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UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

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

Defendants.

Case No. 2:10-cv-1119

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

Date: TBD
Time: TBD
Place: Courtroom 6, 14th Floor
Judge: Hon. John A. Mendez

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I. INTRODUCTION

Plaintiffs, five adult Medi-Cal recipients with severe and persistent mental illness, urgently seek an Order of this Court to prevent Sacramento County ("County") and other Defendants from terminating Plaintiffs' outpatient mental health services after July 31, 2010. Unless Defendants' acts are enjoined, they will cause catastrophic harm to Plaintiffs and thousands of Sacramento County's most vulnerable citizens who comprise the proposed class in this case (the "Proposed Class") – harm including deterioration in their mental and physical condition, institutionalization in locked facilities, and increased risk of injury, even death.

Since the mid-1990s, the County has provided outpatient mental health services to Medi-Cal recipients through regional centers run by nonprofit service providers. These centers provide medication, psychosocial therapy, group counseling, peer support and self-help, and other services based on individualized treatment plans created with input from the patients. The centers' experienced staff know their clients well and, over time, have gained their trust.

Although these regional centers have been extremely successful in helping Plaintiffs and others with psychiatric disabilities remain in their homes and in the community, the County now intends to begin transferring these thousands of fragile individuals to new County-run clinics, staffed by County employees, starting on July 1, 2010 – barely three weeks from now. Yet, as of this date, the County has provided virtually no details concerning what services will be provided at these new clinics; how and by whom these services will be delivered; or whether County workers are qualified or adequately trained to deliver them. The County nonetheless plans to de-fund the existing centers over the course of two months, starting on August 1, 2010.

While the County will undoubtedly claim that it intends to provide the same level of care, there is simply no way for the County to do so. It is undisputed that the County is both cutting the budget for these outpatient mental health services and replacing independent contractors with County workers who are more costly. Moreover, the County has not even formulated any plans for critical steps such as transferring patient records and working with individual patients on a successful transition of their services.

As will be discussed below, Plaintiffs are likely to prevail on their claims that the threatened service terminations violate the Americans with Disabilities Act, the Rehabilitation Act of 1973, provisions of the California Government Code, the Medicaid Act, and the Due Process Clauses of the United States and California Constitutions. In addition, the California Department of Mental Health has warned the County that the County's interpretations of applicable law are incorrect, and that the State will not approve the County's current plans.

Plaintiffs, through their counsel, have sought to engage County officials to avoid the necessity of bringing this motion, but have not been provided with anything close to sufficient information to suggest that medically necessary mental health services will be continued as required by law. Hence, the Court's intervention is necessary to preserve the status quo and to prevent the predictable, avoidable and catastrophic consequences of the County's threatened actions.

II. STATEMENT OF FACTS

A. Sacramento's Mental Health System

Under federal and state law, California counties may elect to be the only provider of mental health services for low-income Medi-Cal recipients residing in the county. *See* Welf. & Inst. Code § 5775(c); Cal. Code Regs. tit. 9, § 1810.305. Defendants County and its Department of Behavioral Health Services ("DBHS") have assumed this responsibility for County residents.

"Serious mental illness is chronic, relapsing illness, which without appropriate community services will result in frequent re-hospitalizations and mortality." Franczak Decl., ¶ 14. The County's Mental Health Plan ("MHP") serves approximately 20,000 Medi-Cal recipients with mental illness; of these, approximately half are adults over the age of 18. Ex. A at 48 (2009 APS Rpt.).[1] These Medi-Cal clients must utilize County-designated facilities for their treatment, and may not choose their own providers. In exchange, the County is required to provide them with medically necessary mental health services (Welf. & Inst. Code § 5777(a)(1); Cal. Code Regs. tit.

[1] Unless otherwise stated, all exhibits are attached to the Declaration of Margaret Branick-Abilla filed in support of this Motion for Preliminary Injunction. All other cited declarations ("Decl.") are also filed concurrently with this Motion.

9, § 1810.345(a)), for which it receives reimbursement from the federal and state governments. The County Mental Health Plan's total budget for fiscal year 2009-2010 is approximately $186 million. Ex. A at 5 (2009 APS Rpt.).

According to the state's quality review team, "the core mental health specialty services" available to Medi-Cal recipients in the County are provided by four Regional Support Teams ("RSTs"). *Id.* at 6. The RSTs, the centerpiece of the outpatient mental health system, were established beginning in 1993 following an intensive review and evaluation of County mental health services by a County-sponsored Redesign Committee comprised of mental health providers, clients, and family members. Stoneking Decl., ¶ 15. As a result of its research and analysis, the Redesign Committee determined that services should be made available to medically indigent clients through regional mental health centers located in their communities. *Id.*, ¶¶ 16-19. Accordingly, the RSTs were put in place to offer community-based "comprehensive mental health and medication services" (Ex. B at 13-14 (Service Directory, attached to "Access to Services" policy)), including individual and group therapy, psychiatry services and medication management, case management to help clients access other services such as housing, and self help, peer counseling and peer support. *See* Stoneking Decl. ¶¶ 16-19; Bates Decl., ¶¶ 5-6; Place Decl., ¶¶ 10-13. The RSTs use a "recovery model" approach, which involves the patient in developing an integrated plan designed to help her achieve her stated goals. Stoneking Decl., ¶ 17.

The RSTs are operated by private, non-profit organizations under contract with the County, and together serve approximately 3,600 clients per year. Ex. A at 3 (2009 APS Rpt.) The four RSTs are: Northgate Point in the northern part of the County; Human Resource Consultants ("HRC") in the eastern part of the County; Visions Unlimited in the southern part of the County; and El Hogar in downtown Sacramento. The staff of the RSTs are culturally and linguistically representative of their communities, which ensures that they are fluent in the clients' native languages and aware of cultural considerations affecting recovery. Stoneking Decl., ¶ 23; *see also* Bates Decl., ¶¶ 7-8 (Visions Unlimited staff speak Spanish, Hmong, Mien, Hindi, Tagalog, Farsi and Arabic); Buck Decl., ¶ 13 (Northgate serves clients who speak Russian,

Hmong, Spanish and Laotian); Saetane Decl., ¶ 3 (Mien-speaking provider explains that mental illness is considered shameful among the Mien, who have developed unique terminology for describing symptoms); Ortiz Decl., ¶¶ 9-10 (Spanish-speaking provider recognizes that Latino clients and their families fear stigma and embarrassment from mental illness, and will not discuss such sensitive, personal issues through an interpreter). The RSTs also provide transportation services, assistance with maintaining housing, in-home visits, and hospital visits. Napper Decl., ¶ 11; T. Johnson Decl., ¶¶ 1, 5, 9; Kirby Decl., ¶¶ 11,12; Buck Decl., ¶ 12.

The stories of the individual Plaintiffs exemplify the remarkable successes achieved under the recovery model administered by the RSTs. Plaintiff Leslie Napper, for example, has been diagnosed as having bipolar and schizoaffective disorders and has been a patient of the Northgate RST for the last eight years. Napper Decl., ¶¶ 2-3. "Before I started going to Northgate, I used to think a lot about killing myself because I was so depressed and discouraged." *Id.* She "bounced back and forth between different mental hospitals and mental facilities," including approximately five hospitalizations at the County Mental Health Treatment Center ("MHTC") and three or four stays at crisis residential facilities. *Id.*, ¶ 6. Becoming a client at Northgate "made the difference" for her, as the staff and programs gave her a "sense of responsibility" for her life. *Id.*, ¶ 7. She has not been in an institution for three or four years. *Id.*

Another Plaintiff, Ted Yannello, "was so depressed that [he] sat in a closet by [himself] for hours" after graduating from college in 1992. Yannello Decl., ¶ 4. Mr. Yannello was hospitalized on many occasions, including at least eight times at the MHTC. *Id.* He began participating in the El Hogar RST approximately ten years ago and reports that the "program has been a miracle for me." *Id.*, ¶ 3. He now has a daily routine of doing some yard work, reading the Bible and cooking his own dinner, and is "much more functional and productive." *Id.*, ¶ 6. Mr. Yanello is even able to hold down a part time job. *Id.*, ¶ 8. "Taking my medications, counseling and prayer all go hand in hand to help me keep a positive state of mind." *Id.,* ¶ 6. Other clients of the RSTs attest to similar experiences. *See, e.g.,* Fischer Decl., ¶ 4 ("[S]ince I have been with Northgate, my hospitalizations are fewer. Before Northgate, I would be in and

out of facilities."); Conners Decl., ¶ 9 (Human Resource Consultants RST "has always been a haven, a sanctuary, for me.").

In addition to the RSTs, the County refers mental health clients to two other non-profit programs under contract with DBHS. The first program is the Consumer Self-Help Wellness and Recovery Center ("CSH"), which has two sites (North and South), and serves 2,600 adults annually. Ex. C (Wellness and Recovery Center Statistics, Fiscal Year 2009-2010). The second program is called Transitional Community Opportunities for Recovery and Engagement ("TCORE"), which serves clients who are being discharged from acute treatment settings or at risk of entering acute care settings and are not linked to ongoing services, such as the RSTs. Cline Decl., ¶ 7. TCORE currently serves nearly 640 people. Risley Decl., ¶ 6.

Plaintiff Jacquie Eichhorn-Smith is a current client of TCORE, having been diagnosed as bipolar with borderline personality and post traumatic stress disorders. Eichhorn-Smith Decl., ¶¶ 1-2. From 2006 until 2008, she was hospitalized approximately 20 to 25 times per year for hurting herself. *Id.*, ¶ 5. "On a number of occasions when I cut myself, I used the skills I learned in nursing to sew my cuts closed." *Id.* Since Ms. Eichhorn-Smith began receiving treatment from TCORE in May 2008, she has significantly reduced the number of times that she has injured herself and been hospitalized. *Id.*, ¶ 1. She feels that she has made "significant progress with TCORE" and plans to go back to school and find a job. *Id.*, ¶ 12.

B. Previous Budget Cuts and Their Impacts

This is not the first time Sacramento County has cut services to members of the Proposed Class. In April 2009, the County cut millions of dollars from its mental health budget, reducing and terminating outpatient services to thousands of clients. Ex. A at 5-6 (2009 APS Rpt.); Ex. D at 2 (5/7/09 DBHS Meeting Minutes). As a result, clients ended up in hospital emergency rooms that "are not accustomed to clients who are in psychiatric emergencies" (Place Decl., ¶ 22) or "got lost" as a result of changes in service and went without mental health services for months at a time (T. Johnson Decl., ¶ 13). At that time, County officials *admitted* that the discontinuance of services to thousands of clients as a result of the cuts would "inevitably lead to a significant impact to the jail, emergency rooms, and the MHTC as well as other adverse health outcomes for

the individuals currently in treatment." Bates Decl., ¶¶ 17-18 & Attachment C. There is no doubt that the same impacts, or worse, will be felt if the County implements its current plans.[2]

C. The County's Current Proposed Terminations and Reductions of Medi-Cal Mental Health Services

On March 16, 2010, Defendant Mary Ann Bennett, the County's Mental Health Director, announced a proposed reduction of $17.5 million in DBHS expenditures for the 2010-2011 fiscal year. Ex. E (3/16/10 Bennett Memo). The bulk of the cuts – $11.5 million – were aimed at provider and professional services, including "our contracted providers and the vital services they provide to our clients." *Id.* The County later announced that effective June 30, 2010, it planned to terminate all funding for the four RSTs and TCORE. *See* Ex. F (4/1/10 DBHS Meeting Minutes & Attachment B).

At a public meeting on April 1, 2010, Bennett unveiled the County's proposal to open new County-operated clinics that would be staffed with County employees displaced from other positions. Ex. F at 2-3 (4/1/10 DBHS Meeting Minutes & Attachment B). The County acknowledged that the budget reductions would affect "6,500 individuals," that the County was "planning services for approximately 5,000 to 6,000 of [sic] consumers currently in services," and that the County would reduce caseloads by referring clients to alternative clinics and primary care physicians instead of the County's programs. *Id.* The April 1 plan stated that the new clinics would be staffed by 28.6 county employees identified for termination from other positions, but whose jobs, the County asserted, were "protected" by Section 71-J of the County Charter.[3] *Id.* In

[2] Even before the current round of service cuts, the Sacramento Mental Health Plan was unable to provide timely access to outpatient mental health services to all qualified patients. The state's quality review team found that in 2008, the "system [did] not have sufficient program capacity to provide services." Ex. G at 13 (2008 APS Rpt.). The reviewers found that timely access to services was the County's "greatest systemic challenge," with wait times of up to five months for psychiatry appointments and excessively large caseloads of 130-150 adult consumers per staff member. *Id*. at 3

[3] County Charter Section 71-J imposes certain conditions on the County before it may contract out county services. *See* Ex. H (Sacramento Co. Charter § 71-J). The County currently asserts that Section 71-J requires the termination of existing mental health services contracts to preserve County jobs in the face of budget cuts. *See* Ex. F at 2-3 (4/1/10 DBHS Meeting Minutes & Attachment B).

addition, the County stated its intention to contract with University of California, Davis to provide medical staff in the County clinics. *Id.*; *see* Risley Decl., ¶ 12 (noting concern that "second year residents do not have the requisite training and experience to treat our clients").

As of this date, the County still has provided virtually no details about critical issues concerning the planned County clinics, including (1) the overall budget for the clinics; (2) who will staff them, how they will be recruited and hired, how they are qualified and/or how they will be trained in the recovery model; (3) whether these workers have language abilities and cultural backgrounds comparable to the staffers they are replacing; (4) how they will develop or adopt individual treatment plans for over 5,000 clients; (5) how they can possibly prepare these clinics to open on July 1; and (6) what the client-to-staff ratios will be.

Defendants have not explained how they will be able to provide all necessary services to the same number of clients for less money and with fewer staff members than the contract programs, especially when they have *admitted* that County staff are more costly than the contract staff. *See* Ex. I at 3 (8/20/09 DBHS Meeting Minutes). Defendants have not announced any concrete arrangements to transition existing clients from the RSTs, TCORE and CSH to new treating staff at the County clinics, nor have Defendants addressed critical logistical details such as the copying of clients' records at the current facilities, the transfer of client data and charts to the new facilities, and the scheduling of appointments for clients with new providers. Bolte Decl., ¶ 20, Risley Decl., ¶ 15; Bates Decl., ¶¶ 27-28.

Worse yet, the few details the County *has* provided are constantly changing. For example, the County initially announced that it was going to lease four sites for the new county clinics as early as April 27, 2010. Bolte Decl., ¶ 19. The County later stated that it could not sign any leases until after the Board of Supervisors voted on the matter in the middle of June. *Id.*, Attachment B. That would leave *one or two weeks* for the County to establish fully functioning new clinics ready to serve over 5,000 seriously ill clients effective July 1, 2010.

Then, on May 21, 2010, County officials informed Plaintiffs' counsel that in addition to its own original redesign proposal, the County was still considering two other proposals for the delivery of services; that County staff would not make a recommendation for the redesign to the

Board of Supervisors until at least June 10; and that the Board would not consider the redesign until at least June 14. Freeman Decl., ¶ 8. At the same meeting, the County unofficially indicated that it would allow the RSTs and TCORE to remain open until August 1, 2010, and that some funding might be available after that date, on a steadily diminishing basis, over the course of approximately two months as clients were transitioned to the new County clinics. *Id.*

The County insists, however, that even though it does not yet know, and has not yet announced, most of the critical details concerning how its new clinics will operate, it will open them on July 1, 2010, and it will immediately begin encouraging Proposed Class members to transfer their care to the new clinics. *Id.*

The County is refusing to send notices of action to current clients of the RSTs, TCORE or CSH regarding the termination of these programs and the changes in their providers and in their care. Bolte Decl., ¶ 20; Place Decl., ¶ 40. The County has instructed the soon-to-be terminated contract providers to tell clients themselves, through a generic form letter. Bolte Decl., ¶ 20 & Attachment B; Place Decl., ¶ 39 & Ex. 1.[4]

The County's hasty and poorly-conceived plan to dismantle the programs currently serving Plaintiffs and the Proposed Class has drawn a sharp rebuke from the State Department of Mental Health ("DMH"). On May 5, 2010, DMH's Chief Counsel, Cynthia Rodriguez, wrote to the County Counsel, stating that the County's interpretations of applicable state law and the County Charter were neither "correct [n]or legal;" expressing "concern" over "clinical and quality of care issues," the County's lack of a transition plan, and its intention not to notify consumers of changes in their providers; and concluding, "DMH will not be able to approve [the County's] plan updates or contracts until the resolution of these issues." Ex. J at 1, 3 (5/5/10 letter from DMH to County Counsel). To date, none of these issues has been resolved to DMH's satisfaction. On two separate occasions, the *Sacramento Bee* has published editorials stating that the County's plan is "ill-advised" and "should be a non-starter," and that it should be enjoined "[u]nless the county

[4] The County held public meetings to inform clients about the County's plans, but the information provided was limited to the tentative locations of the County clinics. *See* Place Decl., ¶ 38.

provides more proof it has its act together." Exs. K, L (*Sacramento Bee* editorials, 5/14/10 and 6/4/10).

D. Impacts of the County's Threatened Actions on the Proposed Class

Even if the County could provide equivalent levels of services under its replacement system – and there is no evidence that it can or will – the County's abrupt termination of the services provided by the RSTs, TCORE and CSH threatens devastating impacts on the members of the Proposed Class. Plaintiffs submit herewith the declarations of two experts who graphically, and in detail, describe the likely impacts of the County's proposed plans on Medi-Cal recipients. Dr. Beth C. Stoneking, a licensed clinical social worker and certified psychiatric rehabilitation practitioner with 40 years of experience in the field, served in the County's Mental Health Services Department in the late 1980s and early 1990s and initiated the community-based outpatient care model that the County is now planning to dismantle. Stoneking Decl., ¶¶ 7-9, 15-19. Dr. Michael J. Franczak is a licensed psychologist who, over the course of a 38-year career, has served as a clinician, an administrator, and an expert to numerous court monitors and special masters. Franczak Decl., ¶¶ 3-6.

In Dr. Stoneking's expert opinion, **the County's current proposals "will, if they come to pass, inflict severe and life-threatening injury on thousands of persons who rely on the current system for the provision of effective outpatient psychiatric care . . . ."** Stoneking Decl., ¶ 41. Dr. Franczak likens the County's plan to "asking consumers [of mental health services] to go over a waterfall without any information about what lies at the bottom," and opines that the combination of closing of existing centers, the lack of adequate notice, the lack of transition planning, and the almost certain reduction in services "will most likely result in significant and irreparable harm to individuals with serious mental illness currently served by these programs in the form of harming themselves or others, unnecessary institutionalization in hospital emergency rooms and psychiatric facilities, and increased criminalization of the mental health population." Franczak Decl., ¶¶ 10, 27; *see also* Place Decl., ¶¶ 3, 49 (Long time RST

Executive Director "truly foresee[s] an upcoming disaster for low income residents of Sacramento County with intense mental health needs.").[5]

People with severe mental illnesses are extremely fragile individuals who need continuity of care and access to services to survive; building a bond between clients and service providers is the most important predictor of success in treatment of persons with mental illness. Franczak Decl., ¶ 13.[6] Clients are far more likely to attend appointments, take their medications, and benefit from rehabilitative services if they trust their providers. *Id.*

The current providers do "a remarkably good job of providing needed specialty mental health services to medically indigent residents of Sacramento County at a reasonable cost." Stoneking Decl., ¶ 20. Their success is attributable to multiple factors, including working with patients to devise individualized treatment plans combining medication, individual and group therapy, counseling, peer support and opportunities for developing life skills; geographical accessibility; the availability of workers who are culturally, ethnically and linguistically representative of the client communities; and the fact that the clients "know and trust the staff of these programs." *Id.*, ¶¶ 21-24. Numerous declarations from clients attest to this.[7]

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[5] Some of the threatened harm is already occurring. The telephone line for Access, the County's central mental health referral center, is already failing to refer callers for mental health services. *See, e.g.,* Freeman Decl., ¶ 10; Balaoro Decl., ¶¶ 11-13 (client discharged from a locked facility called Access line two months ago and was never connected to services).

[6] Many class members have lived through deeply traumatic experiences, and acknowledge that they have great difficulty in placing trust in others. *See, e.g.*, Connors Decl., ¶ 11 (it "is difficult for me" to "learn to trust new providers" and "[w]hen I'm in a new place I try not to attach to anyone."); Haidary Decl., ¶ 6 ("I have a lot of issues with, and mistrust of people in the mental health system and the police, so it has taken me several years to even let the help come in.").

[7] *See, e.g.*, Fischer Decl., ¶ 5 ("I have been seeing a really wonderful psychiatrist . . . for about three years whom I trust . . . ."); Mangio Decl., ¶ 15 ("[I]nteraction with Northgate staff is deeply personal. I am doing things now for myself that I never thought I could do."); Klee Decl., ¶¶ 11-12 (discussing necessity of building trust with clients so that appropriate treatment may be given); Hushen Decl. at 2:10-11 ("Tearing these clients away from the support system that they have developed over the years is like ripping them up by the roots."). As Ms. Napper attests, "I am very attached to the people there – my doctor, my service coordinator, and the other clients in my groups. I cannot imagine that there is any place like it. The idea of this place closing is like losing my family." Napper Decl., ¶ 12.

Although the County appears to believe it can easily transfer patients to new providers, "[m]ental health care providers are not interchangeable." Franczak Decl., ¶ 15. The day-to-day support provided by RSTs "is critical to ensuring that their clients take their medications, attend counseling sessions, attend skill development groups and avoid deterioration in their mental status." Stoneking Decl., ¶ 24. Thus even if the County opens up new clinics in the coming months, many individuals will not make appointments with them or continue taking their medications. *See id.*, ¶¶ 28-29, 31, 38.[8]

Any transfer of mental health patients from one set of providers to another requires carefully planned, individualized transition plans. Health records need to be transferred, and more importantly, patients must understand what is happening to them and be able to establish trusting relationships with their new providers. *Id.*, ¶¶ 30-31. There is no evidence that any planning, let alone the careful planning required for such a transition, has taken place. The County's "chaotic, slipshod and woefully insufficient" transition will cause irreparable harm to the members of the Proposed Class, both because some of them will inevitably "fall through the cracks" due to poor execution, and because others will have trusted relationships disrupted. *Id.*, ¶ 29; *see also* Franczak Decl., ¶ 27 ("The lack of planning, failure to adequately transition clients, and failure to have alternative services in place . . . will result in catastrophic harm to those currently served and their families.").

The County's threatened acts will result in the following types of harm to Plaintiffs.

Drastic declines in mental health. As a result of the County's threatened actions, some class members are likely to stop taking their medications and attending their counseling sessions; these individuals "are at serious risk of becoming delusional, suicidal, and harmful to themselves and others as their mental illness symptoms increase and their mental status deteriorates to the sad

[8] The County's plan to refer some patients to primary care doctors will not work either, because the clients often cannot secure services from these providers. Bates Decl., ¶ 16. Some primary care physicians believe that prescribing psychiatric medications is outside their expertise; even when they feel competent in this area, they "do not have the requisite time to assume the additional responsibility of determining what type of psychiatric medications and the appropriate dosages for the clients, let alone have any time to build trust with the client." Risley Decl., ¶ 10.

level of grave disability." Stoneking Decl., ¶ 39; *see also* Cline Decl., ¶ 13 ("If someone who is schizophrenic misses an injectable medication, they may begin hearing voices. For some clients, the voices may direct them to do harmful things to themselves or others."); Risley Decl., ¶ 17 ("If mental health consumers cannot receive appropriate services, they will engage in inappropriate behavior. This may result in the involvement of law enforcement and arrests.").

Adverse impacts on physical health, up to and including death. Defendants' actions will also cause grave harm to Medi-Cal recipients' physical health. *See* Cline Decl., ¶ 17 (physical ailments will go untreated); *see also* Steele Decl., ¶¶ 8-9; J. Johnson Decl., ¶ 8. They may become so disoriented that they no longer carry out normal activities of daily living, such as shopping, cooking, cleaning their homes and clothing, dressing, bathing, and caring for themselves. *See* Stoneking Decl., ¶ 39. These clients may experience crises so severe that they require intervention by police and emergency services personnel. *Id.* Dr. Risley, the psychiatrist for one of the RSTs and TCORE, states that he would be "surprised" if one of his patients, who has kidney disease, "is still alive three months after TCORE closes," since the staff "works closely with [the patient] to make sure that his psychiatric and medical needs are met." Risley Decl., ¶ 1.

Increased homelessness. Defendants' actions will almost certainly cause many class members to lose their housing and become homeless. *See, e.g.,* T. Johnson Decl., ¶¶ 5-6; Boynton Decl., ¶ 1. Josephine Balaoro operates sixteen homes in the County that provide room and board for individuals with mental illnesses, most of whom depend upon the RSTs for their mental health services and assistance when they are in crisis. Balaoro Decl., ¶ 1, 7-9. Without that assistance, Ms. Balaoro believes that "90% of the time, the person would end up in a [locked] facility or wander the streets." *Id*., ¶ 1.

Risk of institutionalization. The County's actions will also place class members at great risk of unwanted institutionalization in other psychiatric facilities, including hospitals, psychiatric health facilities, locked psychiatric nursing homes and other institutions. Dr. Michael Franczak, a court-recognized expert in mental health care, declares:

> Without adequate services in place and effective transition, these individuals will experience significant deterioration in their mental status, an increase in symptoms, and a reduction in their ability to relate to others. They may become delusional or disoriented. They also may become suicidal or dangerous to themselves and others. **As a result, they will likely end up in hospital emergency rooms, psychiatric institutions, or jail.**

Franczak Decl., ¶ 17 (emphasis added); *see also* Stoneking Decl., ¶ 5 (County plan will place clients "at risk of institutionalization or acute, more expensive services in crisis facilities, hospital emergency rooms, institutes for mental disease ("IMDs"), jails and even prisons."). Multiple declarants state that the planned cuts will likely throw them into crisis, requiring hospitalization. *See, e.g.*, Fischer Decl., ¶ 13, Napper Decl., ¶ 5; Eichhorn-Smith Decl., ¶ 12; Boynton Decl., ¶ 10.

Once hospitalized, timely discharge and a return to the community will be even more difficult for clients. Stoneking Decl., ¶ 39 ("The trauma of institutionalization can often worsen the downward spiral for these individuals by further destabilizing them, making it extremely difficult for them to move back into the community."). Moreover, the County's proposed actions will mean that clients who are presently in institutions will languish there even longer, because even before the latest proposed cuts, state reviewers found that the County's Mental Health Plan was "unable to successfully support planned discharge" for clients in institutions. Ex. G at 11 (2008 APS Rpt.). According to state reviewers, a third of the beds at the County's inpatient MHTC facility are occupied by clients who are ready for discharge but "awaiting placement," which indicated "an inability to access lower levels of care after hospitalization." Ex. A at 13 (2009 APS Rpt.). It costs far more to institutionalize individuals with mental illness than it does to provide outpatient mental health services that allow them to live in community-based settings. *See* Place Decl., ¶¶ 31-32; Bates Decl., ¶ 4.

III. PLAINTIFFS MEET THE REQUIREMENT FOR GRANTING A PRELIMINARY INJUNCTION

A. Standards for Preliminary Injunction.

"A plaintiff seeking a preliminary injunction must establish that he is [1] likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in his favor, and [4] that an injunction is in the public interest."

Am. Trucking Ass'ns v. City of Los Angeles, 559 F.3d 1046, 1052 (9th Cir. 2009); *Winter v. Natural Res. Defense Council*, 129 S. Ct. 365, 374 (2008). Plaintiffs meet all four criteria.

B. Plaintiffs are Likely to Succeed on the Merits of Their Claims That Defendants' Program Cuts Unlawfully Discriminate Against Persons with Disabilities in Violation of the ADA, the Rehabilitation Act, and Section 11135 of the California Government Code.

The Americans with Disabilities Act ("ADA") prohibits discrimination by all public entities against persons with disabilities. *See* 42 U.S.C. § 12101 (2008). Title II of the ADA, which governs public programs such as Medi-Cal, provides:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132. Section 504 of the Rehabilitation Act of 1973 ("Section 504") similarly prohibits discrimination by recipients of federal funds. 29 U.S.C. §§ 794-794a.[9]

Under the ADA, a "qualified individual with a disability" is "an individual with a disability who, with or without reasonable modifications to rules, policies, or practices" meets the "essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131.[10] All of the named Plaintiffs are "qualified individual[s] with a disability" and they receive community mental health services through Medi-Cal. *See* Napper Decl., ¶¶ 2-3; Fischer Decl., ¶ 2; Eichhorn-Smith Decl., ¶ 2; Yannello Decl., ¶¶ 3-5; Mangio Decl., ¶¶ 2, 9.

The Ninth Circuit has emphasized that "the ADA must be construed broadly in order to effectively implement the ADA's fundamental purpose of providing a clear and comprehensive

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[9] In addition, Section 11135 of the California Government Code prohibits discrimination against persons with disabilities in programs receiving state funds, such as Medi-Cal, and further mandates that state-funded programs comply with the same protections as those specified under the ADA. Cal. Gov. Code § 11135. Plaintiffs are likely to succeed on the merits of their Section 11135 claim for the reasons set forth below for their ADA and Section 504 claims.

[10] *See also* 29 U.S.C. § 705(2) (substantially similar definition under Section 504). Plaintiffs' analysis of the ADA applies equally to Section 504. *See Miranda B. v. Kitzhaber*, 328 F.3d 1181, 1188 (9th Cir. 2003).

national mandate for the elimination of discrimination against individuals with disabilities." *Barden v. City of Sacramento*, 292 F.3d 1073, 1077 (9th Cir. 2002) (internal citations omitted). Defendants' actions violate the ADA in multiple ways, as discussed below.

a. The Increased Risk of Institutionalization Resulting from Defendants' Plans Violates the ADA's Integration Mandate.

Unjustified isolation of persons with disabilities, especially in institutions, is a form of discrimination prohibited under the ADA and Section 504. 42 U.S.C. § 12101; *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999) (ADA); *Frederick L. v. Dep't of Pub. Welfare of the Commonwealth of Pa*., 364 F.3d 487, 491 (3d Cir. 2004) (ADA and Section 504). The ADA and Section 504 specifically mandate that individuals with disabilities be integrated into the community to the greatest extent possible. 28 C.F.R. § 35.130(d) (public entities must "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."); 28 C.F.R. § 41.51(d) (same integration mandate applies to agencies receiving federal financial assistance). These obligations, known as the "integration mandate," are construed and applied in the same manner. *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1179 n.3 (10th Cir. 2003).

As the Supreme Court held in *Olmstead*, the integration mandate requires that persons with disabilities be served in the community when: (1) the state's treatment professionals have determined that community placement is appropriate; (2) community placement is not opposed by the individual; and (3) the placement can be reasonably accommodated, taking into account the resources available and the needs of others with disabilities. *Olmstead*, 527 U.S. at 587. Plaintiffs do not need to wait until they are institutionalized to bring a claim under the integration mandate. Individuals at risk of placement in institutional mental health care facilities are also protected. *See Fisher*, 335 F.3d at 1181.

That Plaintiffs satisfy the first two prongs of the integration mandate is hardly in dispute. The County has determined that community placement is appropriate for Plaintiffs, as its Adult Access Team approves requests for community mental health services for medically indigent County residents. Bates Decl., ¶ 9 & Attachments A & B. Plaintiffs' declarations establish their

strong desire for continued community placement. *See, e.g.*, Eichhorn-Smith Decl., ¶¶ 1, 7-9; Fischer Decl., ¶¶ 7-11; Yanello Decl., ¶¶ 5-7.; Mangio Decl., ¶¶ 13-15; Napper Decl., ¶¶4-5.

The third prong requires the County to make "reasonable modifications in policies, practices, or procedures" so as to avoid discrimination on the basis of disability, "unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7); *Olmstead,* 527 U.S. at 604. Here, it cannot be disputed that the County is *capable* of making the "reasonable modifications" necessary to avoid discrimination, since it has been doing so for many years. Thus the only question is whether the County will be able to sustain an affirmative defense that *continuing* to provide such services would "fundamentally alter" its program. Under settled law, it will be unable to do so. A plaintiff's request to retain an existing program is not a "fundamental alteration" of that program, since the plaintiff is "not demanding a separate service or one not already provided . . . ." *Fisher*, 335 F.3d at 1183.

Plaintiffs anticipate that the County will attempt to establish the "fundamental alteration" defense by arguing that Plaintiffs' requests are unreasonable in light of current budget constraints. Courts, however, have rejected the argument that fiscal burdens somehow justify failing to make reasonable modifications to implement the integration mandate. *See id.*; *Frederick L.*, 364 F.3d at 495 (fundamental-alteration defense based on fiscal concerns alone would be inconsistent with *Olmstead*); *Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Pub. Welfare*, 402 F.3d 374, 380 (3d Cir. 2005) (same). Moreover, any argument about fiscal constraints would require consideration of the higher cost of County staff in the County's proposed plan, as well as the increased costs that will result from increased hospitalizations and in-patient services. *Fisher,* 335 F.3d at 1183; *see* Place Decl., ¶ 32; Bates Decl., ¶ 4.

If the County insists on moving forward with its as-yet undisclosed and undefined plans, it must do more than merely suggest that alternative services will somehow appear, since breaks in service will expose Plaintiffs to increased risks of severe harm. Where defendants "refuse to specify how they will ensure their continuing compliance with the ADA and Rehabilitation Act," they "bear the burden of ensuring more than a 'theoretical' availability of such services."

Brantley v. Maxwell-Jolly, 656 F. Supp. 2d 1161, 1174 (N.D. Cal. 2009) (citation omitted). In *Brantley,* the Court enjoined the California Department of Health Care Services from implementing cuts to the Medi-Cal Adult Day Health Care program, noting:

> Defendants have failed to implement any means of ensuring that, if and when the cuts take effect, the necessary alternative services will be identified and in place for Plaintiffs so that there will not be a period where they are not receiving the care prescribed [in the care plans] . . . . Given their precarious conditions, even temporary gaps in services would present serious consequences for Plaintiffs and place them at great risk of being institutionalized.

Id. Here, too, Defendants as yet have not specified how they will replace the services they are planning to eliminate. This is plainly insufficient; they must ensure not only that an adequate replacement system is in place, but that there is sufficient time and planning to enable clients to transition successfully to the new system. According to Dr. Franczak, "a reasonably effective transition process," which allows time to relocate clinic sites, transfer client records, train staff and transition clients, would "take a minimum of six months." Franczak Decl. ¶ 19. Defendants, however, have stated that they will open their new clinics in *barely three weeks*.

b. Defendants Are Violating the ADA's Prohibition on Employing Methods of Administration that Result in Discrimination.

The ADA prohibits methods of administration or contractual arrangements which, though neutral on their face, have a discriminatory effect. Under the regulations implementing the ADA, a public entity may not:

> directly or through contractual or other arrangements, utilize . . . methods of administration: (i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability; [and] (ii) 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). Section 504 contains similar requirements. *See* 28 C.F.R. § 41.51(b)(3)(i); 45 C.F.R. § 84.4(b)(4).

Here, by substituting understaffed County clinics for existing programs, the County will be eliminating key services that enable many patients to access those programs, including transportation services, assistance with maintaining housing, in-home visits, and hospital visits.

See supra page 4:5-7; Stoneking Decl., ¶ 5 (discussing impossibility of providing comparable services due to proposed reductions in staff). Those whose mental health disabilities require them to have these supports in order to access outpatient services will lose those services, and many will be at risk of hospitalization.

Defendants' plans (1) to disrupt the timely and effective treatment that Plaintiffs have been receiving; (2) to terminate this treatment without having in place any transition plan, let alone an adequate plan; and (3) to relegate Plaintiffs to little more than crisis care and locked facilities all constitute methods of administration that violate the ADA.

C. Plaintiffs are Likely to Succeed on the Merits of their Claims that the Proposed Cuts Violate the Medicaid Act's Sufficiency, Comparability, and Reasonable Standards Requirements.

Plaintiffs are all Medi-Cal recipients who have an entitlement to mental health services under federal Medicaid law. Medicaid is a joint federal and state medical assistance program for certain groups of low-income people, the objective of which is to provide medical assistance to individuals whose resources are insufficient to meet the costs of necessary medical services, and to furnish "rehabilitation and other services to help such . . . individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1. Participation is voluntary, but once a state chooses to participate, it must comply with the Medicaid Act and its implementing regulations. *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1154 (9th Cir. 2007).[11] The County is directly responsible for complying with these federal requirements because it agreed to serve as the Mental Health Plan responsible for providing specialty mental health services to all Sacramento Medi-Cal recipients. *See* Welf. & Inst. Code §§ 5775, 5776, 5777. In doing so, the County agreed, *inter alia*, to "comply with all applicable federal laws, regulations and guidelines" (Welf. & Inst. Code § 5776), and to provide "medically necessary mental health services to Medi-Cal beneficiaries" (*id*., § 5777(a)(1)).

[11] As the Ninth Circuit held in *Independent Living Center of Southern California, Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008), all of the Medicaid provisions at issue are also enforceable directly under the Supremacy Clause.

The County's proposed actions violate Medicaid Act's requirements of *sufficiency*, *comparability* and *reasonable standards*.

Services funded through Medicaid must be "**sufficient** in amount, duration, and scope to reasonably achieve [the Medicaid Act's] purpose." 42 C.F.R. § 440.230(b) (emphasis added); *see, e.g., Lankford v. Sherman*, 451 F.3d 496, 511-13 (8th Cir. 2006) (providing oxygen and other limited respiratory equipment, but not other equipment necessary to assist in breathing, violated the sufficiency requirement); *Mitchell v. Johnson*, 701 F.2d 337, 347-51 (5th Cir. 1983) (limitation of preventative dental checkups to every three years and elimination of other services violated the sufficiency mandate); *Weaver v. Reagen*, 886 F.2d 194, 197-200 (8th Cir. 1989) (denial of AIDS medication to individuals for whom drug is medically necessary violates sufficiency).

Second, the services provided to certain groups of Medicaid recipients must be **comparable** in "amount, duration, and scope" to those provided to other recipients, a requirement that applies to the services provided to recipients in one county as compared to those provided to recipients in other counties. 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. §§ 440.240(a), (b)(1). This Court has interpreted the comparability requirement as "creat[ing] an equality principle by which all categorically needy individuals must receive medical assistance which is no less than that provided to any other categorically or medically needy individual." *Sobky v. Smoley*, 855 F. Supp. 1123, 1139 (E.D. Cal. 1994); *see also Charpentier v. Belshe*, No. CIV S-90-758, 1994 WL 792591 at *5 (E.D. Cal. Dec. 21, 1994) (limiting reimbursement for those eligible for both Medi-Cal and Medicare to no more than 20% of Medicare's reasonable charge while placing no such limitation on Medi-Cal-only recipients violates comparability requirement).

Third, Medicaid-funded services must be provided by utilizing "**reasonable standards**" that are "consistent with [Medicaid's] objectives." 42 U.S.C. § 1396a(a)(17) (emphasis added); *see, e.g., Hern v. Beye*, 57 F.3d 906, 910-11 (10th Cir. 1995) (state law restricting medically necessary treatment to those whose lives were at risk was not a reasonable standard); *Preterm, Inc., v. Dukakis*, 591 F.2d 121, 131 (1st Cir. 1979) (state could not restrict medically necessary

services solely on basis of diagnosis); *Weaver*, 886 F.2d at 199 (rejecting limitations on access to AIDS drugs where such limits interfered with medical judgment).

Defendants' proposed cuts will violate all three of these Medicaid Act requirements. First, closing the RSTs and further reducing Medi-Cal funded mental health services will result in insufficient services being available to county members who are in need of them. The County cannot credibly argue that it can create a fully-functioning mental health system for over 5,000 people within a matter of weeks, especially if the County cannot act until after the Board of Supervisors approves the plan to set up County-operated clinics at a meeting in mid-June. *See* Bolte Decl., Attachment B.

Second, Defendants will be unable to provide mental health services comparable to those available in other counties, given the inevitable disruption in continuity of care and vastly reduced levels of services that will occur as a result of the proposed cuts. Although every California county is facing budget cuts, no other county has proposed the draconian measures that Sacramento County intends to take here: dismantling the bulk of its existing mental health system and interrupting the treatment provided to the great majority of its adult recipients. This will constrain Medicaid recipients to attempting to obtain necessary mental health services through as yet unidentified, unstaffed, and non-established treatment centers. The unprecedented and needless disruption in treatment alone is sufficient to violate the comparability requirement.

Third, Defendants have failed to utilize reasonable standards in their decision to destroy a fully-functioning mental health delivery system and substitute a sm aller, more costly and less efficient County-operated system, without basing this decision on any data or expert testim ony, and in fact, in the face of exte nsive expert testimony to the cont rary. The proposed term inations and reductions are not a reasonable approach to providing the mental health services needed by severely mentally ill clients in the County. Ac cordingly, Plaintiffs have a strong likelihood of success on their Medicaid claims.

D. Plaintiffs are Likely to Succeed on their Due Process and Medicaid Act Claims Because Defendants Have Failed to Provide Adequate Pre-Termination Notice and Opportunity for a Hearing.

Medicaid recipients' statutory entitlement to benefits is protected by the Due Process Clause of the Fourteenth Amendment. *See Atkins v. Parker*, 472 U.S. 115, 128 (1985) (statutory entitlements, such as Food Stamps, "are appropriately treated as a form of 'property' protected by the Due Process Clause"); *Lewis v. Rendell*, 501 F. Supp. 2d 671, 692 (E.D. Pa. 2007) (citations omitted) ("plaintiffs receiving Medicaid benefits have a constitutionally protected property interest in those benefits").[12] Procedural due process requires that the government provide Medicaid recipients notice and an opportunity for a hearing before withdrawing benefits. *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 786-87 (1980); *see also Goldberg v. Kelly*, 397 U.S. 254, 264 (1970) (termination of public benefits "pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits").

The Medicaid Act and regulations also provide statutory rights to written notice and a fair hearing before services are denied. 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.220; *Catanzano v. Dowling*, 847 F. Supp. 1070, 1081-1082 (W.D.N.Y. 1994) ("A state Medicaid agency *must* comply with these notice and hearing requirements in order to comply with federal law as a condition of its participation in the Medicaid program" (emphasis in original)). Under the regulations, at the time of any action affecting an individual's claim to services, an individual must receive written notice: (1) of the right to a hearing; (2) of the method by which she may obtain a hearing; and (3) that she may represent herself or be represented by another. 42 C.F.R. §§ 431.210, 431.206(b). If the Medicaid recipient requests a hearing, the agency "may not terminate or reduce services until a decision is rendered after the hearing . . . ." 42 C.F.R.

[12] The California Constitution likewise provides that a "person may not be deprived of life, liberty, or property without due process of law or denied equal protection of the laws." Cal. Const. Art. I, §§ 7, 15. However, "procedural due process under the California Constitution is 'much more inclusive' and protects a "broader range of interests than under the federal Constitution . . . ." *Ryan v. Cal. Interscholastic Fed'n San Diego Section*, 94 Cal. App. 4th 1048, 1069 (2001).

§ 431.230(a); *see also* Cal. Code Regs. tit. 22, § 51014.1 (requiring comparable notice to Medi-Cal recipients prior to reduction or termination of services).

The County's current plan not to notify benefit recipients of the planned elimination of services plainly violates Plaintiffs' due process and statutory rights to notice and a hearing. At a meeting on April 28, 2010, Defendant Bennett stated that recipients affected by the redesign would not receive Medi-Cal notices of action. Bolte Decl., ¶ 20. For Plaintiffs and the Proposed Class, whose Medi-Cal outpatient mental health services will be terminated, reduced or suspended, the violations of law could not be clearer.

E. Plaintiffs Will Suffer Irreparable Harm in the Absence of an Injunction.

The Proposed Class consists of Medicaid recipients who need outpatient mental health services. Generally, in Medicaid cases, "[t]he nature of [plaintiffs'] claim – a claim against the state for medical services – makes it impossible to say that any remedy at law could compensate them." *McMillan v. McCrimon*, 807 F. Supp. 475, 479 (C.D. Ill. 1992). In particular, irreparable injury is shown where a state denies "needed medical care" to Medicaid recipients. *Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982); *see also Brantley*, 656 F. Supp. 2d at 1176-77 (cuts to Medi-Cal Adult Day Health Care program caused "particularly irreparable and imminent" harm to program beneficiaries). "To allow a serious illness to be untreated until it requires emergency hospitalization is to subject the sufferer to the danger of a substantial and irrevocable deterioration in his health." *Mem'l Hosp. v. Maricopa*, 415 U.S. 250, 261 (1974).

Absent a preliminary injunction, thousands of Medi-Cal recipients in this County will soon be denied medically necessary, outpatient mental health services. Based on his 38 years of experience in the field of behavioral health care, Dr. Franczak has concluded that Defendants' actions "will most likely result in significant and irreparable harm to individuals with serious mental health illness" where such harm will include "increased hospitalization, use of emergency rooms, jail, prison, homeless shelters and death due to suicide." Franczak Decl., ¶¶ 10-11; *see also id.*, ¶ 14 (suicide is the leading cause of death of younger people with schizophrenia). In support of this preliminary injunction motion, Plaintiffs have filed not only their own declarations but also numerous declarations from class members, services providers and experts attesting to

the widespread irreparable harm which will result from the closures of the RSTs and the TCORE program and the sharp reduction in funding for CSH. An award of monetary damages cannot possibly compensate Plaintiffs and the Proposed Class for the devastating harms threatened by the County's proposed actions.

To give just one more example, Channel Kirby is a former dental hygienist who in 1991 experienced a "great tragedy" in her family which resulted in her placement in the Victim-Witness Program. Kirby Decl., ¶¶ 2-3. The program's therapists, however, could not help her as she "continued to have plans to kill" herself. *Id.* Ms. Kirby has both bipolar and post traumatic stress disorders. *Id*., ¶ 2. "When I'm not doing well, I can stay in my house for weeks on end. I don't bathe, I don't brush teeth and I think about not wanting to be here on this earth." *Id*., ¶ 6. For the last six years, Ms. Kirby has been receiving mental health services from HRC, where she has learned coping skills and benefited from the services of HRC's therapists, counselors, physicians and other staff. *Id*., ¶¶ 6-12. She was "devasted" to learn that HRC would be closed, stating: "HRC has been life support for me. I've come down a long dark road and HRC helped me come into the light of hope. Where am I going to go? What am I going to do about my medication?" *Id*., ¶ 13.

F. The Balance of Equities Favor Plaintiffs.

The Ninth Circuit has made it clear that the harm to low income citizens from loss of medical benefits greatly outweighs the expense to government entities of providing those benefits, even during a budget crisis. *See Indep. Living Center of S. Cal. Inc. v. Maxwell-Jolly*, 572 F.3d 644, 657-58 (9th Cir. 2009) (any harm to state from fiscal crisis "was outweighed by the hardships likely to be suffered by Medi-Cal beneficiaries, who would be forced to go without medical care"); *Beltran*, 677 F. 2d at 1322 ("balance of hardships tipped sharply in favor of plaintiffs" when "balancing the medical or financial hardship to the plaintiffs-appellees against the financial hardship to the state resulting from its inability to recover for medical services"). Indeed, the Ninth Circuit has "repeatedly recognized that individuals' interests in sufficient access to health care trump the State's interest in balancing its budget." *Dominguez v. Schwarzenegger*, 596 F.3d 1087, 1098 (9th Cir. 2010).

In fact, not only will Plaintiffs benefit from the granting of the preliminary injunction, but so will Defendants. By all accounts, the County will spend much more for its employees to perform the same work now being done by employees of the contracting agencies. *See* Ex. I at 3 (8/20/09 DBHS Meeting Minutes); Stoneking Decl., ¶ 40. Inasmuch as the disruptions and loss of services will also cause some class members to end up in institutions, such as the MHTC, the cost of such institutional care greatly exceeds the cost of outpatient treatment at the RSTs and the other programs at issue. Place Decl., ¶ 32 ("At capacity, our RST costs $9.33 per client per day," whereas "the treatment center costs over $1,000.00 per client per day"); Bates Decl., ¶ 4 ("The Treatment Center daily cost to treat each consumer is $1,095, whereas the RST daily cost to treat each consumer is $9.33.").

G. An Injunction is in the Public Interest.

The public interest is also squarely on Plaintiffs' side here. As described above, both the California Department of Mental Health and the *Sacramento Bee* have already voiced their opposition to the County's proposed redesign plan. As the Ninth Circuit has also held:

> State budgetary considerations do not therefore, in social welfare cases, constitute a critical public interest that would be injured by the grant of preliminary relief. In contrast, there is a robust public interest in safeguarding access to health care for those eligible for Medicaid, whom Congress has recognized as "the most needy in the country."

Indep. Living, 572 F.3d at 659 (citation omitted); *see also Rodde v. Bonta*, 357 F.3d 988, 999 (9th Cir. 2004) (closing a hospital that served most of the county's disabled patients was against the public interest because it would cause "increased delays in treatment and prolonged suffering and illness among all those who rely upon it"). Finally, an injunction will vindicate the public policy – as expressed by Congress in enacting the ADA and Section 504 – in eliminating the "serious and pervasive" social problem of discrimination against people with disabilities. 42 U.S.C. § 12101.

IV. PLAINTIFFS SHOULD NOT BE REQUIRED TO POST BOND

Federal Rule of Civil Procedure 65(c) "invests the district court 'with discretion as to the amount of security required, *if any*.'" *Jorgensen v. Cassiday*, 320 F.3d 906, 919 (9th Cir. 2003) (emphasis in original, citation omitted). A district court can waive the posting of a bond where

important federal rights are involved, *see, e.g., Cont'l Oil Co. v. Frontier Ref. Co.*, 338 F.2d 780, 782 (10th Cir. 1964), or where giving security would effectively deny access to judicial review. *See, e.g., Save Our Sonoran, Inc. v. Flowers*, 408 F.3d 1113, 1126 (9th Cir. 2005). Exercise of that discretion is particularly appropriate in an action brought by a class of indigent plaintiffs. *See, e.g., Walker v. Pierce*, 665 F. Supp. 831, 843-44 (N.D. Cal. 1987).

V. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court enter the proposed preliminary injunction and not require Plaintiffs to post a bond.

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Respectfully submitted,

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