.[8]

64. Once COVID-19 enters a psychiatric facility, the results can be disastrous. As one infectious disease expert explained, "[i]t's the worst of all worlds . . . You get one case in these [psychiatric] institutions, and you've got 10 in the next few days. These are almost invariably very high-risk patients. They're elderly, they have chronic medical conditions, they're on medications. It's a mess."[9]

65. In light of the "substantial risk of coronavirus spread with congregation of individuals in a limited space such as in an inpatient or residential [mental health] facility," the federal Substance Abuse and Mental Health Services Administration ("SAMHSA") has advised "that outpatient treatment options, when clinically appropriate, be used to the greatest extent possible."[10]

---

[8] Masha Gessen, *Why Psychiatric Wards are Uniquely Vulnerable to the Coronavirus*, THE NEW YORKER, Apr. 21, 2020, https://www.newyorker.com/news/news-desk/why-psychiatric-wards-are-uniquely-vulnerable-to-the-coronavirus.

[9] Kit Ramgopal, *Coronavirus in a Psychiatric Hospital: 'It's the worst of all worlds,'* NBC NEWS, Apr. 17, 2020, https://www.nbcnews.com/health/mental-health/coronavirus-psychiatric-hospital-it-s-worst-all-worlds-n1184266 (last updated Apr. 27, 2020) (discussing COVID-19 outbreak at Western State Hospital, one of the largest psychiatric institutions in the western United States).

[10] SAMHSA, Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 (revised May 7, 2020) https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf; see also Bazelon Center for Mental Health Law, During the Pandemic, States and Localities Must Decrease the Number of Individuals in

C. DSH-Patton Is A Cramped, Congregate Setting, Not Designed to Permit Social Distancing or to Foster Infection Control.

66. DSH-Patton is one of the largest psychiatric hospitals in the country. The facility currently operates approximately 1,527 beds in 33 units, and employs approximately 2,380 people. DSH-Patton patients often stay in the facility for a decade or more, sometimes longer than the time they would have served had they been convicted and served their time in state prison.

67. Within DSH-Patton, social distancing is virtually impossible. Defendants hold patients in units with approximately 50 other patients. Patients share bedrooms, bathrooms, common areas, and telephones, and eat meals in a communal setting. In some cases, five patients share a bedroom. In most bedrooms, there is less than six feet of space between each bed.

68. Many units at DSH-Patton are connected to "sister" units, meaning that 100 patients interact regularly and share common areas. For example, the "sister" units share a common room where patients from both units watch television, play cards and games, and do art projects. In addition, patients from the "sister" units line up in the same area for medications. Patients from different units and part of the facility pass each other with less than six feet of space.

69. Every day, staff members—which include psychiatrists, psychologists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, registered dieticians and other clinical and administrative staff— enter and exit the facility and come into close contact with Plaintiffs. Contrary to DSH protocols, patients report that staff members do not properly wear face coverings, or do not wear face coverings at all, inside the patient areas.

Psychiatric Hospitals, By Reducing Admissions and Accelerating Discharges (Apr. 15, 2020) (urging state hospitals to accelerate discharges and noting that people with serious mental illness tend to have more medical issues than the population at large), http://www.bazelon.org/wp-content/uploads/2020/04/4-15-20-BC-psych-hospitals-statement-FINAL.pdf.

70. Upon information and belief, DSH-Patton staff also do not regularly or adequately sanitize tables and chairs in any of the shared spaces on the units, and they do not sanitize the patient phones between each use.

71. DSH staff themselves have expressed concerns that "[t]here are lapses for the staff members and lapses for patients where there are all these areas that the virus can seep in."[11] Staff have reported that masks are worn inconsistently, that some staff have been unable to get tested, and that patients sent out for COVID-19 treatment are not retested or quarantined when they return to the facility.[12]

72. Upon information and belief, DSH-Patton is even less able to maintain infection control if the facility's ventilation system uses recycled air. Growing research shows that aerosolized particles of COVID-19 can disseminate much further than six feet, and may spread even farther through fans or air conditioners. Thus, people can become infected by the virus simply by breathing the air, even after a person with the virus has left the area.

73. Recently, Dr. Katherine Warburton, DSH's Medical Director, stated that DSH is no longer running psychiatric hospitals, but rather running infection treatment. Dr. Warburton acknowledged that COVID-19 "spreads like wildfire" once it gets into a state hospital.[13]

D. DSH-Patton Is in the Midst of a Growing COVID-19 Outbreak.

74. Although DSH-Patton avoided the COVID-19 virus for more than two months, once the virus entered the facility it quickly took hold.

---

[11] Lee Romney, *Patients, Staff at State Hospitals Worry Coronavirus Will Wreak Havoc*, KQED NEWS, Apr. 13, 2020, https://www.kqed.org/news/11812116/patients-staff-at-state-hospitals-worry-coronavirus-will-wreak-havoc.

[12] *Id.*

[13] Sarah Dowling, *As State Hospitals Battle Coronavirus, Yolo County Inmates Await Treatment*, WOODLAND DAILY DEMOCRAT, July 19, 2020, https://www.dailydemocrat.com/2020/07/19/as-state-hospitals-battle-coronavirus-yolo-county-inmates-await-treatment/.

75. On June 1, 2020, DSH-Patton announced that it had four confirmed cases of COVID-19 in its patient population.

76. Less than three weeks later, on June 17, 2020, the virus spread to at least sixty-three (63) patients and twenty (20) staff. By June 22, 2020, the number of confirmed cases at DSH-Patton jumped to seventy-six (76).

77. As of the date of this filing, at least 112 patients at DSH-Patton have tested positive for COVID-19, including individuals who have had contact with Plaintiffs. Additionally, at least 147 DSH-Patton staff members and onsite on-DSH personnel have tested positive for the virus. At least two patients have died from COVID-19.

78. San Bernardino County, where DSH-Patton is located, has the fourth highest total number of COVID-19 cases of all California counties. San Bernardino County is on the California Department of Public Health ("CDPH") "watchlist," and local health officials have noted that hospitals are reaching "surge capacity" because of an influx of new COVID-19 cases from local facilities, including hospitals.[14] CDPH has identified DSH-Patton as a "driver" in San Bernardino County's "elevated disease transmission and increasing hospitalizations."[15]

79. In an effort to address the COVID-19 outbreak at DSH-Patton, Defendants placed at least 15 units, or approximately 650 patients, on isolation or quarantine by June 23, 2020. Patients on isolation or quarantine do not receive access to a number of services, including recreation, canteen, and specialty medical appointments. Despite these measures, the numbers of people testing positive at DSH-Patton continue to rise.

80. Plaintiffs and other patients at DSH-Patton are now stuck in their units,

---

[14] Alex Wigglesworth, *Coronavirus Packs San Bernardino Hospitals; Imperial County Told to Reinstate Stay-at-Home Order*, L.A. TIMES, June 26, 2020, https://www.latimes.com/california/story/2020-06-26/california-coronavirus-cases-surpass-200-000-as-hospitalizations-mount.

[15] *County Data Monitoring*, CAL. DEP'T OF PUB. HEALTH, https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CountyMonitoringDataStep2.aspx (last updated July 30, 2020).

living in constant fear for their personal health and safety. In the words of one patient, people detained there feel like they are "waiting to die."

E. COVID-19 Poses a Heightened Risk of Harm, including Severe Illness or Death, to Plaintiffs and the Class They Seek to Represent.

81. As set forth above, Plaintiffs and hundreds of other patients at DSH-Patton live with multiple medical conditions that the CDC has identified as significantly increasing their risk of severe illness or death if they contract COVID-19.

82. Plaintiffs' medical conditions are typical of the patient population at DSH-Patton. As research has shown, people with mental illness, including patients at DSH-Patton, are more likely than the general population to live with serious medical conditions and chronic disease, including many diseases that have been identified by the CDC as high-risk factors for COVID-19.[16]

83. For example, Mr. Hart is diagnosed with Chronic Obstructive Pulmonary Disease ("COPD"). COPD has been found to be associated with "substantial severity and mortality rates"[17] and an "over five-fold increased risk of severe COVID-19."[18] The COVID-19 case fatality rate for individuals with chronic respiratory disease is 2.7 times that of the average infected individual.[19] Like Mr. Hart, more than 22% of people with serious mental illness have been diagnosed with COPD, or approximately 336 patients at

[16] Marc De Hert, et al., *Physical Illness in Patients with Severe Mental Disorders: Prevalence, Impact of Medications and Disparities in Health Care*, 10(1) WORLD PSYCHIATRY 52 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048500/.
[17] Jaber Alqahtani, et al., *Prevalence, Severity and Mortality associated with COPD and Smoking in patients with COVID-19: A Rapid Systematic Review and Meta-Analysis*, PLOS ONE, May 11, 2020, https://doi.org/10.1371/journal.pone.0233147.
[18] Giuseppe Lippi, et al., *Chronic Obstructive Pulmonary Disease is Associated with Severe Coronavirus Disease 2019 (COVID-19)*, 167 RESPIRATORY MEDICINE (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7154502/.
[19] Beth Sissons, *How Does COVID-19 Affect COPD?* MEDICAL NEWS TODAY, https://www.medicalnewstoday.com/articles/covid-19-and-copd (last updated May 19, 2020).

DSH-Patton.[20]

84. Mr. Longstreet, Mr. Gluck, and Mr. Hart have hypertension, which the CDC has identified as a risk factor for increased COVID-19 severity. Hypertension has been identified as a "leading factor" in COVID-19-related deaths.[21] In fact, research has shown that people with hypertension may be as much as twice as likely to die from COVID-19. Approximately 51% of patients with serious mental illness, or around 779 patients in DSH-Patton, have hypertension.[22]

85. Patients at DSH-Patton are also more likely than the general population to be obese and to have obesity-related medical conditions, such as type 2 diabetes and cardiovascular disease.[23] Approximately 52% of people with serious mental illness are obese,[24] and more than 28% have type 2 diabetes, which is more than double the rate of the general population.[25] Based on the total population at DSH-Patton, these percentages translate to approximately 794 patients who are obese, and 428 patients with type 2 diabetes, respectively. Mr. Waldrop and Mr. Hernandez have type 2 diabetes and severe obesity.

---

[20] Seth Himelhoch, et al., *Prevalence of Chronic Obstructive Pulmonary Disease Among Those with Serious Mental Illness*, 161 AM. J. PSYCHIATRY 2317 (2004), https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.161.12.2317.

[21] Tarryn Mento, *Hypertension Continues to Be Top Underlying Health Condition Among Local COVID-19 Deaths*, KPBS NEWS, May 30, 2020, https://www.kpbs.org/news/2020/may/30/more-half-san-diegans-who-died-covid-19-had-high-b/.

[22] Christoph U. Correll, et al. *Findings of a U.S. National Cardiometabolic Screening Program Among 10,084 Psychiatric Outpatients*, 61(9) PSYCHIATRIC SERVICES 892 (2010), https://pubmed.ncbi.nlm.nih.gov/20810587/.

[23] Tim Bradshaw and Hilary Mairs, *Obesity and Serious Mental Ill Health: A Critical Review of the Literature*, 2(2) HEALTHCARE 166 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4934464/.

[24] Correll, *supra* note 22.

[25] Christina V. Mangurian, et al., *Diabetes and Prediabetes Prevalence by Race and Ethnicity Among People with Severe Mental Illness*, DIABETES CARE, May 2018, https://care.diabetesjournals.org/content/early/2018/05/14/dc18-0425.

86. The CDC has identified type 2 diabetes and obesity as risk factors for severe COVID-19 illness. Research has shown the mortality rate of COVID-19 patients with diabetes to be approximately three times the general rate.[26] The CDC has also found that obesity, defined as a body mass index ("BMI") of over 30, increases an individual's risk for severe illness. Research has shown that the need for mechanical ventilation because of COVID-19 increases with BMI, with individuals with a BMI over 35 seven times more likely to need the intervention.[27] Mr. Hernandez's BMI is 38.1. Mr. Waldrop's BMI is 57.8.

87. DSH-Patton patients also have other risk factors, including those related to age, that increase the likelihood of severe complications from COVID-19. Approximately 12% of the DSH patient population, including Mr. Hart, is over the age of 65. Approximately 80% of the deaths in the United States have been among individuals ages 65 and older. The CDC has recognized that the risk of severe illness from the virus increases with age, with a significant increase in risk starting at age 50. Almost one quarter of DSH patients are over 50 years old.

88. The CDC has also reported that people from certain racial and ethnic groups are "at increased risk of getting sick and dying from COVID-19."[28] Recent data from the CDC shows that the age-adjusted COVID-19 death rate for Black people is 3.6 times greater than that for white people.[29] The CDC also found that Black and Hispanic

---

[26] Sten Madsbad, *COVID-19 Infection in People with Diabetes*, TOUCH ENDOCRINOLOGY, https://www.touchendocrinology.com/insight/covid-19-infection-in-people-with-diabetes/ (last visited August 3, 2020).

[27] Arthur Simonnet, et al., *High Prevalence of Obesity in Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2) Requiring Invasive Mechanical Ventilation*, 28(7) OBESITY 1195 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7262326/.

[28] *Health Equity Considerations and Racial and Ethnic Minority Groups*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html (last updated July 24, 2020).

[29] Tiffany Ford, et al., *Race Gaps in COVID-19 Deaths are Even Bigger than They Appear*, BROOKINGS INSTITUTION, June 16, 2020, https://www.brookings.edu/blog/up-front/2020/06/16/race-gaps-in-covid-19-deaths-are-even-bigger-than-they-appear/.

Americans under age 65 die from COVID-19 at significantly higher rates than white patients.[30] Approximately twenty six percent (26%) of DSH patients, including Mr. Longstreet, are Black. Twenty-four percent (24%), including Mr. Hernandez, are Hispanic.

89. Plaintiffs and the class of people they represent all live in significant fear that they will face severe illness or death from contracting COVID-19 at DSH-Patton.

F. Defendants Have Failed to Protect Plaintiffs and the Plaintiff Class in the Face of the Grave Risk Posed by DSH-Patton's COVID-19 Outbreak.

90. On March 21, 2020, Governor Newsom issued Executive Order N-35-20, which granted Defendant Clendenin additional emergency powers to "waiv[e] any provision or requirement of the Welfare and Institutions Code … [and] any provision or requirement of the Penal Code that affects the execution of laws relating to care, custody, and treatment of persons with mental illness committed to or in the custody of" DSH in order to "protect the health, safety and welfare of patients" committed to DSH's care during the COVID-19 pandemic. Exec. Order N-35-20(5).

91. In a letter on April 20, 2020, Plaintiffs' legal counsel at Disability Rights California, along with the California Public Defenders Association, the ACLU of Northern California, and California Attorneys for Criminal Justice, called on Defendants to assess all DSH residents and release high-risk patients in light of the heightened danger of COVID-19. Advocates also called on Defendants to reduce DSH's overall population to allow for social distancing.

92. On May 20, 2020, Disability Rights California sent a letter to Defendants offering input on ways that DSH may exercise its authority to facilitate patient discharges or transfers to safer settings. *See, e.g.* Exec. Order N-35-20; Welf. & Inst. Code §§ 4146,

[30] Jonathan M. Wortham, et al., *Characteristics of Persons Who Died with COVID-19 – United States, February 12-May 18, 2020,* MORBIDITY AND MORTALITY WEEKLY REP., https://www.cdc.gov/mmwr/volumes/69/wr/mm6928e1.htm (last updated July 17, 2020).

7250, Penal Code §§1603-04.

93. To this day, Defendants have not taken steps to meaningfully reduce the population at DSH-Patton to allow for greater social distancing, and have failed to exercise their authority under the Executive Order and their traditional powers to protect high-risk patients from COVID-19. Indeed, Defendants initially utilized the authority under the Executive Order to *suspend* discharges, refusing to release eligible patients from DSH facilities to the community, even though some patients were ready for discharge and had court orders for release.

94. Defendants did initially suspend most admissions to DSH facilities to limit the introduction of the virus. Unfortunately, this response left hundreds of people in county jails without access to care, and Defendants restarted admissions. Over the period that Defendants suspended admissions, the waitlist of people needing a bed in their facilities almost doubled.

95. Defendants' primary response to the pandemic within DSH-Patton has been to limit programming, including most therapeutic groups and classes. Defendants' other response has been to "lock-down" or quarantine whole units of patients when there is a single positive test. Although patients on a quarantined unit cannot interact with patients in outside units, they still mingle with one another within a unit, using the same bathrooms and telephones, allowing the virus to continue to spread.

96. Ultimately, Defendants' efforts to limit the spread of COVID-19 at DSH-Patton have not proved effective. The number of people testing positive for COVID-19 at DSH-Patton continues to rise. Defendants continue to detain Plaintiffs and the class members they seek to represent at DSH-Patton, putting them at grave risk of severe illness or death.

CLASS ACTION ALLEGATIONS

97. Plaintiffs bring this action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure on their own behalf and on behalf of all persons similarly situated.

98. Plaintiffs seek to represent a class consisting of:

> All individuals who are currently confined at DSH-Patton or will be confined in the future during the COVID-19 pandemic and who, pursuant to CDC guidelines, are or might be at high risk of becoming severely ill or dying from complications related to COVID-19 (the "Class").

99. This Class is so numerous that joinder of all members in one action is impracticable. Defendants confine over 1,500 people at DSH-Patton, and a disproportionately high number of DSH-Patton patients have conditions identified by the CDC as risk factors for COVID-19 complications.[31] Based on the prevalence of several of CDC risk factors in the population of people with serious mental illness, at least half of the patients at DSH-Patton, or approximately 764 people, are likely in the Class. Further, because the population changes on a daily basis, it is inherently fluid and the Class includes future members whose names are not known at this time.

100. Common questions of law and fact apply to all Class members. These common questions of fact and law include but are not limited to: (1) whether Defendants are holding significant numbers of patients who have conditions that, per the CDC, put them at high risk for severe illness or death if they contract COVID-19; (2) whether COVID-19 is spreading throughout DSH-Patton; (3) whether Defendants have implemented adequate emergency measures during the COVID-19 crisis to protect DSH-Patton residents from substantial risk of serious harm and death, including by expeditiously (a) identifying all individuals at high risk for severe illness due to COVID-19; (b) implementing a process for assessing transfer or discharge options that adequately account for the risk of severe illness due to COVID-19; (c) modifying their policies and practices to accommodate people with disabilities that put them at risk of severe illness due to COVID-19; and (d) identifying and utilizing safe, non-congregate, community

[31] *See* Marc De Hert, et al., *supra* note 16; Tim Bradshaw and Hilary Mairs, *Obesity and Serious Mental Ill Health: A Critical Review of the Literature*, 2(2) HEALTHCARE 166 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4934464/.

placements for individuals at risk of severe illness due to COVID-19; (4) whether continuing to detain Class members with high risk factors for COVID-19 in the current conditions at DSH-Patton violates the Due Process Clause of the U.S. Constitution because the conditions of confinement subject Class members to an unreasonable risk of serious harm; (5) whether Defendants' actions and omissions violate the ADA.

101. Defendants' practices and the claims alleged herein are common to all members of the Class.

102. Plaintiffs' claims are typical of those of the Class. Plaintiffs, like all other patients confined at DSH-Patton, are currently being held in conditions that put them at substantial risk of serious harm. Plaintiffs, like other members of the Class, have underlying conditions that enhance their risk of severe illness or death from COVID-19.

103. The legal theories on which Plaintiffs rely are the same or similar to those on which all Class members would rely, and the harms suffered by them are typical of those suffered by all other Class members. Absent class certification, separate actions by individuals would in all likelihood result in inconsistent and varying decisions, which in turn would result in conflicting and incompatible standards for Defendants.

104. Plaintiffs will fairly and adequately protect the interests of the Class; the interests of the Class representatives are consistent with those of the Class members. In addition, counsel for Plaintiffs are experienced in class action and civil rights litigation.

105. Counsel for Plaintiffs know of no conflicts of interest among Class members or between the attorneys and Class members that would affect this litigation.

LEGAL FRAMEWORK AND ALLEGATIONS

106. The Court has authority to order appropriate relief to protect Plaintiffs and the class they seek to represent from the dangers posed by COVID-19 under the Fourteenth Amendment and the ADA.

A. This Court Has Authority to Order Appropriate Relief to Vindicate Plaintiffs' and Class Members' Fourteenth Amendment Rights, and Such Relief Is Appropriate Here.

107. The Due Process Clause of the Fourteenth Amendment requires Defendants to provide Plaintiffs conditions of confinement and services necessary to ensure their reasonable safety. *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982). The United States Supreme Court has held that state agencies cannot "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering." *Helling v. McKinney*, 509 U.S. 25, 33 (1993). Conditions of confinement that are inadequate to ensure a patient's safety and well-being are improper, regardless of whether the state deliberately created those conditions. *Oregon Advocacy Center v. Mink*, 322 F.3d 1101, 1120-21 (9th Cir. 2003) (holding that civil detainees are not required to satisfy heightened "deliberate indifference" standard of liability); *King v. County of Los Angeles*, 885 F.3d 548, 556-57 (9th Cir. 2018) (same).

108. The Court has authority to order broad relief, including Plaintiffs' release or transfer, to ensure that Plaintiffs' constitutional rights are protected. *Stone v. City & County of San Francisco*, 968 F.2d 850, 861 (9th Cir. 1992) (amended) ("Federal courts possess whatever powers are necessary to remedy constitutional violations because they are charged with protecting these rights.").

109. Recently, courts have exercised this authority to remedy constitutional violations due to the dangers posed by COVID-19 infections inside locked facilities. *See, e.g.*, *Fraihat v. U.S. Immigration and Customs Enforcement*, No. 19-1546, 2020 WL 1932570, at *21, *28 (C.D. Cal. Apr. 20, 2020) (granting nationwide preliminary injunction requiring ICE to identify high-risk detainees and implement measures for their protection from COVID-19, including through release); *Torres v. Milusnic*, No. 20-4450, 2020 WL 4197285, at *23-24 (C.D. Cal. July 14, 2020) (requiring Bureau of Prisons to exercise powers granted under CARES Act to identify high-risk detainees and evaluate them for release to home confinement); *see also Castillo v. Barr*, No. 20-00605, 2020 WL 1502864, at *5-6 (C.D. Cal. Mar. 27, 2020) (ordering release of high-risk immigration detainees due to dangers posed by COVID-19 inside facility); *Ortuño v.*

Jennings, No. 20-02064, 2020 WL 1701724, at *4 (N.D. Cal. Apr. 8, 2020) (same); *cf. Xochihua-Jaimes v. Barr*, 962 F.3d 1065, 1066 (9th Cir. 2020) (sua sponte ordering that petitioner "be immediately released from detention" due to the "rapidly escalating public health crisis" caused by COVID-19).

110. These issues are also currently being litigated in lawsuits involving the rights and safety of patients in psychiatric facilities who are at high risk related to COVID-19. *See, e.g.*, *Wilkes v. Lamont*, Case No. 20-594 (D. Conn. filed Apr. 30, 2020); *Doe v. Mikula*, Case No. 2084-1407 (Mass. Sup. Ct., Suffolk Cnty. filed July 1, 2020).

111. In the face of the threat from COVID-19, social distancing and hygiene measures are Plaintiffs' only defense. As the rapidly escalating outbreak at DSH-Patton shows, those protective measures are exceedingly difficult, if not impossible, to achieve in the congregate, dense living environment of DSH-Patton, even in the face of Defendants' attempts to limit the spread. Plaintiffs and the class they seek to represent share bedrooms, toilets, sinks, showers, and telephones, eat in communal spaces, and are in close and constant contact with other detainees and staff that rotate in and out of the facility. These conditions pose an unacceptably high risk of infection and, as a result, Plaintiffs and the proposed class face substantial risk of serious harm from continued detention in this setting.

B. The ADA Requires Defendants to Make Disability-Related Reasonable Modifications to Protect Plaintiffs and Class Members from COVID-19.

112. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

113. In addition, the ADA requires that all covered entities provide reasonable modifications in their policies, practices, and procedures in order to give people with disabilities an equal opportunity to benefit from the entity's programs, services, and activities. 28 C.F.R. § 35.130 (b)(7).

114. The ADA also prohibits public entities from utilizing criteria or methods of administration that "have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities." 28 C.F.R. § 35.130(b)(3).

115. Plaintiffs are "qualified" for Defendants' programs, services, and activities, which include providing safe, constitutional living conditions during confinement, medical care, rehabilitative services to prepare for reentry into the community, and discharge planning. *See* 42 U.S.C. § 12131(2); 28 C.F.R. § 35.104; 28 C.F.R. pt. 35, app. B ("[T]itle II applies to anything a public entity does.").

116. Plaintiffs' counsel have requested that Defendants create a systemic emergency plan to protect patients during the COVID-19 pandemic, including by immediately identifying all high-risk patients and implementing a process for transferring as many of those patients as possible to safer, non-congregate settings. To date, Defendants have failed to develop and implement any such plan.

117. Defendants have consistently refused requests to accelerate discharge procedures, even for patients who are at or near discharge ready, and have failed to reasonably modify their policies to give due weight to COVID-19 risk factors when evaluating patients for transfer. For example, Plaintiffs Hart and Longstreet have requested reasonable accommodations to Defendants' discharge planning process in order to facilitate their accelerated discharge or transfer out of the facility to a safer, non-congregate setting. Defendants have denied their requests.

118. Even where Defendants agreed to assess a patient for transfer, those assessments have gone nowhere. For example, Mr. Longstreet, who receives minimal treatment and has nearly completed all of his discharge goals, requested an accelerated process to effectuate his transfer out of DSH-Patton before he contracts COVID-19. Defendants refused to modify their normal procedures, and only evaluated Mr. Longstreet for transfer to another congregate facility, which ultimately refused to accept

him without a "medication evaluation" from DSH. Instead of accelerating a medication evaluation or identifying alternative placement options, Defendants simply gave up, refusing to take any further steps to transfer Mr. Longstreet out of DSH-Patton.

119. Defendants have also failed to make any modifications necessary to ensure that high-risk people with disabilities receive treatment and other services provided by Defendants while being reasonably protected from contracting, and even dying from, COVID-19.

120. Defendants also utilize methods of administration that discriminate against Plaintiffs and the class they seek to represent. When making determinations for discharge or transfer, Defendants do not consider the additional risk that COVID-19 causes Plaintiffs because of their disabilities.

121. Further, Defendants are failing to provide treatment to Plaintiffs and others similarly situated in the "most integrated setting." Under the ADA, the "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. pt. 35, app. B. Continued confinement in a psychiatric institution with only other individuals with disabilities, when unnecessary, violates the ADA. Here, Plaintiffs would be able to receive the same treatment they are currently receiving at DSH-Patton outside of the facility, in locations that do not place them at risk of severe illness or death.

INJUNCTIVE AND DECLARATORY RELIEF ALLEGATIONS

122. An actual controversy exists between Plaintiffs and Defendants regarding their respective legal rights and duties. Defendants' conduct as alleged above has caused and, absent injunctive relief, will cause Plaintiffs irreparable harm.

123. In the absence of immediate relief, Plaintiffs will continue to be deprived of these rights. There is no adequate remedy at law for the continuing violations by Defendants of Plaintiffs' constitutional and statutory rights.

CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF

Violation of Fourteenth Amendment Due Process Clause
Right to Reasonable Safety in Confinement

(Fourteenth Amendment; U.S.C. § 1983)

124. Plaintiffs repeat and reallege the allegations contained in all preceding paragraphs as though fully set forth herein.

125. Defendants violate the Due Process Clause of the Fourteenth Amendment when they subject Plaintiffs and the Class to conditions of confinement that create a substantial risk of serious harm to their safety and health.

126. Defendants' polices, practices, acts and omissions, including the conditions of confinement in which they are holding Plaintiffs, subject Plaintiffs and the Class to heightened risk of contracting COVID-19, for which there is no vaccine, effective treatment, or cure. Plaintiffs and Class members cannot take steps to protect themselves from the spread of COVID-19—such as social distancing, hand-washing hygiene, or self-quarantining—and Defendants have not provided adequate protections to guarantee their care and safety. Defendants are continuing to subject Plaintiffs and the Class to a substantial risk of serious harm by failing to timely: (1) identify individuals who are high risk for severe illness and/or death from COVID-19, (2) evaluate these individuals for discharge or transfer to alternative, non-congregate settings outside of DSH-Patton, (3) take all necessary steps to effectuate the discharge or transfer of these individuals from DSH-Patton, and (4) implement all appropriate measures to protect patients inside DSH-Patton from COVID-19 infection.

127. Defendants' actions and inaction violate the rights of Plaintiffs and the Class under the Due Process Clause of the Fourteenth Amendment.

128. There is no reasonable justification for the Defendants' actions.

129. Plaintiffs and the Class have suffered and will suffer injury as a proximate

result of Defendants' violation of their rights under the Due Process Clause of the Fourteenth Amendment.

130. Plaintiffs and the Class are entitled to declaratory relief, injunctive relief, attorneys' fees, and costs.

SECOND CLAIM FOR RELIEF

Violation of Title II of the ADA

(42 U.S.C. § 12131 *et seq.*, 28 C.F.R. § 35.130)

131. Plaintiffs repeat and reallege the allegations contained in all preceding paragraphs as though fully set forth herein.

132. Plaintiffs are qualified individuals with disabilities within the meaning of Title II of the ADA and meet the essential eligibility requirements for the receipt of services, programs, or activities of Defendants. 42 U.S.C. § 12102(2)(b); 42 U.S.C. § 12131(2).

133. DSH is an agency of the State of California and a public entity as defined in 42 U.S.C. § 12131(1). DSH's agents, directors, and officers are therefore subject to Title II of the ADA. 42 U.S.C. § 12131(1); 42 U.S.C. § 12132.

134. Defendants have violated the ADA and its implementing regulations by discriminating against Plaintiffs and the Class on the basis of their disabilities, including by:

a. Failing to reasonably modify their policies and practices to allow Plaintiffs to meaningfully participate in Defendants' programs, including their program for discharging or transferring patients to community-based or other alternative settings where they can more safely receive services, 28 C.F.R. § 35.130(b)(7);

b. Utilizing methods of administration that deprive Plaintiffs of equal access to the benefits of the programs and services that Defendants provide to other individuals, 28 C.F.R. § 35.130(b)(3);

c. Failing to administer services, programs, and activities in "the most integrated setting" appropriate to Plaintiffs' needs, 28 C.F.R. § 35.130(d).

135. These failures have the effect of defeating or substantially undermining participation by Plaintiffs and the Class in Defendants' programs at DSH-Patton. *See* 28 C.F.R. § 35.130(b)(3)(ii).

136. Providing modifications of Defendants' discharge policies and practices would not fundamentally alter Defendants' programs, services, or activities.

137. Plaintiffs and the Class have suffered and will suffer injury as a proximate result of Defendants' violation of their rights under the ADA.

138. Plaintiffs and the Class are entitled to declaratory relief, injunctive relief, attorneys' fees, and costs.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that the Court take jurisdiction and order the following:

1. Enjoin Defendants, their subordinates, agents, employees, and all others acting in concert with them from subjecting Plaintiffs and the Class to the unlawful acts and omissions described herein, and issue an injunction to remedy the violations of the Plaintiffs' and the Class's rights, including ordering Defendants to undertake the following:

   a. Identify all members of the Class by utilizing current CDC guidelines on COVID-19 high-risk factors and provide Plaintiffs' counsel such list, updated at least monthly;

   b. Conduct expedited individualized assessments of all members of the Class to effectuate their safe discharge or transfer from DSH-Patton to a safe, non-congregate setting. In conducting these assessments, Defendants must:

      i. Adequately address each Class member's risk of severe illness or

death from contracting COVID-19 at DSH-Patton;

ii. Consider the full range of alternative treatment options, including discharge or transfer to a community setting, a family member's home, temporary leave, conditional release, permanent or temporary housing accommodations, tele-medicine, and intensive case management services. Under no circumstances should an individual be transferred to another congregate setting with a heightened risk for COVID-19 infection;

iii. Seek input from the Class member, the Class member's treatment team, family members and others who assist them, and other supportive decision makers as determined by the patient; and

iv. Use all powers and procedures available under the law, including under Executive Order N-35-20, to expeditiously transfer or discharge the class members to a safer, non-congregate or less congregate setting;

c. Provide updates, no less frequently than monthly, to the Court about the discharge or transfer of Class members; and

d. Take all necessary precautions pursuant to CDC Guidelines and the Constitution to protect from COVID-19 infection any Class members who are not transferred or discharged, and remain in DSH facilities;

2. Appoint an independent court-appointed monitor(s) or special master(s) to ensure compliance with the Court's order, and provide the monitor(s) with access to units, transfer or discharge discussions, and confidential communication with Class members, to assess and report on (a) the adequacy of Defendants' actions to effectuate safe discharge or transfer of Class members, and (b) the adequacy of conditions, policies, and precautions at DSH-Patton to protect those Class members who remain in detention at

the facility;

3. Retain jurisdiction of this case until Defendants have fully complied with the orders of this Court, and there is reasonable assurance that Defendants will continue to comply in the future absent the Court's continuing jurisdiction;

4. Award Plaintiffs' reasonable attorneys' fees, costs, expenses and disbursements as authorized by law; and

5. Grant further relief as the Court may deem just and proper.

DATED: August 5, 2020

Respectfully submitted,

/s/ Samantha Choe

SAMANTHA CHOE (SBN: 252002)
schoe@cov.com
ADDISON THOMPSON* (SBN:330251)
athompson@cov.com
SYLVIA HUANG* (SBN: 313358)
syhuang@cov.com
ANNIE SHI (SBN: 327381)
ashi@cov.com
Covington & Burling LLP
415 Mission St., Ste. 5400
San Francisco, CA 94105
Telephone: (415) 591-6000

/s/ Anne Hadreas

JENNIFER STARK (SBN: 267062)
Jennifer.Stark@disabilityrightsca.org
AARON FISCHER (SBN: 247391)
Aaron.Fischer@disabilityrightsca.org
ANNE HADREAS (SBN: 253377)
Anne.Hadreas@disabilityrightsca.org
SARAH GREGORY (SBN: 303973)
Sarah.Gregory@disabilityrightsca.org
KIM PEDERSON (SBN: 234785)
Kim.Pederson@disabilityrightsca.org
Disability Rights California
1330 Broadway, Suite 500
Oakland, CA 94612
Telephone: (510) 267-1200
Facsimile: (510) 267-1201

Attorneys for Plaintiff

SAMANTHA CHOE (SBN: 252002)
schoe@cov.com
ADDISON THOMPSON* (SBN: 330251)
athompson@cov.com
SYLVIA HUANG (SBN: 313358)
syhuang@cov.com
ANNIE SHI (SBN: 327381)
Covington & Burling LLP
415 Mission St., Ste. 5400
San Francisco, CA 94105
Telephone: (415) 591-6000

JENNIFER STARK (SBN: 267062)
Jennifer.Stark@disabilityrightsca.org
AARON FISCHER (SBN: 24739
Aaron.Fischer@disabilityrightsca.org
ANNE HADREAS (SBN: 253377)
Anne.Hadreas@disabilityrightsca.org
SARAH GREGORY (SBN: 303973)
Sarah.Gregory@disabilityrightsca.org
KIM PEDERSON (SBN: 234785)
Kim.Pederson@disabilityrightsca.org
Disability Rights California
1330 Broadway, Suite 500
Oakland, CA 94612
Telephone: (510) 267-1200
Facsimile: (510) 267-1201
Attorneys for Plaintiffs

* *C.D. California admission application forthcoming*

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

EASTERN DIVISION

RICHARD HART et al., individually and on behalf of all others similarly situated,

Plaintiffs,

v.

STEPHANIE CLENDENIN, Director of California Department of State Hospitals, in her official capacity et al.,

Defendants.

Case No. 5:20-cv-1559-JGB-SHK

DECLARATION OF ELIZABETH JONES

Date: TBD
Time: TBD
Judge: Hon. Jesus G. Bernal
Courtroom: 7D

Compl. filed: 08/05/2020

I, Elizabeth Jones, declare:

1. I have been retained by Plaintiffs as an expert witness in the above captioned matter.

Relevant Experience

2. I have over 35 years of experience in implementing or monitoring federal and state court orders regarding services for individuals with a mental illness and/or a developmental disability. A copy of my CV is attached here as **Exhibit A.**

3. I have had administrative responsibility for four institutions including three public psychiatric hospitals for individuals who were admitted with forensic or civil commitment status. I was the Receiver of a psychiatric hospital in Maine and I directed hospitals in Massachusetts and the District of Columbia. In each of these settings, I worked closely with clinical staff to design and effectuate individualized plans so that discharges to the community could occur in a timely and responsible manner.

4. Currently, I am the Independent Reviewer for a Settlement Agreement between the United States Department of Justice and the State of Georgia, *United States v. Georgia*, No. 10-249 (ND. Ga.). In part, this Agreement requires the development of community-based services for adults at risk of hospitalization in a state psychiatric facility or in the process of being discharged from one. I have consulted on the implementation of similar agreements in Oregon and North Carolina.

5. From 2004 until 2017, I served as the Court Monitor in *Evans v. Bowser*, No. 76-293 (D.D.C.), a federal class action lawsuit concerning the care and treatment of people with intellectual and developmental disabilities in the District of Columbia. As Court Monitor, I oversaw and reported on implementation of court orders related to the development of community-based, individualized services/supports for former residents of the District-operated Forest Haven

institution (now closed) for children and adults with intellectual and/or developmental disabilities.

6. As an expert consultant, I have had experience in reviewing the status of individuals in public and private institutions in Massachusetts, Texas, New York, Illinois, North Carolina, and Virginia. I have testified about institutional conditions and the development of alternative community-based programs in Massachusetts, Illinois, Utah, and New York.

7. I have previously consulted with California's Protection and Advocacy system for persons with disability regarding services available for persons at risk of institutionalization in Alameda County. My work on the Alameda County matter included touring the psychiatric hospital, a mental health rehabilitation center, Alameda County Jail, and a review of the community-based services available for persons with serious mental illness who have experienced psychiatric institutionalization.

8. I have recently provided expert input in cases involving the threat that COVID-19 poses to individuals in locked psychiatric institutions, including in Washington D.C., Connecticut, and California.

9. In order to complete this Declaration, I reviewed numerous documents including: the Class Action Complaint in this case; the affidavits of named plaintiffs and class members; policies, reports, memoranda, letters, and plans issued by the Department of State Hospitals ("DSH"); the State of California's July 2020 audit of the *Lanterman-Petris-Short Act*; letters from DSH to the Public Guardian of twelve counties regarding the discharge of clinically eligible LPS patients; materials related to DSH's Conditional Release Program, and recent COVID-19-related litigation.

10. Based on the information that I have reviewed and carefully considered, it is my professional opinion that critical action needs to be taken now to discharge high-risk patients from DSH-Patton in light of the COVID-19 outbreak.

Many patients at Patton do not require inpatient care, and there are many options for discharging patients safely from Patton to less restrictive settings. Given the extraordinary risks high-risk patients currently face at DSH-Patton, efforts to utilize and, if necessary, expand community-based options must be taken immediately.

Patton State Hospital is rife for the spread of COVID-19 and extremely dangerous for patients who are high risk.

11. The spread of COVID-19 in large, crowded, congregate settings such as psychiatric hospitals is an extremely serious risk, particularly to older adults and individuals with certain medical conditions.[1] This risk is particularly great at a place like Patton State Hospital, one of the largest psychiatric hospitals in the country.

12. I understand that, based on DSH's own assessments, approximately twenty-five percent of its patient population is over the age of sixty. In addition, individuals diagnosed with mental illness have a twenty percent increased risk of morbidity and mortality than the general population. This estimate is in line with my own experience working with individuals with mental illness.

13. Based on information I have reviewed and my experience, it is my opinion that the conditions at Patton appear rife for the spread of COVID-19. Patton operates approximately 1,527 beds and employs more than 2,400 staff who rotate in

[1] *See, e.g.*, *Scientific Brief: SARS-CoV-2 and Potential Airborne Transmission*, https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html (last updated Oct. 5, 2020); Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, CDC, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last updated Dec. 3, 2020); CDC, *People at Risk for Severe Illness, Older Adults*, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html; CDC, *People at Risk for Severe Illness, People with Medical Conditions*, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html; CDC, Health Equity Considerations and Racial and Ethnic Minority Groups, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.

and out of the facility each day. The setting contradicts the very measures urged as precautions to infection from COVID-19. Social distancing cannot be accomplished within the hospital.[2] Patients also report that staff members' adherence to the wearing of masks is not consistent; there are limited opportunities for disinfecting shared spaces including bathrooms, telephones, and common areas on the unit; and staff float between units regardless of whether the units are under quarantine.[3]

14. I am aware that Patton is currently in the midst of a major COVID outbreak. The number of positive tests and deaths at Patton are currently the highest among all of the state hospitals.

15. I have been informed that some of the named plaintiffs in this lawsuit, including Mr. Longstreet, Mr. Hernandez, and Mr. Waldrop, have recently tested positive for COVID-19. I understand that seventy out of 100 people in their units may have recently tested positive as well.

16. The gravity and urgency of the situation cannot be overstated. I am extremely concerned that Mr. Longstreet, Mr. Hernandez, Mr. Waldrop, and other patients at Patton who are older and/or have certain medical conditions are now facing severe risk of harm or death from COVID-19 at Patton.

Many Patients from Patton Do Not Require Inpatient Care.

17. Based on the materials I have reviewed and my experience, it is my opinion that there are significant numbers of high-risk patients at Patton who do not require an inpatient level of care – in other words, many patients can be safely and effectively placed and served in a less restrictive and less congregate setting.

18. As but one data point, I understand that, as of January 2020, a state audit found that at least 138 individuals being treated at DSH facilities under the

[2] For example, there are up to five people to a bedroom and bathrooms, day rooms, and telephones are shared by up to fifty people at a time. Some spaces, such as dining halls and narrow hallways are shared by up to 100 people at a time.

[3] *See, e.g.*, Declarations of Ervin Longstreet, Aldo Hernandez, Charles Gluck, Graham Waldrop, Albert Aleman, Charles Jackson, and Jose Marin.

Lanterman-Petris-Short Act were ready for discharge, but had not yet been discharged to lower levels of care. As of mid-August, DSH sent letters to the Office of Public Guardian in Los Angeles stating that it had identified at least thirty-five patients who were clinically ready for discharge to the community. DSH sent similar letters on behalf of individuals ready for discharge to the Public Guardian Offices in the Counties of Orange, Alameda, Contra Costa, Modoc, Monterey, Napa, San Francisco, Santa Clara, Shasta, Stanislaus, and Tulare.

19. While it is unclear exactly how many patients DSH considers to be ready for discharge from Patton at this time, it appears from the declarations and documents that I have reviewed that there remain a substantial number of patients who could be discharged to a less restrictive setting that is appropriate to their individual circumstances.

20. While I support the movement of patients out of DSH-Patton, I am concerned that transferring patients to another congregate setting may simply transfer the risk of infection. In my opinion, it would be far safer for high risk patients to be discharged to less-congregate and less restrictive settings.

There Are Many Options for Discharging Patients from DSH-Patton to Less Restrictive Settings.

21. These are not ordinary times and therefore compel different strategies. Among any of the strategies DSH is implementing in response to the COVID-19 pandemic, increased attention must be paid to responsible, expedited discharge, particularly for patients who are high risk for severe illness or death from COVID-19.

22. Releasing high risk individuals from congregate settings in light of serious risk posed by COVID-19 is not unique. Indeed, courts within California have already ordered the release or transfer of individuals from locked, congregate facilities such as jails, prisons, and immigration detention centers. *See, e.g.*, *Roman*

v. Wolf, 977 F.3d 935, 939, 9943 (9th Cir. 2020); *In re Von Staich*, 56 Cal. App. 5th 53 (Cal. Ct. App., Oct. 20, 2020); *Torres v. Milusnic,* --- F.Supp.3d ---, 2020 WL 4197285 (C.D. Cal. July 14, 2020); *Ahlman v. Barnes*, 445 F.Supp. 3d 671 (C.D. Cal. May 26, 2020); *Zepeda-Rivas v. Jennings*, 445 F.Supp. 3d 36 (N.D. Cal., Apr. 29, 2020); *Fraihat v. U.S. Immigr. & Customs Enf't*, 445 F. Supp. 3d 709 (C.D. Cal. Apr. 20, 2020).

23. There are viable options to discharge individuals from Patton to community-based settings—not other congregate settings—in a safe and clinically responsible manner. These options include programs such as Full Service Partnerships / Assertive Community Treatment teams and Supported Housing. Additionally, some individuals have families and other natural supports who are willing and eager to be of help (including in the provision of housing), and these natural supports need to be utilized. If necessary, other possible programs that can facilitate discharge of high-risk patients from DSH-Patton include Assisted Outpatient Treatment and DSH's Conditional Release Program.

24. **Full Service Partnership programs ("FSPs") and Assertive Community Treatment ("ACT") teams** are community-based treatment programs targeted to individuals with serious mental health disabilities who have the highest level of need. Most FSPs use the "ACT model" as the primary mode of service delivery – which includes teams of professionals and peers who deliver a full range of services to clients in their homes or the community. FSP/ACT services may include rehabilitative mental health services, intensive case management, crisis services, substance use disorder treatment, peer support services, and supported employment. These services are available 24 hours per day, 7 days a week, with someone always available to handle emergencies. The ACT and FSP models have proven effective in reducing psychiatric hospitalization and incarceration. For example, an Illinois study found an 85% reduction in inpatient hospital days over

the course of a year for participants in one ACT program.[4] There are also ACT protocols designed specifically for forensic populations (known as Forensic Assertive Community Treatment, or "FACT") that have achieved substantial reductions in returns to custody.[5]

25. **Supported Housing** is often paired with FSPs or similarly intensive services.[6] Supported housing typically includes two components: (1) a rental subsidy for the individual with a mental health disability, and (2) services to support the individual's successful tenancy. The support services can include case management, training in independent living skills, medication management and/or other services. Community-based outpatient treatment that includes supported housing has proven extremely effective at improving outcomes for individuals with serious mental illness.

26. Defendants can also leverage natural supports, such as family members or others who are willing to provide housing or can otherwise assist with a patient receiving mental health care in the community. For example, Plaintiffs Longstreet, Hernandez, Gluck, and Waldrop have stated that they have family members who would be eager to help with their transition into the community. Defendants should do everything possible to use these supports to plan and effectuate swift and

---

[4] Gold Award: Helping Mentally Ill People Break the Cycle of Jail and Homelessness The Thresholds, State, County Collaborative Jail Linkage Project, Chicago, 52 PSYCHIATRIC SERVICES 1380 (2001).

[5] J. Steven Lamberti et al., Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness, 55 PSYCHIATRIC SERVICES 11, 1285-1293, 1289 (2004); Karen J. Cusack et al., Criminal Justice Involvement, Behavioral Health Service Use, and Costs of Forensic Assertive Community Treatment: A Randomized Trial, 46 Community Mental Health J. 356 (2010).

[6] Housing is included in the "full spectrum of services" provided under FSPs, which includes, but is not limited to "rental subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program and transitional and temporary housing." 9 C.C.R. § 3620(a)(1)(B)(iii). California Welfare and Institutions Code section 5892.5 defines "housing assistance" to include rental assistance, operating subsidies, move in costs and utility payments, as well as capital funding to build or rehabilitate housing for homeless or at-risk persons with mental health disabilities.

successful discharge as well as investigate whether other people may have similar familial resources.

27. **Assisted Outpatient Treatment** ("**AOT**") is a civil, legal procedure in which a court can order individuals with serious mental illness to follow a treatment plan in the community. The goal of AOT is to improve access and adherence to behavioral health services and thereby avert relapses, repeated hospitalizations, etc. This program is available for high-risk patients getting released from Patton, if absolutely necessary.

28. **Conditional Release Program ("CONREP")** is a DSH-operated system of community-based services that treat patients whose psychiatric symptoms have been stabilized and are no longer considered to be a danger. As part of CONREP, patients must agree to follow a treatment plan designed by the outpatient supervisor and approved by the committing court. The court-approved treatment plan includes provisions for involuntary outpatient services. Research indicates that patients who participate in CONREP have low rates of reoffending and demonstrate significant improvements in employment, social support, and independence.

29. These options for discharge are in line with DSH's own policies regarding mental health treatment, which make clear that—even without the pressing need created by the pandemic—discharge plans can include release to family, friends, and county mental health facilities, in addition to CONREP.[7]

30. In order to actually effectuate discharge of patients from Patton, however, DSH will need to make a concerted effort to identify and leverage resources to utilize and, if necessary, expand service capacity in the community.

31. Defendants should convene meetings with community stakeholders to

[7] While DSH's discharge policy also allows for discharge to skilled nursing facilities and shelters, given the high risk of COVID-19 spreading in congregate facilities, I do not recommend that any individuals be transferred to these types of facilities or to any jails.

identify potential resources, including sites for temporary housing. Defendants should also take specific actions to incentivize community-based agencies to participate in discharge planning, and to provide technical assistance, identification, and remediation.

32. To the extent that expansion of community-based services is necessary, it is important to note that programs such as ACT, FSP, and FSP Housing Support are more cost-effective than institutionalization as it exists in DSH facilities. For example, the RAND Corporation studied the cost of FSP programs in Los Angeles County between 2012 and 2016. It estimated that the program resulted in savings of between $75 million and $90 million in comparison to the government costs incurred for behavioral health inpatient stays.[8] Even if the targeted population in this matter would require additional housing subsidies, the savings over institutionalization would still be substantial.

33. In order to remove patients from the dangers of the institutional setting and conditions at Patton, the following actions should be taken without delay:

a. Defendants should compile a list of all patients who are over age 50 and/or suffer from an underlying health condition that puts them at high risk of severe illness or death from COVID-19 according to the CDC.

b. Clinicians should conduct an individualized assessment of every high-risk patient to determine whether they are ready for discharge. In conducting these assessments, clinicians should build on existing systems of care and, wherever possible, recommend and help to facilitate release.

c. Defendants should investigate and identify existing placement and service capacity in the community, including public and private service

[8]McBain, Ashwood, Eberhart, Montemayor, & Azhar, *Evaluating Cost Savings Associated with Los Angeles County's Mental Health Full Service Partnerships*, RAND Corp. https://www.rand.org/content/dam/rand/pubs/research_reports/RR2700/RR2783/RAND_RR2783.pdf.

providers as well as private residences that are clinically appropriate for the patient, to provide the reasonable services and supports necessary to facilitate the safe and effective discharge of patients.

d. The Department of State Hospitals, in coordination with other entities, should develop a timely plan to effectuate the safe discharge of high-risk patients as quickly as practicable. As noted above, this plan should include specific actions to incentivize community-based agencies to participate in the planning, to provide technical assistance, identification, remediation.

e. Finally, to the extent necessary, the Department of State Hospitals must finalize the discharge for DSH-Patton patients with Public Guardians.

Conclusion

34. In conclusion, it is my opinion that critical action needs to be taken now to discharge high-risk patients from Patton. Given the extraordinary risks to patients in congregate settings like those at Patton, efforts to utilize and, if necessary, expand community-based options are necessary both to realize the requirements of *Olmstead v. L.C.* 527 U.S. 581 (1999), and to mitigate the elevated and avoidable risks to patients' health and well-being. There is no time to waste.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct to the best of my knowledge, and that this declaration is executed at Silver Spring, Maryland this 12th day of December, 2020.

Elizabeth Jones

SAMANTHA CHOE (SBN: 252002)
schoe@cov.com
ADDISON THOMPSON* (SBN: 330251)
athompson@cov.com
SYLVIA HUANG (SBN: 313358)
syhuang@cov.com
ANNIE SHI (SBN: 327381)
Covington & Burling LLP
415 Mission St., Ste. 5400
San Francisco, CA 94105
Telephone: (415) 591-6000

JENNIFER STARK (SBN: 267062)
Jennifer.Stark@disabilityrightsca.org
AARON FISCHER (SBN: 24739
Aaron.Fischer@disabilityrightsca.org
ANNE HADREAS (SBN: 253377)
Anne.Hadreas@disabilityrightsca.org
SARAH GREGORY (SBN: 303973)
Sarah.Gregory@disabilityrightsca.org
KIM PEDERSON (SBN: 234785)
Kim.Pederson@disabilityrightsca.org
Disability Rights California
1330 Broadway, Suite 500
Oakland, CA 94612
Telephone: (510) 267-1200
Facsimile: (510) 267-1201
Attorneys for Plaintiffs

** C.D. California admission application forthcoming*

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

EASTERN DIVISION

RICHARD HART et al., individually and on behalf of all others similarly situated,

Plaintiffs,

v.

STEPHANIE CLENDENIN, Director of California Department of State Hospitals, in her official capacity et al.,

Defendants.

Case No. 5:20-cv-1559-JGB-SHK

DECLARATION OF HEATHER C. LEUTWYLER, PHD

Date: TBD
Time: TBD
Judge: Hon. Jesus G. Bernal
Courtroom: 7D

Compl. filed: 08/05/2020

I, Heather Leutwyler, declare:

1. I have been retained by Plaintiffs as an expert witness in the above captioned matter.

2. I have worked for over fifteen years caring for and doing research with people who have a serious mental illness ("SMI"). My work has focused primarily on patients with SMI who are transitioning from inpatient psychiatric hospitals or correctional facilities into community-based mental health facilities in California. My curriculum vitae is attached as **Exhibit A**.

3. I have extensive clinical and research experience relating to the components of successful transition from institutional settings to community settings for people with SMI. I have worked in a variety of community-based mental health facilities that accept patients from institutional settings, from locked mental health treatment facilities to lower-level transitional residential and supportive housing programs. Part of my work is to help my clients transition from higher to lower levels of care.

4. I have published studies in peer-reviewed journals, including Aging and Mental Health, the Community Mental Health Journal, Advancing Corrections, and the International Journal of Prisoner Health. I have received numerous grants to conduct research about people living with SMI, including funding from the National Institute on Aging and the Tobacco-Related Disease Research Program.

5. In 2020, I published a study titled *Community Transition from the Criminal Justice System for Older Adults with Schizophrenia—a Pilot Study* in Advancing Corrections Journal, which concluded that older adults with schizophrenia may successfully transition into community settings with medication management, housing, and case management. The study is attached hereto as **Exhibit B**. In 2017, I published a study titled *Case Management Helps Prevent Criminal Justice Recidivism for People with Serious Mental Illness* in the International Journal of Prisoner Health, which concluded that case management is an essential component of successful transition of

people with SMI from locked facilities to community settings. The study is attached hereto as **Exhibit C**.

6. I have expertise relating to the physical health of people with SMI, including infectious disease in congregate living facilities for people with SMI. As a board-certified Nurse Practitioner, I provided on-site nursing care to people with SMI living in a 89-bed mental health treatment facility in California. In that role, I was responsible for disease prevention and the treatment of people with SMI who became sick as viruses spread through the facility each winter.

7. I have provided on-site nursing care to people with SMI living in transitional residential housing for the past 14 years. In that role, I provide clinical expertise in diagnosing and treating health conditions, as well as providing disease prevention and health management tools specific to people living with SMI.

8. My research work also includes determining the factors associated with poor physical health in older adults living with a with SMI and the development and testing of interventions to improve health outcomes. I am currently conducting a pilot program to examine the feasibility and efficacy of interventions for smoking cessation in adults with SMI. I am also the clinical mentor for the University of California, San Francisco ("UCSF") Street Nursing Project funded by the Cigna Foundation and the Rita & Alex Hillman Foundation, which provides outreach and medical referrals for people experiencing homelessness.

9. I am a tenured Associate Professor and Vice-Chair in the Department of Physiological Nursing at the UCSF School of Nursing. I am also Associate Director for the UCSF Hartford Center of Gerontological Nursing Excellence. I hold a PhD in Nursing from UCSF. My doctoral dissertation focused on the poor physical health of older adults with schizophrenia. I also hold a Bachelor of Science in Neuroscience, a program that provided a strong foundation for understanding the neurobiology of mental illness.

Summary of Documents Reviewed

10. In order to complete this declaration, I reviewed the clinical records of 12 Department of State Hospital ("DSH") patients, including the clinical records of all Plaintiffs named in this action. These records included treatment plans written by the patients' psychiatrist and psychologist, progress notes, and assessments and reports from the treatment team. The treatment teams included registered nurses, social workers, rehabilitation therapists, psychologist, and psychiatrists.

11. I also reviewed other documents, including the Complaint filed on August 5, 2020; declarations of five class members; medical literature and policy recommendations relating to COVID-19 and the heightened health risks for people with SMI; and research relating to mental health services and programs in California.

The Congregate Setting of DSH Facilities Puts the Large Number of DSH Residents with High-Risk Factors for Severe Illness or Death from Covid-19 in Enormous Peril

12. Based on my experience working with people with SMI in various treatment settings, my research, and my review of relevant materials for this case, it is my strong opinion that there are hundreds of DSH-Patton patients who are at grave risk of severe illness or death if infected with COVID-19.

13. DSH has estimated that nearly 25% of its patient population is age 60 or older, a factor that puts people at increased risk of severe illness or death if they contract COVID-19. This translates to approximately 375 DSH-Patton patients that are over age 60, based on an estimated patient population of 1,500.[1] The Centers for Disease Control and Prevention ("CDC") estimates that eight out of ten deaths in the United States have

[1] According to the DSH website, DSH-Patton operates approximately 1,527 beds. *Department of State Hospitals – Patton*, DEP'T OF STATE HOSPITALS, https://www.dsh.ca.gov/Patton/index.html (last visited Dec. 9, 2020).

been in adults 65 years old or older.[2]

14. In addition, it is almost certain that hundreds of DSH-Patton patients have medical conditions that put them at high risk of serious illness or death if infected with COVID-19. My experience and extensive research in the field confirm that people with SMI tend to have multiple medical comorbidities secondary to their psychiatric treatment, including many comorbidities that have been identified by the CDC as increasing the risk of severe illness from COVID-19 infection.[3] For example, people with SMI are more likely than the general population to be obese and to have obesity-related medical conditions, such as type 2 diabetes.[4] People with SMI are also at higher risk for coronary heart disease, vascular disease, congestive heart failure, and hypertension.[5]

15. The fatality rate of COVID-19 infection for people with these medical conditions is by some estimates as high as 20%.

---

[2] *People at Increased Risk – Older Adults*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html (last visited Dec. 9, 2020).

[3] *People at Increased Risk – People with Certain Medical Conditions*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (last visited Dec. 9, 2020).

[4] *See, e.g.*, Marc De Hert, et al., *Physical Illness in Patients with Severe Mental Disorders: Prevalence, Impact of Medications and Disparities in Health Care*, 10(1) WORLD PSYCHIATRY 52-77 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048500/; Davy Vancampfort, et al., *Risk of metabolic syndrome and its components in people with schizophrenia and related psychotic disorders, bipolar disorder and major depressive disorder: a systematic review and meta-analysis*, 14(3) WORLD PSYCHIATRY 339-347 (2015), https://pubmed.ncbi.nlm.nih.gov/26407790/.

[5] *See, e.g.*, Christoph U. Correll, et al., *Prevalence, Incidence and Mortality from Cardiovascular Disease in Patients with Pooled and Specific Severe Mental Illness: A Large-Scale Metanalysis of 3,211,768 patients and 113,383,368 Controls* published 16(2) WORLD PSYCHIATRY 163-80 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5428179/; Christoph U. Correll, et al., *Findings of a U.S. National Cardiometabolic Screening Program Among 10,084 Psychiatric Outpatients*, 61(9) PSYCHIATRIC SERVICES 892 (2010), https://pubmed.ncbi.nlm.nih.gov/20810587/.

16. Data also show that people from racial or ethnic minority groups, including people from Black, Indigenous, and Latinx populations, are at increased risk for illness or death due to COVID-19.[6]

17. The individual Plaintiffs in this case have multiple risk factors that put them in danger of dying from COVID-19. These factors are typical of the comorbidities I see in my patients with SMI.

a. **Mr. Longstreet** is an African American man with multiple comorbidities, including hypertension, high cholesterol, and high Body Mass Index.

b. **Mr. Hernandez** is a Latino man with multiple comorbidities, including coronary artery disease, type 2 diabetes mellitus, hypertension, hyperlipidemia, and obesity, with a Body Mass Index of 38.1.

c. **Mr. Waldrop** has multiple comorbidities, including type 2 diabetes and severe obesity, with a Body Mass Index of 57.8, and requires a CPAP machine to treat his sleep apnea.

d. **Mr. Gluck** has multiple comorbidities, including type 2 diabetes, hypertension and obesity, with a Body Mass Index of 32.

18. The American Medical Association, the CDC, and the medical literature recommend the following infection control measures to protect high-risk patients from COVID-19 in congregate settings like DSH-Patton: social distancing; protection of high-risk patients, including through release as necessary; staff cohorting to reduce spread within the facility; consistent use of personal protective equipment; screening and testing; and hygiene and sanitation.

19. Social distancing is one of the most important components of infection

[6] *COVID-19 Hospitalization and Death by Race/Ethnicity*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (last visited Dec. 9, 2020).

control and requires patients and staff to maintain at least six feet between themselves and others at all times.

20. The DSH-Patton patient declarations I reviewed affirmatively demonstrate how social distancing is not possible in bedrooms, bathrooms, and common areas at DSH-Patton. Approximately 50 patients reside in each unit and share one bathroom. Patients have been required to eat in communal dining areas. According to the patient declarations I reviewed, some of the bedrooms are so small that patients are able to touch the adjacent beds while sitting or lying on their own beds. In this type of environment, maintaining adequate physical distance and ensuring high touch areas are frequently cleaned would be incredibly challenging, if not impossible.

21. Due to these crowded living conditions, patients at DSH-Patton are at increased risk of contracting COVID-19 as compared to community mental health facilities and transitional housing programs, which have patient populations that are far smaller than DSH-Patton. In contrast to the units at DSH-Patton that crowd 30, 40, or even 50 patients together, community-based programs typically house between five and twenty patients, often with only one or two patients per room.

22. The Substance Abuse and Mental Health Services Administration ("SAMHSA") is the federal agency charged with leading public health efforts in the area of mental and behavioral health nationwide. It is housed within the U.S. Department of Health and Human Services. Due to the high prevalence of CDC-identified risk factors in the SMI population, SAMHSA has issued guidance recommending that patients with SMI be treated in outpatient community placements to the greatest extent possible during the pandemic, and that inpatient psychiatric treatment be reserved for patients whose conditions are "life threatening."[7] The SAMHSA guidance recognizes that community-

[7] SAMHSA, *Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic* (Revised May 7, 2020), https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf; *see also* SAMHSA, *Covid19: Interim Considerations for State Psychiatric Hospitals* (May 8, 2020),

based programs provide a critical resource for treating patients during the pandemic.

23. Similarly, the American Medical Association ("AMA") has called for "compassionate release" or "medical release" of people living in correctional facilities who have serious medical conditions and/or advanced age, in order to protect them from the heightened risk of COVID-19 infection inside locked facilities.[8]

24. The Mental Health Services Oversight and Accountability Commission ("MHSOAC") is an independent state agency that was created to provide oversight, accountability and leadership to California's mental health system. MHSOAC has found that people with mental health conditions, including those with SMI, are at higher risk of contracting COVID-19 if they live in confined psychiatric facilities. In addition, MHSOAC recognizes that people with SMI face a higher risk of illness or death if the virus is contracted, due to medical comorbidities and a high susceptibility to stress caused by the pandemic, including from quarantine and isolation. MHSOAC recommends that people with mental health needs, including those with SMI, can and should be safely and effectively treated in a community setting to the greatest extent possible.[9]

25. The Judge David L. Bazelon Center for Mental Health Law ("Bazelon Center"), a nationally recognized mental health advocacy organization, has called on states, localities, and hospitals to take "aggressive action to reduce the number of people confined in psychiatric hospitals" during the pandemic.[10] To facilitate a decrease in the

---

https://www.samhsa.gov/sites/default/files/covid19-interim-considerations-for-state-psychiatric-hospitals.pdf.

[8] American Medical Association, *AMA policy calls for more COVID-19 prevention for congregate settings* (Nov, 17, 2020), https://www.ama-assn.org/press-center/press-releases/ama-policy-calls-more-covid-19-prevention-congregate-settings.

[9] Mental Health Services Oversight and Accountability Commission, *Together We Can: Reducing Criminal Justice Involvement for People with Mental Illness* 26 (2017), https://mhsoac.ca.gov/sites/default/files/2020-07/ADA%20REPORT_MHSOAC_Crim_Just_MH_Report_Remediated0720.pdf.

[10] Judge David L. Bazelon Center for Mental Health Law, *During the Pandemic, States and Localities Must Decrease the Number of Individuals In Psychiatric Hospitals, By Reducing Admissions and Accelerating Discharges* (Apr. 4, 2020), http://www.bazelon.org/wp-content/uploads/2020/04/4-15-20-BC-psych-hospitals-

psychiatric inpatient population, the Bazelon Center has called for "accelerat[ion]" of discharges, increased "support of community providers of outpatient mental health treatment," and increased "access to housing" to "meet the needs of people with [SMI]."[11]

There are a Range of Step-Down and Community Placements that Can Safely and Effectively Serve DSH Residents with COVID-19 Risk Factors.

26. There are a range of step-down and community placements within California's community mental health system that can safely and effectively serve many DSH residents, including many who are at elevated risk very severe COVID-19 illness. Through effective individualized assessments, a discharge/treatment planning team can identify appropriate housing and services that are tailored to individual patient needs for many DSH-Patton residents. Given the extraordinary health risk to DSH-Patton patients under current conditions, these assessments are critically necessary to facilitate implementation of SAMHSA, AMA, and MHSOAC guidance to move high-risk patients out of DSH-Patton congregate settings.

27. There are four major components of successful transition from inpatient care to step-down or community-based mental health treatment, which in my opinion can be applied to safely move DSH-Patton residents into settings with reduced COVID-19 infection risk: (1) development of a Wellness Recovery Action Plan® ("WRAP"); (2) appropriate transitional housing with support services tailored to the individual's needs; (3) Assertive Community Treatment ("ACT"); and (4) access to appropriate healthcare and mental health services in the community.

a. **Wellness Recovery Action Plan (WRAP)**. The WRAP is an evidence-based, peer-led, behavioral health self-management intervention used to

---

statement-FINAL.pdf.

[11] *Id.*

prepare patients for transition to a community placement.[12] Development of the WRAP provides patients with individualized wellness tools and teaches capacity building, disease management, and crisis aversion strategies that they can employ once in the community. Studies have shown that consumers of WRAP are better able to take responsibility for their own wellness and have significantly increased rates of success living in community settings.[13]

b. Development of a WRAP is standard practice for people preparing to discharge from DSH. WRAPs are developed by the patient in close coordination with DSH staff, including the patient's psychiatrist and social workers. Familiarity with the WRAP is one of the primary ways that DSH evaluates a patient's readiness for community placement.

c. During the pandemic, WRAPs should be updated to consider the physical and mental health risks of being confined at DSH-Patton, and should include affirmative and achievable steps that facilitate an individual's step-down to a community placement.

d. **Appropriate Transitional Housing with Support Services.** Transitional housing is an evidenced-based model for promoting social rehabilitation, integration, and self-care. Many programs provide multidisciplinary treatment teams on-site. Staff have access to patients' WRAPs and help them to implement the plan in the community.

e. Studies have shown that transitional housing with appropriate

---

[12] Judith A. Cook, et al., *Results of a randomized controlled trial of mental illness self-management using wellness recovery action planning*, 38(4) SCHIZOPHRENIA BULLETIN 881 (2012), https://academic.oup.com/schizophreniabulletin/article/38/4/881/1868636.

[13] Judith A. Cook, et al., *Developing the evidence base for peer-led services: Changes among participants following Wellness Recovery Action Planning (WRAP) education in two statewide initiatives*, 34(2) PSYCHIATRIC REHABILITATION JOURNAL 113 (2010), https://doi.apa.org/doiLanding?doi=10.2975%2F34.2.2010.113.120.

supportive services can greatly reduce rates of hospitalization, incarceration and use of crisis services. One program reduced incarceration by 50%, shelter use by 88%, hospitalization episodes by 71%, and crisis response episodes by 71%.[14]

f. Due to the influx of funding from Mental Health Services Act ("MHSA") and related programs, California offers a variety of programs along a continuum of services that can safely and effectively serve many DSH residents. These programs are provided in a range of settings depending on a patient's needs and circumstances, from highly restrictive locked settings with on-site services to programs with lower-levels of restrictiveness and intensity of care. This range of placements provides a menu of options to help each patient succeed.

g. For example, I previously served as a Nurse Practitioner at Canyon Manor Mental Health Rehabilitation Center, a highly restrictive mental health residential treatment facility with intensive on-site care. Canyon Manor operates 89 beds over two acres of property, with one to two patients per room and outdoor space for eating and relaxing. I currently work with various transitional residential programs through the Progress Foundation, which typically operate five to fifteen beds per facility. These settings provide safe, structured, social rehabilitation residences that are staffed by highly trained counselors 24-hours a day, with daily contact by Nurse Practitioners and other providers as needed.

h. DSH discharge plans and WRAPs should include consideration of these transitional settings to meet individualized needs while safeguarding high-risk patients during the pandemic. To facilitate successful transition, transitional programs should be provided in conjunction with mental health and support services, including ACT and ongoing mental health appointments, as discussed below.

[14] Bazelon Center for Mental Health Law, *A Way Forward: Diverting People with Mental Illness* 4-5 (2014), http://www.bazelon.org/wp-content/uploads/2017/11/A-Way-Forward_July-2014.pdf.

i. **Assertive Community Treatment (ACT)**. ACT is an evidence-based treatment model that involves a multidisciplinary team providing individualized assessment and comprehensive support services. ACT is designed for individuals transitioning from an institutional to community setting and has been shown to reduce inpatient hospitalizations and to decrease recidivism.[15]

j. Case managers are an essential part of the ACT team and play a critical role in coordinating mental health services, healthcare, housing, transportation, employment, social relationships, and community participation. Case managers help patients with activities of daily living, access to technology and support services, attending support groups, and navigating appointments.

k. Case management also plays a key role in identifying inadequately treated mental illness and preventing recidivism. Case managers are often the first to notice when a patient starts to experience increased symptoms or reduced function, and can intervene early to help with symptom management, access appropriate services, and prevent hospitalization.

l. **Access to healthcare and mental health services in the community.** DSH must ensure that a patient's physical and mental health issues are being managed. Pre-discharge assessments must ensure a patient's symptoms are relieved and that they have access to medications. In addition, DSH social workers can help patients work on community integration prior to re-entry, including help applying for government benefits.

m. Once in the community, patients must have continued access to healthcare and mental health services. Providers must frequently re-assess the patient's physical and mental health, including symptom and medication

[15] Thomas Marquant, et al., *Forensic Assertive Community Treatment: A Review of the Literature*, 52(8) COMMUNITY MENTAL HEALTH J. 873 (2016), https://link.springer.com/article/10.1007%2Fs10597-016-0044-0.

management. These services may be provided either on-site at the transitional housing placement or at outpatient visits. ACT or transitional housing support staff must ensure that patients attend appointments and take medications.

A Significant Number of DSH Residents Can Be Safely and Effectively Discharged to an Alternative Placement with Appropriate Supportive Services

28. Based on my experience working with SMI patients and my review of DSH-Patton patient records, many DSH patients can safely and effectively transition to less restrictive settings with appropriate support services.

29. DSH patients' discharge and treatment plans reveal that while safe and effective discharge is feasible for many patients, not enough has been done to actualize discharge goals and prioritize high-risk patients during the pandemic. Discharge planning continues to rigidly apply pre-pandemic criteria without considering the physical and mental health risks of continued confinement at DSH-Patton. Even high-risk patients that are documented as having a viable WRAP and a plan for step-down community treatment face life-threatening delays in discharge.

a. **Ervin Longstreet.** DSH identified Mr. Longstreet as appropriate for discharge in July 2020. However, he continues to be confined at DSH-Patton and has faced multiple delays to discharge that have put him at an unreasonable and extreme risk of illness from COVID-19. I am informed that he tested positive for COVID-19 on or about December 7, 2020.

b. DSH initially recommended Mr. Longstreet for transfer to Sylmar Health & Rehabilitation Center ("Sylmar"), a smaller step-down mental health treatment facility, in July 2020. Sylmar declined to admit Mr. Longstreet on July 15, 2020. On September 28, 2020, DSH again recommended Mr. Longstreet for transfer to Sylmar. Although it's been over five months since DSH recommended him for discharge, he still has not been transferred out of the facility.

c. There is no clinical justification for these delays, and there is no

indication that DSH attempted to place Mr. Longstreet at an alternative facility that could meet his needs. Mr. Longstreet has multiple comorbidities that put him at significant risk if he is exposed to COVID-19, but his DSH records do not appear to contain any meaningful consideration of those risks or the need to transfer him to a less-congregate setting to protect him from the spread of COVID-19 inside DSH-Patton.

d. With appropriate supports, Mr. Longstreet can be safely and effectively treated in a structured transitional setting. DSH has determined that "Mr. Longstreet's risk for future violence is rated Low at this time." According to his records, Mr. Longstreet has a WRAP in place that he can discuss "from memory" and has been "observed translating this plan into action within the hospital." He understands his symptoms, triggers, and self-management goals. He understands his medication regime and has completed group programming, although I understand that group programming is no longer available due to COVID-19 restrictions.

e. Although he fears for his life, Mr. Longstreet has coped well with the stressors presented by the pandemic, managing stress by "reading, listening to music, and meditating." Records from July, August, and September 2020 state that Mr. Longstreet is in "stable condition," has "no worsening or exacerbations in mental health problems," is "compliant with his medications" with no side effects reported, and presents "no behavioral issues."

f. I have seen patients like Mr. Longstreet do well in structured transitional community placements with appropriate support services and ACT. Transitional housing and ACT/case management staff can help Mr. Longstreet implement his WRAP in the community, support medication and symptom management, navigate appointments, and ensure access to therapy and healthcare. Mr. Longstreet has stated that he wants to find a sponsor and attend Alcoholics

Anonymous meetings after he leaves DSH.

g. Mr. Longstreet's success will be aided by family support and employment goals. He has maintained connection with family members who have expressed their willingness to assist him, including by providing housing and support. His records from September 2020 state that he was planning to send a cake, flowers, and a card to his daughter for her birthday and wants to "be a part of his children and grandchildren's lives." He also holds a job within DSH-Patton and seeks to find employment in the community, which will assist in community integration.

h. **Aldo Hernandez.** DSH evaluated Mr. Hernandez for discharge through the Conditional Release Program (CONREP) on March 31, 2020. That evaluation indicates he has met major treatment goals for discharge. However, he continues to be confined at DSH-Patton and is at an unreasonable and extreme risk of illness if he is infected with COVID-19.

i. With appropriate supports, Mr. Hernandez can be safely and effectively transitioned to a structured living environment that presents a lower risk of COVID-19 infection.

j. According to his records, Mr. Hernandez has a WRAP in place and is documented as being able to speak about it from memory. He understands his symptoms, triggers, and self-management goals. He understands and is adhering to his medication regime and states that he is committed to maintaining sobriety. Prior to the COVID-19 pandemic, Mr. Hernandez was actively participating in group programming, although I understand that group programming is no longer available due to COVID-19 restrictions. He states that he will accept supervision and support by the San Bernardino County CONREP team to assist with community integration.

k. Mr. Hernandez has multiple comorbidities that put him at significant

risk if he is exposed to COVID-19, but his DSH records do not appear to contain any meaningful consideration of those risks or the need to transfer him to a less-congregate setting to protect him from the spread of COVID-19 inside DSH-Patton.

l. I have seen patients like Mr. Hernandez do well in structured transitional community placements with intensive support services, regular visits by Nurse Practitioners, and ACT. Transitional housing and ACT/case management staff can help Mr. Hernandez implement his WRAP in the community, support medication and symptom management, navigate appointments, and ensure access to therapy and healthcare. Mr. Hernandez would benefit from a program that can help him build skills related to activities of daily living and support his goals of losing weight and maintaining his physical health.

m. Mr. Hernandez's success will be aided by family support and his employment goals. Mr. Hernandez's clinical records indicate that he has maintained relationships with a network of family members who live in Southern California and appear to be very supportive of him. He has also held employment in housekeeping and IT roles at DSH-Patton. He states that he wants to earn his GED and would like to volunteer or work in food service. The prospect of employment for Mr. Hernandez, even if an un-paid role, will aid with community integration.

n. **Richard Hart.** DSH identified Mr. Hart as a candidate for discharge in February 2020. However, he continued to be confined at DSH-Patton until September 2020, when he was discharged to a community placement. This seven-month delay in his discharge put him at an unreasonable and extreme risk of infection and illness from COVID-19. There is no clinical explanation for this delay. DSH evaluators had identified him as having a "low" risk of violence, he understood his WRAP, attended group programming, and had coping and self-

management skills. I have seen patients like Mr. Hart succeed in transitional residential programs with appropriate support services.

o. Mr. Hart has multiple comorbidities that put him at significant risk if he is exposed to COVID-19, including recent lung cancer and Chronic Obstructive Pulmonary Disease, but his DSH records do not appear to contain any meaningful consideration of those risks or the need to transfer him to a less-congregate setting to protect him from the spread of COVID-19 inside DSH-Patton. His discharge in September 2020 was long overdue.

p. **Albert Aleman.** Mr. Aleman's records indicate he has met major treatment goals for discharge. He has a WRAP, understands his symptoms, triggers, and self-management goals. He adheres to his medication regime, is actively engaged in treatment, and has an employment history at DSH-Patton. Due to multiple COVID-19 risk factors, Mr. Aleman's continued confinement at DSH-Patton puts him at an unreasonable and extreme risk of illness if he is infected with COVID-19. With appropriate supports, Mr. Aleman can be safely and effectively transitioned to a structured living environment with that presents a lower risk of COVID-19 infection.

q. **James Moore.** Mr. Moore's records indicate he has met major treatment goals for discharge. He has a WRAP, understands his symptoms, triggers, and self-management goals. He adheres to his medication regime, is actively engaged in treatment, and has insight into his mental illness. As a trained magician, he performs for other patients and staff and wants to pursue employment in that field after discharge. Due to multiple COVID-19 risk factors, Mr. Moore's continued confinement at DSH-Patton puts him at an unreasonable and extreme risk of illness if he is infected with COVID-19. With appropriate supports, Mr. Moore can be safely and effectively transitioned to a structured living environment that presents a lower risk of COVID-19 infection.

Deficiencies in DSH's Processes Prevent Eligible Patients from Timely Transitioning to Safe and Effective Community Placements

30. Based on my review of DSH-Patton patient records, several deficiencies in DSH's processes appear to prevent eligible patients from timely transitioning to safe and effective community placements.

31. **Failure to consider COVID-19 risk and to seek out new alternative placements.**

a. A major barrier to discharge or transfer of patients at high risk for complications due to COVID-19 is DSH's use of the same factors for discharge or transfer that were used prior to the pandemic. Although many patients suffer from multiple comorbidities that make them extremely vulnerable if infected with COVID-19, none of the discharge assessments I reviewed considered that fact in determining when and how they could be transitioned out of DSH-Patton.

b. In addition, DSH failed to accelerate or modify the discharge process for high-risk patients even after DSH identified them as ready for discharge, including Mr. Longstreet and Mr. Hart.

c. Given the risk of severe illness or death posed by COVID-19, DSH assessments must be adjusted to account for patients' health risks, including through acceleration of discharge planning for patients who may be safely and effectively treated in transitional programs. DSH must take immediate action to align with SAMHSA, AMA, and MHSOAC guidance calling for the transfer of high-risk patients out of congregate living facilities on an expedited basis.

d. With this finding, I do not suggest that DSH can or should ignore any legal requirements for the discharge of patients held pursuant to a civil or forensic commitment. What I do suggest, strongly, is that DSH's "business-as-usual" processes are deficient insofar as they fail to ensure timely discharge of patients who do meet clinical and legal requirements for discharge, including through

meaningful and current review of each patient's condition and placement/service options that will meet their needs.

32. **Undue and disproportionate emphasis on the committing offense or failed placement.**

a. In DSH's review system, a person's committing offense may pose a barrier to discharge consideration, even if the offense occurred many years ago while the patient did not have access to mental health treatment and medication, and even if the patient is currently meeting DSH treatment goals.

b. In contrast, transitional programs assess the current risks associated with living in a community placement. Any current risks can often be addressed through transfer to a transitional program tailored to the individual's needs, with an appropriate level of restrictiveness, care, and support services.

33. **Treatment and programming not offered at DSH-Patton.**

a. The pandemic's adverse impact on treatment programming at DSH-Patton has created a terrible Catch-22 for patients. DSH-Patton patients are supposed to work towards and achieve certain treatment goals – including completing particular programming offerings – in order to be deemed discharge-ready. But they cannot make progress towards treatment goals because many of these DSH programs have been cancelled or restricted during the pandemic. DSH discharge assessments should account for the fact that these patients are prevented from progressing towards discharge through no fault of their own, and how treatment programming can be appropriately provided in alternative settings that do not pose the same extreme risks of COVID-19 infection as exist in DSH-Patton.

b. Similarly, all visitation of family and friends at DSH-Patton has been suspended indefinitely. Not only does this have negative mental health implications for DSH-Patton patients, it also puts a strain on family support networks that may be integral to discharge planning and readiness, making

successful transition to the community more difficult.

c. Additionally, the records I reviewed do not contain meaningful consideration of the mental health implications relating to continued confinement at DSH-Patton during the pandemic. As MHSOAC recognizes, quarantine and isolation in psychiatric hospitals, as well as the stress associated with the pandemic, can lead to and/or exacerbate mental health conditions. It is clear from the materials I have reviewed that DSH-Patton patients are experiencing enormous stress based on their being held in DSH-Patton's crowded units where COVID-19 is rampant, without any way to protect themselves and without DSH's taking adequate steps to get them to a safer place.

Provision of Safe and Effective Alternative Placements for High-Risk DSH Patients is Achievable

34. The goal of providing safe and effective alternative placements to high-risk DSH patients is achievable. I have treated numerous people with SMI in community settings, including people who were previously incarcerated or living in locked psychiatric facilities. I have also treated numerous people with SMI in community settings who have significant support needs, including needs related to social functioning and physical and mental health. These patients can do well and succeed in community placements with adequate and appropriate support services.

35. The four components of successful transition from institutions to community treatment—WRAP, transitional housing, ACT, and access to appropriate healthcare—are evidenced-based treatment models that are proven to have positive outcomes for patients and to reduce recidivism and re-hospitalization.

36. These treatment models already exist in programs across the state, and have been providing safe and effective treatment to Californians with SMI for years. In 2004, California voters passed Proposition 63, enacted as the Mental Health Services Act (MHSA), which has generated approximately $15 billion for mental health services in

California and has funded community mental health and ACT programs across the state.[16] More recently, millions of dollars in state and federal funding has become available for community services and transitional housing programs during the pandemic.[17]

37. These proven treatment tools can and should be replicated for DSH-Patton patients, either with monies already available to the system or through additional resources. Now is the critical moment to extend these programs to DSH patients, who face unacceptable health risks if they remain in congregate facilities like DSH-Patton.

38. Provision of these programs to DSH patients aligns with guidance from the AMA, SAMHSA, MHSOAC, and the Bazelon Center, which calls on public agencies to expeditiously transfer high-risk individuals out of congregate living facilities and to provide treatment in community programs to the greatest extent possible. The AMA, SAMHSA, MHSOAC, and the Bazelon Center have concluded that community-based treatment is not only viable, it is necessary to protect patients from the physical and mental health risks posed by COVID-19 in congregate facilities.

39. Despite clear guidance from medical and mental health authorities, DSH has failed to take adequate steps to achieve the transfer or discharge of high-risk patients like Mr. Longstreet, Mr. Hernandez, Mr. Hart, Mr. Aleman, and Mr. Moore, who can be effectively served in less congregate, less risky settings.

40. The problem of DSH involuntarily confining people who are ready for discharge predates the pandemic. A report by the Auditor of the State of California

[16] Mental Health Services Oversight and Accountability Commission, *Prop 63/MHSA: The Act*, http://mhsoac.ca.gov/about-us/prop63mhsa/act (last visited Dec. 9, 2020).

[17] *See, e.g.*, Office of Gov. Gavin Newsom, *Governor Newsom Announces Emergency Allocation of $62 Million to Local Governments to Protect People Living in Project Roomkey Hotels* (Nov. 16, 2020), https://www.gov.ca.gov/2020/11/16/governor-newsom-announces-emergency-allocation-of-62-million-to-local-governments-to-protect-people-living-in-project-roomkey-hotels/; Judge David L. Bazelon Center for Mental Health Law, *During the Pandemic, States and Localities Must Decrease the Number of Individuals In Psychiatric Hospitals, By Reducing Admissions and Accelerating Discharges* 2 (Apr. 4, 2020), http://www.bazelon.org/wp-content/uploads/2020/04/4-15-20-BC-psych-hospitals-statement-FINAL.pdf..

identified at least 138 DSH-confined patients who DSH had found appropriate for discharge but had not yet been discharged to lower levels of care.[18] In August 2020, DSH sent letters to California counties to discuss patients who were "prepared to stepdown into placement in the community" but had seen no progress towards discharge. The risks related to mass COVID-19 transmission in DSH demand that all possible steps be taken to get these patients out of harm's way. Notably, DSH's August 2020 letters were apparently limited to patients civilly committed under the Lanterman-Petris-Short Act. It is apparent from my review that there are a sizeable number of forensically committed high-risk patients at DSH-Patton whose discharge is likewise overdue.

41. DSH can safely effectuate discharges even in the midst of the pandemic. To the extent quarantining is deemed necessary to prevent transmission from inside the facility, DSH can utilize COVID-19 quarantine spaces currently in operation or placement in hotels or college dormitories, as other agencies across the state have done through Project Roomkey and similar programs.[19] Any need to quarantine does not and should not prevent eligible patients from discharging to a community placement.

42. The community system has adapted to meet the challenges posed by the pandemic. Therapy and group programming is being offered through expansion of Telehealth services, which employ various technologies and modalities to provide patient care safely during the pandemic.[20] One-on-one therapy and group sessions are being offered outside or online as appropriate. Case managers and transitional housing staff are providing support and encouragement to enable patients to access technologies.

[18] Auditor of the State of California, *Lanterman-Petris-Short Act* (July 2020), *available at* https://www.auditor.ca.gov/pdfs/reports/2019-119.pdf.

[19] Project Roomkey/Housing and Homelessness COVID Response, CAL. DEP'T OF SOC. SERV., https://www.cdss.ca.gov/inforesources/cdss-programs/housing-programs/project-roomkey (last visited Dec. 9, 2020).

[20] Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html (last visited Dec. 9, 2020).

43. In conclusion, the need to transfer medically high-risk patients out of institutional settings has never been more urgent. Large numbers of DSH-Patton patients are at risk of severe illness or death if infected with COVID-19. These patients face unacceptable risk of infection due to the crowded living conditions at DSH-Patton and the outbreaks of COVID-19 in the facility. Although many discharge plans require approval from state court, there are concrete steps that DSH can take right now to effectuate discharge or transfer of high-risk patients. Through effective individualized assessments, DSH can identify appropriate supports that are tailored to patients' needs. These supports, which include WRAP, transitional housing, ACT, and appropriate healthcare, will permit many DSH-Patton patients to be safely and effectively treated in step-down community placements. Now is the critical moment to provide these programs to high-risk patients at DSH-Patton. Failure to meet this urgent need will have dire implications for the health of DSH-Patton patients, DSH staff, and the healthcare capacity of surrounding communities.

I declare under penalty of perjury that the foregoing is true and correct. Executed at Pacifica, California, on December 10, 2020.

Heather Leutwyler

Heather C. Leutwyler, PhD