Mays et al v Sacramento County
Case No. 2:18-cv-02081-TLN-KJN

Mental Health Expert's Third Round Report of Findings

April 25, 2023

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1. Introduction and Background for Third Mental Health Monitoring Report

This is the third Mental Health Monitoring Report since January 2021. Completion of this report was expected to occur by June 2022, but multiple obstacles (e.g., rescheduled site visits due to COVID-19 outbreaks, subject matter expert schedule, newly provided materials) continuously delayed its final production. A significant delay was the occurrence of unexpected medical complications in Fall/Winter 2022 that required a longer period of recovery than expected by the mental health expert and treating medical professional.

To prevent this in the future, this subject matter expert (SME) will have document production deadlines that may result in updated information not being included due to late admissions but would instead be included in a subsequent monitoring report. Because the monitoring process involves a constant state of change, there will always be new data and documents. However, it is important that the Court and all parties be regularly appraised regarding progress (or lack thereof) in compliance with the Consent Decree. This SME takes full responsibility for the current delay and commits to the Court to avoid it in the future.

Background

The Sacramento County Sheriffs' Department continued to operate two jail facilities that provided housing and services to the general detainee populations and those with mental and medical illnesses: the Main Jail (MJ) located in downtown Sacramento and the Rio Cosumnes Correctional Center (RCCC) located in Elk Grove. While the Sacramento County (SacCo) Sheriff's office continued to manage the jails and provide security through their custodial roles, mental health and medical care were provided by different entities, though the same parties as the last mental health monitoring report (hereafter referred to as the Third Mental Health Monitoring Report or TMHMR). Adult Correctional Health (ACH) provided the medical services at both facilities through the Sacramento County Department of Health; the ACH contracted with Jail Psychiatric Services (JPS) through University of California (UC) Davis for mental health services. While documents provided, policies, and medical record documentation referred to JPS as "Adult Correctional Mental Health (ACMH)," this report will continue to identify them as JPS to more easily distinguish them from ACH.

JPS continued to utilize its own nursing staff in the acute psychiatric unit (APU), on 2P, during the monitoring round. All other nursing staff were ACH staff (e.g., health services request triage, medication administration). Sacramento County continued to struggle with a sub-group of seriously mentally ill (SMI) people who have been found incompetent to stand trial (IST). Some of those patients impact the overall SMI population and service need as they wait for placement in State Hospitals with too few beds. Others were present at the facilities in the JPS-administered Jail-Based Competency Treatment (JBCT) program. This treatment program was the product of the Sacramento County Sheriff's Department and Department of State Hospitals to provide competency restoration services. As part of the fiscal year 2022-2023 contract, the program no longer accepted patients from anywhere in the State and only served Sacramento County. Patients in the JBCT were not a focus of current remediation efforts. The actual delivery of those services remained a responsibility of JPS as part of their contract with the County. These treatment activities have historically been prioritized for limited treatment space at both facilities

though JBCT was only provided at RCCC during this review period. It should be noted that as this has been pointed out, custody staff have sought out additional treatment space (e.g., RCCC) and mental health has implemented better scheduling of limited space to reduce the disproportionate emphasis on JBCT access to services. The fact that many of these patients are from the County and remain within the jail pending disposition of their legal cases makes this balance even more critical.

Utilizing point in time data (7/1/22), Defendants reported the following capacity maximums: 1,625 for RCCC and 2,380 for the MJ with a total capacity of 4,005 across the two facilities. However, because of various legislative efforts to reduce capacity at jails across California, Sacramento County efforts to reduce jail population, and continued pandemic conditions, the population remained below maximum capacity throughout the monitoring round. There were 3,354 total detainees in January 2022; 3,336 total detainees in April 2022, and 3,447 as of July 1, 2022. This was approximately a 3% increase between April 5th and July 1st, 2022. From January to July 2022, there were a total of 93 detainees added to the total population[1]. There was an increase of 380 detainees from July 2021 to July 2022 (12% increase) or from the Second Mental Health Monitoring (SMHM) report to the Third Mental Health Monitoring (TMHM) report. Staff continued to report the perception that maintaining the population below maximum capacity made their responsibilities easier to achieve, though the proportion (27-28%) of seriously mentally ill (SMI) detainees generally remained the same and consistent with the SMHM report.

Adult Correctional Health Data[2],[3]

Jail Population for July 1, 2022 (N = 3447 inmates)				
Population[4]	**No MH Condition**	**MH Non-SMI**	**SMI**	**Total**
Average Length of Stay (LOS)[5]	191 days	299 days	250 days	N/A
Sentenced	250 (19%)	221 (18%)	99 (10%)	570 (17%)
Pre-Sentenced	1,050 (81%)	974 (82%)	853 (90%)	2,877 (83%)

[1] While this does not seem like an enormous increase, defendants reported that they suspected greater increases at different points in time not reflected in the monthly point-in-time data. If defendants believe this may drive staffing needs or impact the ability to provide services, they should revise detainee count procedures to capture this data. It would be possible to conduct a pilot project for two to three months to identify if this perception can be demonstrated by data before attempting a large data revision project.

[2] https://www.sacsheriff.com/pages/transparency.php

[3] https://www.dropbox.com/sh/pre9pq4sgjj3l6x/AAACXGc9Uxukjec8St8WBtkpa?dl=0&preview=_MH+Data+2022-7.pdf

[4] Definitions: MH refers to Mental Health; MH Non-SMI refers to individuals diagnosed with a MH condition that is not categorized as a MH SMI diagnosis; SMI refers to individuals with a diagnosis of a Schizophrenia Spectrum and Other Psychotic Disorders, Borderline Personality Disorder, PTSD, Major Depressive Disorder, and/or Bipolar and Related Disorders. Data includes patients served in all jail facilities including the Jail Based Competency Treatment (JBCT) program.

[5] Length of Stay (LOS)–was determined from time of booking until 7/1/2022.

Total	1,300 (37.7% of jail population)	1,195 (34.7% of jail population)	952 (27.6% of jail population)	3,447 (100% of jail population)

**Due to system limitations, count of sentenced and pre-sentenced is not exact. Inmates are only considered sentenced if all outstanding charges are sentenced and/or there are no holds (i.e. warrants from other counties, MH holds, etc.).*

While complete mental health census data was not provided by the County, the following was provided and updated in response to the document request. This data (reported 8/4/22) was that there were 413 "mental health" inmates at the MJ and 82 at RCCC, though 40 of those were identified as JBCT level of care (LOC), for a total of 455 total non-JBCT level of care patients. A roster by level of care indicated 16 patients in the acute psychiatric unit (APU), 61 patients in the Intensive Outpatient Program (IOP), and 200 in the Enhanced Outpatient Program. Comparing caseload data with the SMI data in the table above suggests that there were approximately[6] 457 patients diagnosed with SMI who were not receiving care at the EOP level or higher, including JBCT. The County reported that 63% (2,147) of the population (as of 7/1/22) had received mental health services during their incarceration. As of September 2, 2022, there were 30 patients on the APU pre-admit waitlist and 86 patients awaiting transfer to a State Hospital due to being found IST. The APU waitlist had been reduced to 21 people (10/25/22) and Appendix G provides length of stay on waitlist. The average length of stay on the waitlist was 9.7 days while the mode was five (5) days. There were two outliers of 45 and 49 day waits.

There was some difficulty in understanding the mental health data because terminology has varied over time[7]. Based on current policy, the following LOC were identified: 1) acute psychiatric inpatient, 2) intensive outpatient, 3) enhanced outpatient which was sometimes referred to as OPP or OP services and EOP, and 4) general population (GP) level 3 case management (CM). The data did not generally identify GP level 3 CM in caseload lists. While the RCCC data did indicate OP and IOP, the MJ mental health data did not. The two specialized programs at RCCC include the JBCT program and a higher security (e.g., locked doors with food ports) IOP for men. At the MJ, there were several specialty programs including the Acute Psychiatric Unit (APU) inpatient treatment program (2P) and IOP/EOP services for both men and women. There had been an expansion of treatment services available to "high security" patients at the MJ. The County established eight (8) "high custody" beds for female IOP patients. It was reported that the male high security beds had been fully implemented by September 2022.

Because of the different uses of terminology for the mental health continuum of care, it is recommended that any necessary changes be made to the existing policy so that it aligns with current levels of care and be updated as that evolves. The tracked data (produced as part of the document request and internal continuous quality improvement) should then be examined and

[6] Due to different data production points.

[7] It is recognized that defendants provided a table of current and historic "naming traditions" in an effort to clarify this confusion. However, as stated caseload data varied and even current medical record entries varied in how certain levels of care were referenced.

modified so that it aligns with the existing LOC and their acronyms. While staff have reportedly been provided with an appropriate acronym list, medical record review indicated that they did not consistently utilize it. This should be regularly reviewed by supervisors and quality management committees. Sacramento County requires accurate caseload information to be able to conduct reliable bed planning activities. It is also important for providers and experts reviewing cases that documentation utilize only acceptable acronyms. It may be fully understood by managers and supervisors, but it was not clear that all line staff understood based on documentation. Utilization of old terms or previously interim language would contribute to confusion amongst custody staff as well.

Progress

It should be noted that there have been multiple areas of progress as will be discussed in detail further in the report. The County has invested in policy development and has produced a substantial number of policies. Some remain pending SME review because the number and need to review revised policies at times outnumber the SME ability to review. However, Defendants have worked closely with the mental health SME to prioritize policies and training materials for review to help this writer to more effectively review the appropriate policies. One such critical policy with associated training materials recently finalized was for mental health intervention in planned uses of force (UOF).

The County has authorized additional space at the MJ for confidential contacts and this will be reviewed later in detail. At the time of the last report additional space was identified at RCCC which staff have reported was extremely helpful so that they did not have to rely on only scheduled space within the classroom near the IOP. Mental health staff primarily utilize an appropriate office space converted by RCCC custody staff for their space. Mental health staff from the MJ were moved to off-site office space to provide for additional group/individual confidential space on the third floor. Mental health staff have also extended the group schedule in an effort to better utilize existing space.

The County has conducted multiple assessment and feasibility studies regarding the MJ and its capacity to be renovated to allow for compliance with the Consent Decree. This has included an interim proposal regarding the APU to be discussed in section 3 below.

2. Methodology

In December 2021, this mental health expert and the suicide prevention expert jointly updated a document request for Defendants. That document request can be found at the end of this report (see Appendix A). That data was provided in January 2022, though not in the format requested making it more difficult to identify if the data was actually provided. Subsequently due to unanticipated delays in the site visit and subsequent report, updated data was requested and provided in August 2022. Updated data will be provided whenever available. Defendants have been quite responsive to all the MH SME's request for information, data, and documents. They remain hampered by limitations of existing data and tracking systems, including the current electronic health record (EHR) operating system.

The mental health report is based on the mental health SME's findings following document review, data analysis, observation of operations, interviews of staff and consumers (i.e., patients), training documents, and medical record review. It should be noted that only one mental health direct care provider attended the staff interview meeting despite all but mental health supervisors being invited. This is problematic for the SME in understanding the challenges and progress made by the Defendants because staff are an important source of information incorporated into the overall assessment. There are times when line staff have more current and accurate information than supervisory or management staff or are better able to articulate the regular challenges that they face as well as the changes that have resulted in significant improvements for them. It is important that staff feel that they can speak freely to the SME without fear of retribution and that they understand the role of the SME and value of their input. Mental health (and custody) staff were interviewed informally as operations were observed in an effort to supplement staff input. This review included multiple assessments of clinical indicators documentation based on medical record review only. While this author strove to review at least 10 records for each indicator[8], there were times when the 10 cases randomly selected did not include patients who fully met criteria for inclusion. Records were reviewed primarily during the Spring and Summer of 2022. However, updated reviews of the same patients were conducted from October 2022 to January 2023 for the acute, IOP, and EOP levels of care at both facilities to allow for documentation of improvement to be noted by the SME.

Another important source of information was the Defendants' fourth and fifth status report. As stated in the Remedial Plan:

> "Not less than 120 days, and not more than 180 days, after this Consent Decree is approved by the Court, Defendant shall provide to Plaintiffs' counsel and the Court Experts (discussed below) a Status Report which (1) shall include a description of the steps taken by Defendant to implement each provision set forth in the Remedial Plan; and (2) specifies provisions of the Remedial Plan which have not yet been implemented. With respect to the provisions of the Remedial Plan not yet implemented, Defendant's Status Report shall (i) describe all steps taken by Defendant toward implementation; (ii) set forth with as much specificity as possible those factors contributing to non-implementation; and (iii) set forth a projected timeline for anticipated implementation based on the best information available to the Defendant. Not later than the end of each subsequent 180-day period during the term of this Consent Decree, Defendant shall provide to Plaintiffs' counsel and the Court Experts (discussed below) an updated Status Report addressing each item of the Remedial Plan and shall specify whether it believes it is or is not in substantial compliance with each provision of the Remedial Plan."

[8] It should be noted that one patient may represent several different cases for different reviews. An example would be a patient who was at multiple levels of care.

The Defendants have produced their fifth status report and have not yet been able to include all relevant information as discussed in the Consent Decree. The most recent status report was a significant improvement in quality over previous versions. However, Defendants' need to address, with sufficient specificity, each of the listed areas of the Consent Decree with a more detailed definition of how progress would be measured (outcome/performance indicators) using objective data, preferably from the QM/QI audits and committees. The Defendants did produce the Sixth Status Report several weeks prior to the TMHMR, but it was not included in this review but will be utilized in the next MH Compliance report. While the Fourth and Fifth Status reports by Defendants did not address all areas of the Consent Decree as related to mental health care, they did generally note areas that were beyond or outside their focus. The Defendants' Fourth and Fifth Status reports were reviewed and where applicable, incorporated into this monitoring report.

In addition, critical to the findings in this report were the results of two "feasibility" studies completed by Nacht & Lewis (i.e., "Main Jail Capacity to meet the Consent Decree" and "Main Jail 300 West Pod JPS Conversion Feasibility Study"), a study completed by Kevin O'Connell ("Sacramento County Jail Study") on population management options, and Wendy Still, correctional expert, review of those studies; a report on environment of care report by Diane Skipworth, and a written presentation by Eric Jones for the Board of Supervisors (9/14/22) incorporating much of this information.

As mentioned, the medical records for numerous detainees were also reviewed and provided information for this report. Eleven of those records were formalized into case studies. It became clear through documentation review that despite progress in documentation for some on the mental health caseload, conclusions were limited (e.g., spaces declared confidential that were clearly not confidential such as outside control, frequent documentation that confidential space was not available, patients seen cell side) as to actual progress made in the area of confidential space. Because of some limitations and staff errors in documentation in the EHR, ongoing training and supervision is strongly recommended. This was true for multiple areas including diagnostic clarification (e.g., the large number of patients with a diagnosis of Schizoaffective, Bipolar type that was incongruent with baseline data or those who also had diagnoses of amphetamine abuse without clear differential diagnostic justification), adequate record review prior to meeting with patient, clinical decision-making in crisis situations, conducting assessments cell side or attempting to discuss sensitive information cell side, and the lack of appropriate documentation of multi-disciplinary treatment teams (e.g., only one provider noted on treatment plan, no clinical interventions included in treatment plan). Overall, the documentation reviewed was generally improved from one year ago. However, to reach the standard of care and compliance with the Consent Decree, continued improvement will be necessary. Defendants did appear realistic about such matters and about obstacles presented by the EHR and specific forms within the EHR.

In summary, for each Remedial Plan item assessed, this expert reviewed relevant documents and data to include Defendants' fourth and fifth status reports, policies provided to all experts and plaintiffs, training materials, staffing data and information gathered from this expert's staff and detainee interviews, data analysis, and medical record review. The primary focus of this report will be those areas of priority identified and maintained in the prior Monitoring Reports.

Standards for Compliance Determinations

The subject matter experts previously conferred to mutually decide on the standards of compliance for our particular areas of focus. This would allow for greater understanding across areas of focus for all parties, particularly areas of overlap (e.g., medication management is relevant to both mental health and medical; treatment planning for suicidal individuals has an impact in all three areas if injury has occurred). It should be noted that these standards evolved between the draft and final first monitoring reports as a result of feedback from the Parties. Those standards of compliance are as follows (and can be found in expert Mr. L. Hayes first compliance report 1/20/20 and repeated in each mental health report):

1. **Substantial Compliance**. Substantial compliance is defined as having been achieved when Defendants have met compliance with most or all components of the specific area, process, or provision of the Consent Decree for both the quantitative (e.g., 90% performance measure) and qualitative (e.g., consistent with the larger purpose of the *Decree*) measures. If an individual compliance measure necessitates either a lower or higher percentage to achieve substantial compliance (e.g., 85% or 100%), it will be so noted by the expert for that item/area. To be considered to be in "substantial compliance," compliance has to have been sustained for a period of at least 12 months.
2. **Partial Compliance.** Partial compliance indicates that compliance has been achieved on some components of the relevant provision of the relevant provision of the Remedial Plan, but significant work remains. For example, the County has to finalize a policy that is compliant with Remedial Plan requirements, contains adequate operational detail to staff as to how to implement the policy, train staff, and they must have begun implementation of the policy.
3. **Non-Compliance.** Non-compliance is defined as the Defendants have not met all of the components of the specific area, process, or provision of the Consent Decree for both quantitative and qualitative measures and require significant work to meet compliance.

An additional component to determinations of compliance for the MH SME this round has included whether there has been any progress or improvement since the last monitoring round. As a result, some areas that may have been declared "partially compliant" last round may

be considered "non-compliant" this review period due to a lack of continued progress or regression[9].

The TMHM report shall remain structured similar to the Consent Decree sections with comments and recommendations[10] included in each pertinent area. Where language has been copied directly from the Remedial Plan, it shall be noted by including that language in *italics* and the section of the Remedial Plan referenced. The Remedial Plan generally starts each section. Supporting data that has formed the foundation for this report includes (not an exhaustive list) policy from the SSO, ACH, and JPS as well as the National Commission on Correctional Healthcare (NCCHC) for all correctional healthcare services, 2015 mental health standards and 2018 medical standards. Some areas could not be fully assessed due to any of a number of factors: lack of proof of practice, failure to provide documents, proof of practice was not sufficiently detailed or otherwise inadequate, or similar.

There remained challenges in navigating the medical record. While Defendants have acknowledged that the electronic medical record can be challenging, additional documentation was still found to be incomplete or in error at times (e.g., sections that were left blank, sections without clear meaning, constantly repeated information such as current medications in a non-psychiatric progress note, lack of health services request)[11]. Record reviews continued to identify several consistent problems with documentation, primarily that notes would be vague, incomplete, and/or lack specific clinical treatment information. That left this reader confused at times as to the patient's placement and level of care. There were also instances when the provider had clearly not fully reviewed the record or external documentation that was available. Simple monitoring tasks were more cumbersome because of some of these challenges and the need of the SME to review additional documentation to verify simple items. One previous problem with documentation of confidentiality of individual appointments was addressed structurally by ACH and JPS. However, there remained some challenges with reliable data because there were notes reviewed that indicated that the visit was confidential, but then described being cell front or in some other non-confidential area. It was not known if confidential was the default entry or dropdown, but it is recommended that the clinician be required to type this into a narrative area to avoid errors. It must be noted that there did seem to be improvement in this area of documentation in update record reviews, though it also appeared that the occurrence of non-confidential contacts increased. There may be other IT solutions such as indicating only classrooms and "lawyer booths" or other confidential areas within the medical record as confidential so that if there is incongruence in entries, the provider must correct and is not allowed to move on in the note (a "hard" stop that forces immediate correction).

[9] Defendants have noted their disagreement with this definition in this report, though it has been explicitly stated since the first monitoring report.

[10] Some indicators had little to no progress toward compliance. This was not unexpected given that Defendants were encouraged to focus on specific areas in mental health and suicide prevention while physical plant limitations limited other progress. Where there was little to discuss, recommendations remained the same.

[11] This is a default function of the current electronic medical record that requires mental health staff to identify what information was automatically "pulled forward" from the medication record, prior progress notes, and such rather than a product of the current clinical contact.

I would like to thank all SSO, ACH, and JPS staff for their assistance throughout this process. I would like to specifically thank Sandy Damiano, Ph.D., Interim Director of Department of Health Services and Ms. Tianna Hammock, Quality Improvement and Compliance Coordinator, for the continuous provision of information and responsiveness to requests; and Ms. Andrea Javist, Behavioral Health Psychiatric Manager (ACMH/JPS) and her staff for their assistance and responsiveness to requests. I'd like to express my deepest appreciation to Sergeant R. Esty and Lieutenant Culp for their assistance and willingness to generate new ideas toward compliance. Mr. Rick Heyer has been a tremendous asset in facilitating all of these different requests and his efforts have been most helpful.

3. Findings of Various Commissioned Studies – Executive Summary

In the presentation to the Board of Supervisors, Kevin Jones aptly summarizes the findings of the various studies. Some of his highlights include:

- Nacht & Lewis Main Jail Capacity to Meet Consent Decree
  - In order to meet existing needs, the jail's capacity must be reduced to 1,357 beds from its rated capacity of 2,397.
    - a loss of 1,040 beds or nearly 44%
  - Substantial compliance with all consent decree requirements was not possible within the Main Jail.
  - These findings were confirmed by Wendy Still in her peer review (analysis of the methodology and findings) report.
- Kevin O'Connell Population Management Study
  - identified suggestions for reducing the population that included reducing returns to custody, bookings, and lengths of stay.
  - It was estimated that implementation of all of those suggestions, which would require significant multi-department/system resources and community involvement, might reduce the population by 600.
  - This was significantly below the population reduction need identified by Nacht & Lewis above.
- Nacht & Lewis Main Jail 300 West Pod JPS feasibility study (please see Appendix D)
  - While this feasibility study was conducted in response to extreme concerns regarding the APU and the extreme physical plant limitations of current location 2P, the options provided in this study noted that they could not incorporate many of the spaces that JPS identified as necessary for their provision of inpatient treatment.
    - This project would likely take at least two years to complete.[12]
  - Severe physical plant limitations and lack of upkeep for 2P were confirmed by Diane Skipworth in her Environment of Care report findings.

[12] Statement by the County representative during the meeting to review the proposal with All Parties.

        - It should be noted that extensive preventive maintenance and cleaning deficiencies were found throughout the Main Jail and included 3 West.
    - This expert met with All Parties to review the proposal and identified that while the move may increase acute psychiatric beds, it would not provide for sufficient treatment and office space for mental health staff.
        - It would also not likely completely eliminate the waitlist since there is a significant subpopulation of people suffering from acute exacerbation of their mental health symptoms at any given time.

4. Areas of Focus and Memorandum of Understanding

Following release of the first-round monitoring documents by all SMEs, all parties agreed that the subsequent round would be a focused review. While the mental health (MH) SME completed a hybrid of that (i.e., addressing Areas of Focus and remaining mental health elements of the Consent Decree), it was decided to continue that format until all focus areas are resolved. This will better highlight those areas deemed most urgent and crucial as foundational issues that would benefit compliance with multiple areas of the Consent Decree. Without remediation of foundational issues such as space and staffing, significant progress can simply not be made in other areas of the Consent Decree as relates to mental health services. Because of this continued focus, those areas will be reviewed in greater detail than the Consent Decree items not identified as current Areas of Focus. These areas were specifically selected because of the possibility that sustained attention would improve resource allocation and planning and result in dramatically fruitful outcomes across several additional areas. As mentioned previously, resolving space issues would address treatment delivery, treatment access, bed planning, confidentiality and possibly recruitment and retention. Mental health staff were solicited as part of the Document Request to submit a program narrative. They did submit a Program Narrative as well as a program update that included recent successes, opportunities, and obstacles/challenges (January 2022). These are incorporated where indicated (see Appendix B).

Following the Second Mental Health Monitoring report, plaintiffs' counsel pursued dispute resolution with the Defendants regarding specific Areas of Focus identified by the MH and Suicide Prevention SMEs (see Appendix C). This process did appear to increase resource allocation to specific MH areas. The Areas of Focus for the mental health elements of the Consent Decree were as follows, in no particular order:

1. Space – space is at an absolute premium at the Main Jail and lesser so but still a challenge at RCCC. Treatment cannot be provided without acceptable space available for individual and group therapy.
2. Staffing – once space is available there must be sufficient numbers of appropriately licensed competent staff to use that space to deliver appropriate treatment.
3. Use of Force/disciplinary actions – this is a high risk, high liability area that usually involves significant cultural change for both mental health and custody staff to reduce unnecessary uses of force.
4. Treatment – assess need through bed planning and start to increase delivery. When a system is in a state of crisis need studies are not accurate. Only as the system begins to

provide regular, functional services can bed need studies more accurately reflect the need of a functional system.

4. Findings – Areas of Focus

A. Space

A1. Progress and Actions – the Defendants have fixed the lawyer booth previously identified by them as a space for confidential contacts that was broken during the SMHM report. The telephone was not working properly but was fixed by the time of the site visit and staff were using it. Defendants also moved staff out of a classroom on the third floor so that it could be used for confidential individual and group treatment. Two other lawyer booths were reportedly made available to mental health staff, though those have not yet been observed.

In response to the SMEs' monitoring reports and Plaintiffs' dispute resolution process, Defendants undertook several feasibility studies. One required review of the Main Jail physical plant deficiencies as barriers to compliance with the Consent Decree and the other analyzed population-reduction options to reduce space pressures within the system that contribute to an inability to comply with the Consent Decree. The findings of the Nacht & Lewis study (3/31/22) noted that even with significant population reduction, the MJ would not be able to "achieve meaningful compliance" with the Consent Decree. One of their conclusions found:

> "As a final note, though not a focus of the current study or this report, it is important to recognize that there are many factors related the Main Jail's design and construction that, while they might allow remediation to meet a few of the consent decree's requirements, they make such interventions impractical and/or prohibitively expensive. These include structural limitations and the security and operational impacts that result from construction within a jail, especially one that must remain operational 24/7." (Section 4, page 21)

The Board of Supervisors held a public meeting on September 14, 2022, to review these studies and the Consent Decree. There was also a meeting in December 2022 where they reportedly approved recommendations for Jail Population Reduction Plans and Plans to address Jail Facility Deficiencies for the Mays Consent Decree.

Defendants agree that the availability of appropriate space plays a critical role in the delivery of adequate mental health services, particularly within the MJ and to a lesser degree at RCCC. Without space, adding mental health staff would result in diminishing returns due to the lack of treatment space. Defendants have acknowledged this in many ways including implementing interim strategies such as successfully relocating mental health staff to space outside of the MJ building, thereby freeing up at least one classroom so that the space can be modified and used for confidential group and individual treatment on the third floor. While staffing remained an important issue during this monitoring round, space also remained a critical issue despite improvements.

As has been identified in previous reports, the APU has insufficient beds, general space inadequacies (e.g., recreation), and no confidential treatment space for individual or group therapy. Consequently, all individual clinical contacts reviewed occurred cell side although treatment groups were held in the nonconfidential dayroom area when sufficient staffing allowed. As part of the MOA process, the County contracted and completed a feasibility analysis (Nacht & Lewis, 5/27/22, see Appendix D) regarding the use of alternative space for acute psychiatric treatment to identify a possible interim plan. This plan identified two different possible floor plan schematics if acute patients were moved to the third floor (west) where the IOP is currently. This would increase the total beds from 17 to 38 with 10 of those reserved for suicidal patient temporary housing commonly referred to as the SITHU. While this plan indicated that the move could be done in accordance with ligature resistance and safety concerns, the following items requested by JPS and required for adequate treatment could not be accommodated due to a lack of available floor space:

1) Sufficient confidential group treatment space as required for adequate treatment of an acutely ill patient population;

2) Sufficient confidential individual interview space;

3) A confidential multidisciplinary treatment room;

4) Nursing workstation though it should be noted that in one plan the identified custodial space could possibly be shared nursing station/custody station;

5) Mental health private office space to accommodate 5 to 6 people and one shared space though the SME notes that both schematics offered shared office space but capacity remained a concern.

Based on the architectural schematics and the analysis as a whole, while the interim plan would increase bed space and provide three individual interview clinical contact areas, there would be no associated group treatment space. While patients experiencing acute exacerbation of mental health symptoms are typically treated more often individually or in small treatment groups than those requiring lower acuity inpatient treatment, providers would not be able to provide sufficient treatment to meet the Consent Decree and standard of care requirements even with these modifications. All parties understood that this was an **interim** plan and that compliance would not be achieved, though there would be improved individual confidential clinical contact and increased bed space. Despite these potential improvements, further planning is necessary as even this interim plan is likely two years from fruition.

In the meantime, Defendants will continue to maintain a waitlist for what is essentially emergency treatment: acute psychiatric inpatient treatment. They will continue to provide inadequate treatment that does not allow for patient privacy thereby reducing the likelihood that patients will disclose necessary sensitive private information and increasing the risk of a negative outcome (e.g., further decompensation, psychological pain, self-injury, death by suicide). Patients will continue to receive inadequate treatment due to the lack of confidential group treatment space. They will receive primarily medication management and isolation within these limited parameters. All parties agree that the unit was not designed to provide acute mental health care. It has been well documented that the unit has not been maintained well (e.g. Second

MH Monitoring report; Nacht & Lewis, May 2022). Patients continued to spend the majority of their time isolated in their cells, likely exacerbating their mental health status.

Standards of care require that inpatient treatment provided on site must conform to the community legal standards of care including utilization of licensed and/or certified staff. One positive decision for the acute unit was the assignment of a social worker there three days per week[13]. While chart reviews indicated that treatment groups provided by that staff person were sometimes canceled due to "lack of staff," it was unclear if it was due to mental health staff or lack of custodial staffing. There remained no assigned psychologists to the APU to facilitate treatment planning, behavior plans, or psychological assessment. Treatment plans appeared to be developed only by the social worker rather than the multidisciplinary treatment team[14] and did not include interventions. Treatment goals were typically dependent on the patient (Cases 28-30, 32).

As noted previously, it is not practical to escort these patients to another area outside of the unit for a variety of reasons including that many of these patients only have smocks that do not allow for modesty. Escorting patients to another area would require additional staff and close supervision of the patients to be sure that there would be no unnecessary risks (e.g., self-injurious person). Despite the limitations of the physical plant, Defendants must provide adequate treatment to achieve compliance with this element of the Consent Decree and relieve the suffering of those patients in their custody. Since Defendants' contracted feasibility study of the interim plan (Nacht & Lewis, May 2022) documented that all required physical plant spaces (e.g., group treatment rooms, multidisciplinary treatment room) cannot be created, the rendering of the interim plan is inadequate to achieve substantial compliance with the Consent Decree. In addition, that interim plan cannot be expected to be fully implemented for at least two years. It is important that Defendants identify space for confidential individual contacts that meet the Standard of Care or contract with alternative providers of inpatient care (e.g., community psychiatric hospital) until the interim plan can be implemented.

Until adequate psychiatric inpatient treatment can be provided in the jail, it is incumbent upon the Defendants to seek out psychiatric treatment in the community, whether through County Mental Health or private providers, where patients can be placed. Many of the patient population requiring acute care cycle between the community and jail placement. These patients are no greater a threat, in general, than psychiatric patients placed in many community facilities.[15]

While Defendants have reported the allocation of additional confidential space, medical records did not support the ready availability of that space and/or utilization of that space. This reviewer could not locate any audit of the use of confidential space by mental

[13] Defendants noted that FY 2022-2023 had three FTE social work positions to allocate to the APU with 2.0 filled at the time of this report and 1.0 in process. This will be evaluated in the next monitoring report.
[14] This may have been due to problematic charting forms that require revision.
[15] https://store.samhsa.gov/sites/default/files/d7/priv/sma19-5097.pdf.

health staff in the data provided, but that data was provided following this report. Consequently, this SME completed a medical record audit, analyzing 84 clinical contacts across different patients and different levels of care. The APU was excluded due to their known lack of confidential space. Of the 84 contacts, only 22 (26%) of contacts were documented as confidential[16]. There were 62 non-confidential contacts with most occurring at the MJ, consistent with space concerns. The reasons noted by clinicians for non-confidential contacts were most frequently that confidential space was not available (51 or 82%) or that custody staff was unavailable (11 or 18%). Confidential space and the ability to utilize that space when needed clearly remained problematic despite efforts to increase space. Clinicians documented that they used space near the control booth, outside of the dorm/pod, in the dayroom, and on the recreation yard as non-confidential areas. It was also noted that patients were seen cell side, particularly in segregation. That was extremely concerning since segregation is a high risk environment due to increased occurrence of suicide (based on national research), the frequency of patients with safety issues, and the negative impact of the segregation environment on mental status.

Recommendations

1. Defendants must pursue development of appropriate space to allow for compliance with the Consent Decree[17]. Their own contracted consultants found that the MJ cannot be renovated to the degree that compliance will be possible. Defendants had initially planned on building a medical and mental health annex to the MJ. The contracted consultants have clearly documented that need remains and that Defendants will never be fully compliant with the Consent Decree until there is appropriate space and staffing. While there is much discussion about "compliance," **it is important to remember that non-compliance in such critical, foundational areas results in needless human suffering for patients**.
2. The County should immediately begin planning for adequate inpatient services while recognizing that the current housing situation (2P) will never be appropriate for such a unit and that even the interim plan is inadequate and will take at least two years to implement. It does not appear that Defendants' have exhausted all available resources.
    a. The County must seriously review what access to inpatient care may be available in the community and attempt to contract inpatient services with appropriate housing that are not inside of the jails. Other systems have contracted with university hospitals, community hospitals and private hospitals to provide the necessary treatment.

[16] It is recognized that this is an area where defendants have initiated audits and that their results show improvement over time across areas, with the actual percent of compliance varying by area and month. While the defendants' auditing of this process is critical and an improvement from the last monitoring report, it continues to substantiate non-compliance with confidential clinical contacts across areas in the MJ.

[17] In December 2022, the Board of Supervisors approved long-term physical plant improvements including an annex. This will be reviewed in subsequent report but All Parties are reminded that Defendants themselves noted these solutions would not be immediate and would take several years at a minimum. While this is understood by the SME, there remain consequences to the people housed within the jail system currently and until that time.

b. The County should continue to engage in the meet and confer process as outlined in the Memorandum of Agreement with Plaintiffs' attorneys and all SMEs in this case.

3. While Defendants have noted and provided for additional confidential space in the MJ since the last monitoring report, medical record review indicated that space was either not effectively utilized or clearly insufficient. Confidential space the segregation unit, and anywhere that high security detainees are held. Each of these areas has increased demand for mental health services due to evaluations that must be completed, treatment that must be provided, and crisis calls that are likely to occur.
    a. Confidential interview space must begin at intake with nurses conducting screenings in a confidential setting with sound privacy, at minimum. Mental health staff conducting initial assessments and comprehensive intake evaluations must regularly use the "attorney" booth identified for new arrivals. It did appear that initials assessments and comprehensive evaluations were more likely to occur in a confidential space than ongoing assessments and clinical contacts within the facility to include those occurring on mental health units. This may have been due to the location of the initial attorney booth. Defendants need to identify where increased space is currently necessary and be transparent as to what space can be made available to mental health staff. Then JPS may need to increase supervision to ensure that mental health staff use that space or notify supervisors when space is not available or cannot be utilized due to a lack of custody.
4. As Defendants further refine the audit process for confidential clinical contacts, the methodology of these audits must be clearly stated in continuous quality improvement (CQI) studies. For example, is there a report that is utilized so that the data is based on the clinician's selection of "confidential" or is the record reviewed to identify times when the clinician may declare a contact confidential when it actually does not meet standards of confidentiality as noted in the Consent Decree.

<u>B. Staffing</u>

B1. Progress and actions - The County requested and received additional mental health (and health care) positions (see Appendices E & F).

B1.a. The County received the findings of a feasibility study for the Main Jail (MJ).

The County requested and received additional health care positions and expanded the contract for mental health services based on information provided for this report. The needed mental health staff allocations to meet the Consent Decree remained unclear. For example, the County received authorization to increase the JPS contract to allow for expansion of services to those provided in the acute

psychiatric program, complete required disciplinary mental health assessments, and provide constant observation to those on suicide watch. While the expansion of this level of service is a positive development, it is important to remember that any group treatment provided to acute patients is not confidential and the County has still not identified space to provide the acute program with much needed confidential individual space. This limits the "expansion" of treatment for the most acute patients. In addition, record review that many of those groups were canceled due to "staffing" needs without specifying the specific staffing deficiency (e.g., mental health, custody). The IOP also requires additional staffing so that treatment groups can be targeted to the population and maintained at appropriate sizes for clinical groups (e.g., 8-10 patient maximum). While changes to the medical record should help streamline services and increase the efficiency of providers, record review during this round indicated that most detainees continue to be seen primarily cell front or in another non-confidential area. This remained true for the acute program and was especially true for patients in segregation.

The findings of the feasibility study are also critically important to note here. Nacht & Lewis note that the Main Jail was already overcrowded in the 1990s creating challenges with operations, staffing, and safety. They note that the MJ is difficult to manage and creates numerous operational and safety issues. Those operational and safety challenges have been repeatedly documented by mental health staff in the medical record to negatively impact access: examples include treatment groups canceled due to insufficient custody staffing, individual contacts held cellside because of "behavioral" issues or lack of custody staffing, mental health staff unable to go to cell of patients due to lack of custody staff. More staff are required to safely and effectively operate all necessary elements of jail operations than the MJ can accommodate. This is consistent with the SMEs observations.

As of August 1, 2022, JPS reported the following vacancies (please see Appendix F)[18]:

1. Existing Positions at MJ: 1.0 MA for the acute psychiatric unit and 3, 2.0 Outpatient LCSW vacancies with a functional vacancy rate[19] of .15, and 1.0 Outpatient Supervisor vacancy with a functional vacancy rate of .5.
2. Existing Positions at RCCC: 1.0 Outpatient LCSW vacancies with a functional vacancy rate of .33, 5.0 EOP MSW with a functional vacancy rate of .53, and 0 EOP LCSW vacancies but a functional vacancy rate of 2.0.

[18] Defendants reported that some of the staffing data was inaccurate following the draft of this report, but it was the only data provided. It will be updated during the next monitoring report when staffing data is provided.

[19] Functional vacancy rates are based on the utilization of contract, registry, double appointment of staff, and other human resource processes that may allow for coverage of positions when FTEs are not available.

3. The RCCC JBCT program[20]: 1.0 psychologist with functional vacancy of .33, .65 Psychiatrist though functional vacancy was reported as 0.
4. At the time of data production, few of the newly allocated positions were filled as they had only been allocated at the beginning of the fiscal year.

Despite this staffing expansion, record review indicated that the acute psychiatric program was still frequently canceling treatment groups and had not adequately expanded treatment delivery to this acutely ill population even as late as the end of 2022. Patients continued to spend the majority of time isolated in their cells, did not receive daily contacts with a psychologist or psychiatrist as required by California Code of Regulations, Title 22 for acute psychiatric facilities, and did not consistently receive confidential necessary treatment beyond medication management[21]. The service expansion does not fully address the critical services not being provided in acute care (e.g., confidential individual contacts) nor were psychologists added to that package despite complex cases requiring services by a psychologist and psychiatrist and the treatment standard of daily confidential contacts by specific mental health staff. Required treatment team meetings had not been fully implemented and there was no estimate of appropriate staffing needed to implement this part of the Consent Decree. When treatment plans were completed, they were done on an individual provider basis without documented input from the entire treatment team. Treatment for people in acute psychiatric distress continued to be primarily isolation and medication management in the acute unit at the MJ.

While Defendants have promised a staffing analysis, there needs to be recognition by All Parties that space will impact staffing needs and that staffing will evolve as Defendants are able to improve the physical plant and available space. This analysis must start with the requirements of the Consent Decree at each level of care as well as other tasks required of providers (e.g., disciplinary assessments, crisis response, clinical supervision) and determine how many staff of what classification will be necessary for successful implementation. As stated earlier, a system in crisis will have evolving bed and staffing needs as the system improves and becomes more functional, providing consistent increased ongoing treatment and reducing the need for crisis response (though not eliminating it). It is not uncommon for systems with such foundational issues to operate more on crisis or "put out fires" status until those issues are addressed. It would be expected that Defendants' staffing needs will evolve as the system improves.

[20] This data is included because vacancies in the JBCT will require other staff to cover and provide some form of monitoring and treatment to those patients. It is noted that Defendants report that no non-JBCT mental health staff were used to cover JBCT vacancies. The information reported here for JBCT was not used to determine compliance but will be confirmed during the next review period.

[21] Defendants noted in response to this report that psychiatrists were expected to complete daily rounds but those were not always found to be documented in the medical records reviewed.

Until that time, existing staff need to be used in a strategic manner to maximize the amount of direct service available with current staffing levels. The Defendants have discussed this possibility amidst all parties and have extended mental health treatment hours and group schedule to increase the availability of mental health treatment. While the change was reported as in process (due to requirements for notification, union meet and confer sessions, and other formal processes before it can be implemented), the schedule had been modified at least partially by the April 2022 site visit. This was a particularly positive development since recent tours demonstrated that many staff were unable to provide direct service because they were all on site at the same time and there was insufficient therapeutic space and escorting staff to allow those clinicians to be utilized effectively. When a program is as troubled and non-compliant with a Consent Decree as this, it is imperative that when staff are on site, they are able to see patients and provide care. This was a greater challenge at MJ than at RCCC, but it existed at both facilities. Later record reviews noted that patients in the IOP were scheduled for multiple treatment groups per day though those groups were not always offered or cut short due to other obstacles (e.g., custody staffing, limited program due to security).

JPS provides the bulk of its clinical activities almost exclusively by social workers (LCSW, MSW, SWI[22]) without recognition that some services are suitable for delivery by social workers while other treatment requires psychologists due to education, training, and licensure scope of practice. In addition, there are a large number of unlicensed social workers on staff and the majority of those unlicensed providers are tasked with care for higher acuity, more challenging IOP patients. This was concerning though unlicensed social workers indicated that they received their required supervision. Future document requests shall request proof of practice in this area. There is significant workload on the few licensed social workers required to provide this supervision in addition to their other duties. While during the last monitoring report it was noted that it was not clear from the medical records that detainees were being informed of their provider's licensure status, this had begun to improve in late 2022 with at least two providers documenting such in progress notes. Unfortunately, one of those providers was known to be licensed so it did not seem that unlicensed staff had adequately been fulfilling that Board of Behavioral Science requirement. It would be helpful for providers to have a specific form in the EHR that provides the notification documentation for patients and documents that it has been provided. Then providers would only have to document one time for each patient and this could be more easily monitored by supervisors, addressed in EHR reports, and quality improvement audits.

An area of improvement of staffing noted for Defendants included the return of certain management staff (though not to a full-time position) who were more familiar with the Consent Decree, program requirements and needs, and were more

[22] Licensed clinical social worker, Master's of Social Work (unlicensed), social work intern (unlicensed and lack of final SW degree).

experienced managers in providing treatment and managing staff. JPS maintained two experienced managers and established two additional supervisory positions that they filled with equally skilled and experienced supervisors. While there was a recommendation made during the SMHM report for JPS staff to become more familiar with the Consent Decree, that had been achieved during this monitoring round with the existing supervisors and managers. That recommendation has been removed and is seen as completed.

It is important to note the significant impact that custody staffing has had on the provision of care. While staff most often cited the lack of availability of confidential space, interviews during the site visit revealed that both group and individual contacts were regularly impacted by insufficient staffing or staff illness. It is possible that confidential space may not always be available because there were not sufficient custody staff to take the patient to the space. Insufficient staffing has also resulted in program shutdowns and canceled treatment based on provided data and record reviews. "Program shutdowns" or "limited programs" are a directive for the entire watch most commonly that does not typically allow the case-by-case determinations to be made regarding access. There were also times when clinicians would document that patients were seen cell side because of custody preference or custody concerns related to the "behavior" of the patient. This appeared particularly common in segregation (e.g., Cases 39-42, 6, and 7) but did not only occur there (e.g., Case 5). While people often end up in segregation due to their behavior, that behavior may have been a result of un- or under-treated mental illness or an intellectual disability. During those times when mental health documentation noted custody concerns, the documentation frequently did not support that the patient was uncontrollable, excessively agitated or some other behavioral risk. It is possible that this was due to poor documentation by the clinicians, but it seemed more likely that the custodial culture, particularly in segregation, does not support clinically adequate assessment and treatment. This was also mentioned in the Executive Summary of the Medical SMEs Third Monitoring report. For mental health staff, it is expected that a decision to see someone non-confidentially will be based on a documented assessment of the patient's current behavior and clinical rationale for seeing the patient at the cell front. There may be times when the patient is seen cell front for a "check" but the confidential visit is rescheduled. Should that be a component of the clinician's rationale and plan, it should be clearly articulated in the progress note. This documentation should also clearly include any lack of availability of the attorney booth or other appropriate confidential space and/or insufficient custody staff.

<u>Recommendations</u>

1. The requirements of each level of care in the Consent Decree should be identified so that mental health management can calculate the number of services hours required for the capacity that each level of care currently requires. If there is insufficient space allocated to mental health to meet

those requirements, mental health must calculate what the maximum number of patients at each level of care can be treated in accordance with the Consent Decree and these treatment program maximums should be reported to All Parties. If there is insufficient space or treatment providers, JPS must clearly specify what they need to meet the requirements for service and provide this to All Parties.

2. JPS and ACH should analyze the number of unlicensed providers and the supervision workload on licensed providers. Documentation of supervision of each unlicensed provider should be reviewed to determine if licensing regulations are being met. While analyzing the number of staff needed to implement the Consent Decree, the licensure status of the staff should be included in the analysis. These audits and analyses should be provided to All Parties as part of the staffing analyses requirements. It is possible that some of the problems with treatment implementation, treatment planning, and assessment were the result of insufficient clinical supervision of unlicensed hires.
3. Utilize staffing analysis to evaluate existing staffing plans and caseloads to determine what an appropriate caseload would be at each level of care. Establishing maximum caseload expectations allows for Defendants to develop ratio-based staffing. Ratio-based staffing is beneficial as it demonstrates increased staffing need with population increases and provides specificity for each level of care. It also allows for decreased staffing as the patient population decreases.
4. Policy and training directed at custody staff to prevent interference in patient's access to care and expectations regarding confidential clinical contacts.
    a. Policy and training for mental health staff that if they cannot see the patient confidentially, that contact should be rescheduled when clinically possible (e.g., patient 3). For example, there were numerous examples where patients held in segregation did not receive a follow-up attempt at confidential contact. It appeared that it was regular practice to see patients cell side in segregation (and the acute inpatient unit for reasons exhaustively stated above) whereas it occurred in other programs on occasion but did not appear to be regular practice. This was particularly true for segregation reviews. Since the purpose of those reviews are to note decompensation and the need to move a patient, tier/cell front contacts are insufficient and must be rescheduled prior to the next required review.

C. Use of Force/Disciplinary actions involving detainees with SMI and/or intellectual disabilities.

This focus area remains primarily non-compliant though progress was noted Specifically, mental health/JPS made progress during the monitoring period through

policy and training development. JPS completed mental health policy for clinical intervention prior to a UOF with people with mental illness or an intellectual disability. JPS also developed a documentation form for the EHR to document clinical intervention, and PowerPoint training to all clinicians related to Uses of Force. This was approved by All parties and to have been implemented in early 2023. Proof of practice shall be reviewed in the next monitoring period. JPS also provided a UOF training for the acute unit for Involuntary Medication Orders[23]. Despite the progresses of mental health, there has not been similar progress in related policy for custody staff to include de-escalation training for all staff. In addition, while it may be practice to contact JPS at the MJ, that practice only occurs at RCCC when mental health staff are "available." These are significant elements of compliance with the Consent Decree for a high risk, high liability area that require focus and implementation by Defendants in 2023.

It should be noted that data and incident packages were requested for UOF with patients with SMI. The County did not provide any such data that this SME could find in documentation. While it was mentioned earlier that data was not provided as requested, one element that made it more difficult to locate items was errors in folder labeling. For example, the Use of Force was Section 28 but Defendants did not label folders by the section or in keeping with the document request.

The Defendants must have policy for all disciplines including (and especially) custody or facility policy that dictates compliance with the Consent Decree regarding UOF on people with mental illness and/or intellectual disabilities. As part of this process, policies on restraints are being reviewed and revised. The issue of use of force goes beyond the use of restraints, whether custodial or clinical. When working with detainees who may have difficulty following direct orders due to their mental illness or intellectual disability, a different process that incorporates understanding the individual and strives to avoid a use of force is necessary. The Court is reminded that the Medical SMEs noted in their Second Monitoring draft report (p. 8) that custody had contemplated a use of force without utilizing clinical intervention and de-escalation (see Medical SMEs Second Round draft report, p. 8). This underscores the importance of a comprehensive and adequate policy. Utilization of the WRAP restraint system and clinical de-escalation will be addressed through the SMEs review of the use of force policy and concerns regarding the lack of mental health staff involvement in de-escalation of caseload patients.

The same is true for disciplinary actions. These are closely tied to placement in segregation despite the acknowledged harm that can come to the mentally ill in an isolated setting. The current consultation that should occur requires a standardized

[23] It should be noted that while the training was viewed as progress, the use of OC spray was not prohibited despite the acute inpatient unit (2P) not being physically designed in a manner that would prevent harm to others. The training did require acute nursing staff to clear all patients present and appeared to acknowledge the problem with the use of OC in an acute inpatient psychiatric or medical unit.

format across mental health providers and hearing officers so that it is applied fairly across groups of detainees. Defendants did provide a mental health tracking log, but that log did not include the critical element of disposition. Consequently, while clinicians often found a nexus between the patient's mental illness and/or intellectual disability, the outcome of the disciplinary hearing or disposition was unknown, including whether and how mental health input was considered and applied in reaching the disposition. It is recommended that custody staff provide disciplinary disposition outcomes where there has been a mental health assessment to identified mental health supervisory or clerical staff to complete the tracking log. In addition, that information should be noted in the medical record to provide to the clinician for any clinically-indicated follow-up.

These are critical areas in the safe and humane housing of detainees. A person's mental illness or intellectual disability may result in staff misunderstanding the detainee or the detainee failing to understand staff. That can escalate to a formal disciplinary write-up which can then cause the detainee to be moved to restricted housing and interrupt the person's treatment. It may also escalate to a use of force that could have been prevented with proper training and communication between custody and mental health staff. Defendants must prioritize compliance with this area in 2023.

D. Treatment

Treatment expectations have been established through the Consent Decree. Progress that occurred during the monitoring round was development of MH policies that codified for staff the expectations regarding compliance with treatment requirements.

Group treatment was observed during the site visit and the quality had improved overall from the prior visit. Facilitators continued to know their patient population and made efforts to engage all patients. Treatment groups continued to be larger than clinically indicated, but that was discussed with management during the site visit with a compromise of a maximum treatment group size of ten. This does not include recreational or yard groups where the group size may be larger so long as it can be effectively managed by the mental health facilitator(s) assigned. There remained no clinical assignment of patients to groups as evidenced by patient interviews and medical record review. There were times that patients were observed to want to participate and be unable to do so because of group size, but that was expected to improve and will be monitored during the next review period.

An audit completed in March of clinical contacts confirmed that the majority occurred in a non-confidential setting and that reasons for that were not always documented. It should be noted that record reviews completed by the mental health expert confirmed that this continued throughout 2022 and identified some reasons

provided for non-confidential contacts were questionable. For example, a number of contacts were documented to have been non-confidential due to COVID-19 quarantine which should have still allowed the detainee to be seen privately. Others stated that custody would not let the detainee out of cell or some other reason. Defendants have suggested a drop-down menu to ensure standardization for reasons for non-confidential contacts. This would be an improvement to allow for follow-up with custody as to why they did not allow a confidential clinical contact.

REMAINING ISSUES: CONSENT DECREE REQUIREMENTS AND FINDINGS

GENERAL PROVISIONS (Section II of Remedial Plan)
Staffing. The County shall maintain sufficient medical, ***mental health***[24]*, and custody staff to meet the requirements of this Remedial Plan (II.A.).*

- *The parties agree that the custodial and health care staff must be increased to meet minimal constitutional and statutory standards. Presently, there are insufficient deputies to supervise out-of-cell activities for people in the general population and administrative segregation, and to provide security for health-related tasks. The parties agree that reduction in jail population is* one *cost-effective* method *to achieve constitutional and statutory standards. (II.B)*
- *The County intends to hire additional custodial and health care staff. The parties agree that population reduction of the jails will facilitate compliance with this Remedial Plan. All population reduction measures should be designed to promote public safety through evidence-based programs.(II.B.1)*
- *If through the monitoring process it is determined that the County is not fulfilling the provisions of this Remedial Plan due to staffing deficiencies, the parties will meet and confer regarding what steps to take to reduce the population of the jail, including available resources to facilitate population reduction. (II.B.2)*

FINDING/DISCUSSION:
Partially-compliant. (II.A) Staffing was found to be partially compliant due to Defendants' efforts to comply with Consent Decree requirements through increased allocations of mental health positions. Staffing allocations still did not appear sufficient as treatment services in the second half of 2022 remained problematic due at least in part to staffing. Concerns were clearly outlined in the Focus Area of staffing. Based on the 2022-2023 budgeted mental health positions provided by ACH, the agency tasked with managing the contract with UC Davis for the services provided in the jail by JPS, the additional positions listed below have been added. These have been primarily to expand the ability to comply with adequate mental health assessments as part of the disciplinary process. Positions were also added to provide increased treatment to patients in acute psychiatric treatment and to allow for constant observation of patients on suicide

[24] Emphasis is the author's and meant to identify this expert's area of responsibility for this report.

precautions. The following positions have been added (please see Appendix E and F for greater detail on staffing allocations and vacancies:

FY 22-23 Staffing Increases/Allocations

STAFF/DISCIPLINE	ALLOCATION (in FTEs)[25]
LCSW Supervisor	2.0
LCSW	8.0
SWI (a job classification for those with a Master's of Social Work)	5.0
MH worker	16.0

Similar to the previous monitoring round, it appeared that staffing was not seen to be as critical a limiting factor by mental health staff as space. However, despite improvements in mental health services, staff were still not yet expected to perform at Consent Decree standards in *all* treatment areas. This was verified through record reviews that elements of the Consent Decree had not been initiated in multiple areas (e.g., MDTs in outpatient, full MDTs in the acute psychiatric program. In addition, JPS managers need to complete a basic staffing analysis and provide that to this author and All Parties. This analysis would be completed by calculating the treatment hours for the Consent Decree and assessing necessary staffing sufficiency in that context. Therefore, it remains uncertain as to whether staffing is sufficient to meet the Consent Decree requirements. Based on compliance reviews utilizing medical records, staffing is not yet adequate though that is impacted by physical plant concerns particularly at the MJ. As mentioned in the focused area discussion of staffing, it was also not fully clear how the large number of unlicensed staff and requirements for supervision may impact availability of licensed staff for service delivery. It should be noted that not only may the additional LCSW positions be filled by unlicensed staff, but obviously the SWIs would require extensive clinical supervision and training time provided by appropriately licensed staff.

One area ripe for reconsideration of staffing allocation has been brought up repeatedly including in prior monitoring reports and involves JPS using recreational therapists or similar to provide out of cell therapeutic activities that are not primarily clinical. Recreational therapy is an important component of treatment, but social workers are not trained in the provision of recreational therapy (RT). This would allow social workers and psychologists to focus on clinical groups while still ensuring compliance with the Consent Decree regarding the provision of structured out of cell therapeutic activity. Based on the current fiscal year increased staffing allocations, there is a willingness to hire "mental health workers." While it would be unlikely that those individuals would have been trained in the individualized assessment and provision of recreational therapy, it may be possible to

[25] FTE is utilized for full-time equivalent.

utilize this classification with additional training to facilitate some RT groups as an interim solution.

Finally, while this expert has focused primarily on mental health staffing, custody staffing must undergo the same analysis (positions needed for compliance with the Consent Decree in addition to all posts and duties). That information should be provided to All Parties so that the staffing gap in allocations would be known. While there have been improvements in trying to recruit and retain custody staff, additional efforts are needed as the EHR documents that the lack of staffing interferes with access to treatment, leaving people to suffer in their cells. Based on provided data, between January and March 2022, 103 total IOP treatment groups were canceled due to a custody-related reason (insufficient staffing or facility lockdown) at the MJ. There were just 25 IOP custody-related cancellations for January through April 2022, though 20 of those cancellations were due to "floor safety concern." The overall number of groups scheduled during these time periods at each facility was unknown and did not allow for a calculation of the percentage of treatment canceled due to custody factors, though the impact remained significant.

Recommendations:

1. The County should continue to analyze mental health staffing allocation so that services can continue to be expanded in accordance with the Consent Decree. As mentioned in staffing, ACH and JPS have reviewed and plan to extend the offering of therapeutic activities into the evening hours and weekends. This was at least partially implemented during the monitoring round and clearly extended access to services. There was evidence of patients being seen for risk assessments in particular during extended hours.
2. The County should complete a jail workforce/staffing analysis as well to know the number of allocated positions across areas and job class (e.g., deputy, sergeant) necessary to fulfill the expectations of the Consent Decree and facilitate access to care. These findings should be provided to All Parties.
3. Defendants have been directed by the Remedial Plan to begin tracking out of cell and therapeutic activity in a meaningful way (e.g., by patient average per week, by program average per week, refusal averages). Based on the data provided, tracking has started but needs to be refined to be meaningful. Data tracked should include activities scheduled (structured and unstructured) and offered as well as appointment completion with reasons for non-completion. This provides useful information to All Parties about the amount of activity being scheduled, how that may differ from what has actually been offered, and what impacts the lack of access (not offered).
    a. It would be helpful for that data to be monitored monthly by managers to identify trends and patterns. The data would be reported to the Quality Management Committee on a monthly or quarterly basis and focused improvement teams could be created to address any access obstacles.
    b. Being able to meaningfully and accurately track scheduled and completed contacts and therapeutic groups (structured therapeutic activity) and

unstructured therapeutic activity (yard, recreational time) daily and weekly by patient will be critical in demonstrating improvement in providing treatment in specific programs and compliance with the Remedial Plan (e.g. section D.6). Providing raw data by patient by group by day is not a meaningful report as there is little one can do to analyze the data and draw conclusions. The data must be analyzed and presented in reports that include data averaged by patient and program for specific periods (e.g., weekly, monthly, monitoring period) to provide context and a meaningful report. By identifying reasons for cancellation, Defendants can better identify space and staffing needs.

4. Proof of practice will be requested in future document requests to demonstrate Defendants' reported compliance with clinical supervision of unlicensed mental health staff. Utilization of unlicensed staff requires close supervision to ensure that they provide adequate assessment and treatment services that are consistent with the standard of care and Consent Decree[26].
    a. All Parties should consider a brief meeting prior to the next site visit and monitoring report to discuss this matter as it may be an easy process to ensure that All Parties, including the SME, understand the current process.

PRISONERS WITH INTELLECTUAL DISABILITIES

Per the Remedial Plan in the Consent Decree: The County shall, in consultation with Plaintiffs' counsel, develop and implement a comprehensive written policy and procedure regarding prisoners with an Intellectual Disability, including:(Section III.O.1)

a) Screening for Intellectual Disabilities; (III.O.1.a)
b) Identification of prisoners' adaptive support needs and adaptive functioning deficits; (III.O.1.b) and
c) *Monitoring, management, and accommodations for prisoners with Intellectual Disabilities.(III.O.1.c)*

FINDING/DISCUSSION:

Partially Compliant (III.O.l.a-b) and **Noncompliant** (III.O.1.c)

Defendants were found partially compliant because of the numerous efforts on the part of mental health/JPS. JPS developed and provided (MJ and RCCC) an extensive training on brain development. In addition, they developed a training for effective communication with people who meet criteria for the Americans' with Disabilities Act (ADA) This training included identifying patients' needs for accommodation and/or support as well as coordination with custody so that those services are provided and access is not limited. There was a form for an adaptive support survey though medical records did not support documentation

[26] Plaintiffs' attorneys have also indicated that they would like a better understanding of this process. l

of use of the survey[27]. A policy had been approved and training provided based on Defendants' proof of practice. The percentage of compliance by discipline/employee was not provided and could not be completed from the information provided.

Based upon review of medical records, intake mental health assessments were occurring more timely than during the prior monitoring period. However, these assessments were still occurring in a non-confidential setting. It's unclear why they were not conducted in the attorney booth. In addition, while mental health documentation referenced effective communication and patient understanding, there was no evidence of a standardized process or procedure for identifying individuals who required screening and further assessment. In fact, even when mental health staff noted that effective communication was indicated for the patient and that they needed help communicating, there was no alert or problem identified for the patient. There was also little to no evidence to support identifying the person (or not) as intellectually disabled or need for adaptive supports (e.g., cases 16, 22, 23). In fact, mental health documentation was not always consistent in identifying the need for assistance in communication or need for effective communication.

Tracking specific patients who had intellectual disabilities and the need for adaptive supports remained problematic as the Sheriff's Department did not yet have a system. Therefore, the monitoring, management and accommodation (III.O.1.c) for people with intellectual disabilities remained noncompliant. Defendants reported ATIMS would track patients, their needs, and whether they'd received any ADA-related appliances or other supports but that would not be in effect until at least some time this year (2023)[28].

Recommendations:

1. Defendants should monitor compliance with the current policy for screening and assessing intellectual and developmental disabilities and provide proof of practice as part of subsequent document requests. Implementation of the policy will be reviewed as part of the next monitoring report.

- Another aspect of the Remedial Plan requires *a multidisciplinary team that includes appropriate health care staff will monitor and ensure appropriate care for prisoners with an Intellectual Disability. The multidisciplinary team will develop an individualized plan for each prisoner with an Intellectual Disability, which addresses: (1) safety, vulnerability, and victimization concerns, (2) adaptive support needs, (3) programming, housing, and accommodation needs.*

[27] The form was reportedly scanned into the medical record. In lieu of any CQI audits of this area, Defendants may be asked in subsequent document requests to provide the procedure for scanning to assist the SME in locating such scanned forms when present. Scanned forms were reviewed as part of the medical record review, but these forms were not located.

[28] JPS/Mental health specifically reported following the draft TMHM report that they tracked patients, so this information will be included in future document requests.

The multidisciplinary team's (MDT) *plan will be regularly reviewed and updated as needed. (III.O.2)*

2a. **Non-Compliant**. JPS acknowledged during the site visit that MDT meetings were still not fully implemented at all levels of care and for all detainees with mental illness and/or intellectual disabilities. No evidence of such an MDT specific to detainees with an Intellectual Disability and associated treatment plan was identified in the records reviewed.

- *Prisoners with an Intellectual Disability assigned to a work/industry position will be provided additional supervision and training as necessary to help them meet the requirements of the assignment.*

3a. **Not Assessed**. No documentation of this was found in documents provided as part of the document request nor in medical records reviewed. However, Defendants' acknowledgement that they do not yet have an adequate identification, tracking, and monitoring system increases the likelihood that this item has not been accomplished. The tracking system would be a basic requirement to achieve this item.

MENTAL HEALTH CARE

Policies and Procedures

The Remedial Plan states that *the County shall establish policies and procedures that are consistent with the provisions of this Remedial Plan and include the following:(IV.A) (below are sections IV.A.a-h)*

1. *A written document reflecting the complete spectrum ofmental healthcare programming and services provided to prisoners;*
2. *Minimum and maximum timeframes for when each type of mental healthcare service will be completed, including but not limited to laboratory tracking and psychiatry follow-up services, in accordance with prevailing community and professional standards;*
3. *An intake and referral triage system to ensure timely and effective resolution of inmate requests and staff referrals for mental healthcare;*
4. *Specific credentialing requirements for the delivery of mental healthcare services, including but not limited to only qualified mental health professionals may make critical treatment decisions.*
5. *Clinical monitoring of inmates, including but not limited to those who are involuntarily medicated, clinically restrained or secluded, segregated, or on suicide watch;*
6. *Descriptions of specialized mental health programming that specifically identify admitting and discharge criteria and the staff members who have the authority to place inmates in specialized mental health housing;*
7. *Procedures for involuntary medications and other appropriate measures for the management of inmates with serious mental illness who lack the capacity to give informed consent, in accordance with relevant state law;*

8. *Training for all staff members who are working with inmates with mental illness in all aspects of their respective duty assignments.*

FINDING/DISCUSSION:

Partial compliance.(IV.A.1) The County continues to work with its vendors to revise and develop relevant mental health policies. These policies, as updated, are provided to plaintiffs' counsel and the SMEs for review. The SME reviews policies as possible and based on a prioritization worked out with the Defendants. Defendants have been quite responsive in assisting the SME to identify prioritized items and review them timely. Despite this, numerous policies are awaiting **this SME's** review. It is expected that currently outstanding policies will be reviewed in the next quarter.

1. Written document of mental health programming. Detainees continued to report during the April 2022 site visit that they had received various orientation documents that addressed the range of mental health services available. This was also true for detainees interviewed in segregation and those individuals could often show the document to this expert. This document was also provided to this SME by the Defendants. Of detainees interviewed, they did not recall receiving the document while at intake though those with more recent admissions could recall being told by the clinician of some of the information contained in the document if they had an initial intake mental health assessment.
   1a) **Recommendations:** Audits are necessary to support that these documents are disseminated at intake as required for new arrivals.
2. Referral timeframes. Detainees reported that they were not seen timely by their social worker or psychiatrist and often had to submit multiple health services requests (HSRs). This was supported by record review for HSRs though intake referral timeliness had improved since the last review period. Referrals were often completed the day of or within several days for initial arrival assessments. The patient may not be seen by a psychiatric provider, but the medical record would be reviewed for medication verification within a short time of arrival, though not always the day of arrival potentially resulting in missed psychiatric medication doses. Based on the medical record review, the record would be reviewed within the required 48-hour timeframe. The referral process for HSRs seemed to lag at times based on record review. Consistent with policy, the referrals were first reviewed by nursing and then submitted to mental health. Mental health would document the HSR and order a contact but the prioritization of the order was not always clear. If it was emergent, it appeared that mental health staff did try to document the request/order as a "must see" to comply with emergent timelines. Unfortunately, the HSR may have been submitted several days before it was identified as an emergent referral.
   2b) **Partially compliant**. JPS has established timeframes for referrals for various mental health services, developed policy and implemented that policy. While emergent referral continue to require the patient be seen

within six hours rather than the more common standard of every four hours, it was not clear when that clock started. It appeared that it did not start until mental health received the referral and while sometimes this would occur within several hours (usually referrals by custody or nursing), it could also be several days following submission of a HSR before the clock started. This may result in patients submitting emergent referrals (e.g., suicidality, serious medication side effects, acute decompensation) who are not seen prior to a negative outcome that could have been prevented. While All Parties approved this policy, the medical SMEs and this SME have discussed the referral process which functions in a manner that was inconsistent with our interpretation of policy. This was highlighted in the Third Medical Monitoring Report and may require additional clarification between All Parties and all SMEs via remote meeting.

The Third Medical Monitoring Report highlighted flaws in the HSR and referral process including that HSRs were not timely collected, timely triaged, and patients timely seen.[29] This impacts mental health significantly because it builds delays and obstacles to timely access into the system. Mental health must timely receive referrals and HSRs, timely triage and prioritize those referrals, and order contacts that may fall into the timelines of emergent, urgent, and routine. While HSRs were not always found in the medical records, mental health staff did typically indicate when the HSR had been received and patient seen.

2b) **Recommendations:** It is recommended that supervision of the entire process be overseen by an ACH supervisor/manager. ACH has responsibility for the front end of HSRs and initiate multiple mental health referrals. ACH is also responsible for the contract vendor, JPS. The bifurcation of this process currently creates unnecessary obstacles to compliance with Consent Decree requirements. While audits have reportedly been completed based on Defendants' Fifth Status Report, the specific findings were not provided.

Additional audits should be completed for the referral and HSR process for mental health and shared with All Parties. These audits should be provided as part of the next mental health document request for proof of practice and completed audits. Summaries of methodology and findings should be attached to or included with provided audits consistent with the document request.

3-7) **partial compliance**. (IV.A.c-g) The County and/or its vendor, JPS, did have policies to address most of these areas. There remained problems with provision of proof of practice. The intake referral system had improved since the last round significantly for timely referrals to mental health clinicians for initial intake assessments based on record review.

[29] p. 11, Medical Monitoring 3rd Report.

This was not true for initial appointments with psychiatric providers[30] though they did complete medication verification through chart review. It was important that patients have their medications verified and continued timely but that they also be seen by psychiatric providers timely. Concerns have already been discussed regarding unlicensed staff in the staffing sections of this report and apply to the credentialing process. The ongoing monitoring of patients was limited in part by staffing. For example, acute psychiatric patients were commonly not seen by a provider on weekends or one day of the weekend (e.g., cases 24, 31). While Defendants have established policy that establishes levels of care and criteria, staff must utilize terms consistent with that policy. Audits in this area are recommended as well.

8) **partial compliance**. (IV.A.h) There were numerous training curricula provided for the 2022 training period. Compliance data for training was not provided in the format requested and likely not available in that format to Defendants. A tracking system for required training should be established so that it allows summary reports of attendance compliance by discipline/job class.

8.a) **Recommendations.** Continue maintaining data previously provided in the SMHM report that included attendance and compliance rates (i.e., training compliance should include data on 1) required training, 2) required attendees, and 3) percent compliance).

b. As with the last monitoring report, All Parties should meet and confer to clarify which training satisfies which requirements. Plaintiffs have suggested that Defendants clarify their understanding via a chart which can be used by Plaintiffs and the SMEs to ensure agreement. Once that has been established, training records should include required training (including required attendees and percent compliance based on actual attendees [numerator] divided by required attendees [denominator]) and any training that Defendants provide in addition to the required modules.

The County's policies and procedures shall be revised, as necessary, to reflect all of the remedial measures described in this Remedial Plan.(IV.A.2)

FINDING/DISCUSSION:

Partial Compliance (IV.A.2)**.** As mentioned above and described in the County's Fifth Status Report, the County has been in the process of revising its policies to reflect the Consent Decree. While progress has been plenty, while there remain multiple parties who must complete policies, progress has not been consistent across all Defendants. JPS has completed significant relevant policies so that the finding is partial compliance. As the Sheriff's Department continues to focus on policy development and implementation, it is expected that compliance with the Consent

[30] This term includes psychiatrists and psychiatric nurse practitioners (PNP).

Decree will improve.

The County shall continue to operate its acute inpatient program and its Outpatient Psychiatric Pod (OPP) program. The County shall establish a new Intensive Outpatient Program (IOP) for inmates who require a higher level of outpatient psychiatric care than what is provided in the OPP program. (IV.A.3)
FINDING/DISCUSSION:
Partially Compliant. (IV.A.3) This item is complicated by the significant concerns regarding the actual treatment provided to the patients in the 2P APU and IOP as well as the extensive wait lists for its unit-based treatment programs (e.g., inpatient, IOP, and EOP). The acute psychiatric program continued to isolate patients and function much like a restricted housing unit in many of its operations. Because of this, the County has been strongly encouraged to investigate other avenues there may be within County services, including an off-site acute mental health care unit, that would provide an appropriately therapeutic acute care program for this high-needs population. It should also be highlighted that the County maintains a lengthy waitlist for all of its mental health programs (see Appendix C). Defendants should continue to comply with the Memorandum of Agreement and its requirement to assess and meet the need for IOP across patient populations (e.g., women, LGBTQ+, high security). This would be another area where direction to meet and confer with All Parties and SMEs should occur prior to subsequent monitoring reports.

The County shall operate its non-acute mental health programs – IOP, OPP, and General Population-Mental Health – consistent with the JPS Psychiatric Services overview. (IV.A.4)
FINDING/DISCUSSION:
Non-compliant. (IV.A.4) Space limitations continue to impact the ability to provide confidential treatment services consistent with the JPS Psychiatric Services overview and Consent Decree. Improvement was noted in additional treatment groups offered, increased mental health staff availability and extended hours, and additional confidential treatment space. There was better documentation regarding utilization of confidential/nonconfidential space as mental health management staff reiterated to clinical staff the areas considered confidential and the need to utilize confidential space. While there were services being provided, there was not proof of practice that minimum requirements for ongoing confidential treatment services were being met.

While the SME noted improvement in many areas of mental health, the majority of contacts still occurred in non-confidential space based on this author's record review. At times non-confidential space was classified mistakenly as confidential, but this finding occurred far less frequently than during the 2nd monitoring period. At other times patients were seen cellside and a subsequent confidential appointment was not scheduled, even when the contact occurred because of staff or space limitations. Because clinical contacts including segregation reviews cannot be completed cellside, those contacts do not substitute for appropriate clinical contacts and mental health assessments. Even when a patient repeatedly refuses

confidential contact, the patient should be rescheduled and offered confidential contact with a modification to the treatment plan and updated MDT meeting if it continues. JPS staff continued to be forced to provide confidential mental health services in non-confidential settings because the physical plant at the MJ and RCCC provide them with limited to no options in order to meet the expectations for daily individual and group treatment contact. At RCCC this was primarily due to limited group treatment space while at the MJ it was due to both limited individual and group treatment space. In addition, the ability to provide expected treatment was further impacted by the immense need for service as illustrated by the waitlists for those services: 21 waiting for acute inpatient treatment (10/24/22) and 95 awaiting transfer to a State Hospital (data as of 5/3/22).[31]

Recommendations: [Please refer to Space and Staffing sections in Areas of Focus as these areas address foundational needs at the MJ and RCCC that must be resolved before JPS can provide treatment consistent with their Psychiatric Services overview and updated policies]

MENTAL HEALTH CARE

Organizational Structure (IV.B)

1. *The County shall develop and implement a comprehensive organizational chart that includes the Sheriff's Department ("Department"), Correctional Health Services ("CHS"), Jail Psychiatric Services ("JPS"), Chief Administrative Officer, Medical Director of the JPS Program, and any other mental health staff, and clearly defines the scope of services, chains of authority, performance expectations, and consequences for deficiencies in the delivery of mental health care services. (Section IV.B.1)*
2. *A Medical Director of Jail Psychiatric Services shall be designated and shall oversee all mental health care functions in the jails, including psychiatric prescribers and psychiatric nurses. The Director shall possess clinical experience and a doctoral degree. (IV.B.2)*
3. *The Medical Director of Jail Psychiatric Services shall participate in jail executive leadership and shall be responsible for overseeing program development, clinical practice, and policy, as well as interfacing with jail and medical leadership and community mental health. (IV.B.3)*

FINDING/DISCUSSION:

Partially Compliant. (IV.B.1-3) While organizational charts continued to outline reporting structures, they were not integrated. The way the different entities (i.e., Sacramento County Sheriff's Department, ACH, and JPS) worked together and resolved matters across entities on a formal basis was identified. Informal resolution of matters across staff was far less clear. During the site visit, staff across agencies

[31] Updated waitlists were not received for the IOP and JBCT.

reported good working relationships. The contract monitor appointed to JPS continued to be a positive improvement in identifying lines of communication and responsibility.

Recommendations: Continued assessment of this area by experts in future monitoring of the Consent Decree.

MENTAL HEALTH CARE

Patient Privacy (IV.C)

All[32] *clinical interactions shall be private and confidential absent a specific, current risk that necessitates the presence of custody staff. In making such determination, custody and clinical staff shall confer and review individual case factors, including the patient's current behavior and functioning and any other security concerns necessary to ensure the safety of medical staff. Such determinations shall not be based on housing placement or custodial classification.(IV.C.1)*

1. *For any determination that a clinical interaction with a patient requires the presence of custody staff, staff shall document the specific reasons for the determination. Such decisions shall be reviewed through the Quality Assurance process. (IV.C.1.a)*
2. *If the presence of custody staff is determined to be necessary to ensure the safety of medical staff for any clinical counter, steps shall be taken to ensure auditory privacy of the encounter.(IV.C.1.b)*
3. *The County's patient privacy policies, as described in this section, shall apply to contacts between inmates and Triage Navigator Program staff and/or other staff that provide mental health-related services on site at the Jail.(IV.C.1.c)*
4. *Jail policies that mandate custody staff to be present for any mental health treatment in such a way that disrupts confidentiality shall be revised to reflect the individualized process set forth above. Custody and mental health staff shall be trained accordingly.(IV.C.2)*
5. *It shall be the policy of the County that mental health clinicians shall not conduct their patient contacts at cell front except pursuant to documented refusals or specific, documented security concerns that warrant cell front contacts. (IV.C.3)*
6. *For each clinical contact, mental health staff shall document whether the encounter was confidential, including whether it took place at cell front. If the contact occurred at cell front or otherwise was non-confidential, the reasons shall be clearly documented in the individual patient record and for purposes of Quality Assurance*

[32] Bold emphasis added by this author.

review procedures. (IV.C.4)

7. *A process shall exist for sick call slips or other mental health treatment-related requests to be collected without the involvement of custody staff. (IV.C.5)*

FINDING/DISCUSSION:

Non-compliant. (IV.C.1, 2, 5) While staff continued to receive further direction to see patients in confidential settings, record review indicated that most patients were seen in non-confidential settings. Improvement was noted with mental health documentation in that staff were far less likely to misidentify nonconfidential space as confidential. While it had been reported during the last monitoring period that a new program report was developed to assist managers in monitoring confidentiality, this data was not provided to the SME. This SME conducted a limited audit of mental health contacts (excluding the acute unit where all contacts were nonconfidential), and found that most contacts occurred in nonconfidential settings and that clinical contacts in segregation were primarily cellside.

Non-Compliant (IV.C.2, 4) This item was noted as non-compliant because it continued to be the exception rather than the norm that mental health staff saw patients in confidential space. The only exceptions to this were IOP groups at the MJ and individual contacts at RCCC. The feasibility studies and their associated peer review have noted that the MJ will not be able to provide sufficient confidential space even with modification. Defendants have been very honest in acknowledging their physical plant limitations.

Recommendations: [Please see the Space Focus Area.] Defendants must continue to address physical plant and any other deficiencies that will prevent them from reaching substantial compliance.

CLINICAL PRACTICES (IV.D)

The Remedial Plan states that *Mental health staff shall develop and maintain at each jail facility an accurate case list of all prisoners requiring mental health treatment services at the jail ("caseload") which, at a minimum, lists the patient's name, medical chart number, current psychiatric diagnoses, date of booking, date of last appointment, date of next appointment, and the name of the treating prescriber. (IV.D.1)*

FINDINGS/DISCUSSION:

Partially compliant. (IV.D) ACH and JPS do utilize an electronic record which includes the patient's name, diagnoses, XREF, booking date and number, and much of the information listed for this item. However, waitlist reports continued to contain limited information. There were several lists provided but none met the standard established in the Consent Decree. Defendants continue to work with their EHR and electronic databases to produce certain required reports.

Recommendations:

1. Continue to work with IT and the EHR vendor to develop appropriate reports that meet Consent Decree requirements and provide proof of practice.
2. It is recommended that JPS include the date the patient was placed on the waitlist to all waitlist reports.

- *Qualified mental health professionals shall have access to the patient's medical record for all scheduled clinical encounters.(IV.D.2)*

- *Qualified mental health professionals shall provide individual counseling, group counseling, and psychosocial/psychoeducational programs based on individual patients' clinical needs. (IV.D.3)*

FINDINGS/DISCUSSION:
Partially Compliant. (IV.D.2 & 3) These two items continue to be negatively impacted by the frequency of cell front and nonconfidential contacts. The EHR obviously cannot be taken cell front. Clinicians were observed utilizing the medical record during observed individual contacts. Unfortunately, the documentation of individual contacts does not typically substantiate implementation of evidence-based and individualized clinical interventions. Group treatment documentation was better in specifying interventions used and/or treatment goals, though individualization of documentation remained a challenge. Finally, identification of individual patient needs requires an adequate current mental health assessment and individualized treatment plan. Mental health assessments often did not meet that standard (e.g., Case 1-4) nor did treatment plans. Some of the inadequacies in the treatment plans was due at least in part to the treatment plan form. There was not a space to indicate treatment interventions or staff responsible for that intervention. Treatment plans included treatment goals that were primarily patient responsibilities with little to no specification as to what treatment groups or individual treatment would be provided to the patient to reach the treatment goal (e.g., patient will take psychotropic medication 80% of time, patient will utilize coping skills and have no disciplinary actions). Consequently, documentation of individual contacts were primarily "check ins" with limited actual treatment. Improvement of clinically appropriate individualization of patient treatment plans remains an essential need in order to achieve and demonstrate compliance with treatment-related Consent Decree/Remedial Plan provisions (see IV.D.8 for further discussion).

- A *qualified mental health professional shall conduct and document a thorough assessment of each individual in need of mental health care following identification.(IV.D.4)*
- *The County shall ensure prompt access to psychiatric prescribers following intake and in response to referrals and individual patient requests in accordance with the referral and triage timelines defined in the Access to Care provisions, below. (IV.D.5)*
- *The County shall, in consultation with Plaintiffs' counsel, implement an electronic system for tracking mental health evaluation, treatment, and other clinical contacts, as well as sick call slips and other mental health treatment- related requests or referrals. (IV.D.6)*
- *The County shall develop and implement an electronic tracking system with alert and scheduling functions to ensure timely delivery of mental*

health services to individual patients.(IV.D.7)

FINDING/DISCUSSION:
Partially Compliant. (IV.D.4-7) Identification, assessment, referral to prescribers following intake, and electronic tracking of this process with alert and scheduling functions are at various stages of implementation. Timely referrals to mental health have improved at intake though challenges remain for timely appointments with psychiatric providers. The intake mental health screening and assessments were not conducted in a confidential setting which may negatively impact the intake process and identification of patients who need mental health services. Only after the patient is referred to a non-prescribing clinician do they typically get referred to see a psychiatric provider. This process is not sped up for new arrivals who report currently taking psychotropic medication even when that is confirmed, usually through medication verification by the psychiatric provider though the provider will write an order. While providers did typically write orders for continuation of medication when verified, there was no face-to-face assessment to identify current needs of the patient given the acute stressor of incarceration. The standard of care requires that medications be provided in a timely manner (NCCHC, essential standard J-D-02) and does provide for several options, including verbal bridge orders. Because the standard of care requires that medications only be prescribed when indicated, psychiatric providers generally must conduct a face-to-face assessment. In most cases, given a bridge or medication verification order, this would likely be a routine referral, though urgent and emergent referrals would also be expected. The referral to a psychiatric provider as part of the intake process and timely clinical contact is required by the Consent Decree. Finally, record review did not support that releases of information (ROIs) were routinely requested even when patients reported prior psychiatric hospitalizations.
Recommendations.

1. Improve the quality of the initial mental health assessments and continue to increase the use of confidential space for these important assessments.
2. The mental health staffing analysis recommended in the Staffing Focus Area should assist in identifying if there are adequate psychiatric providers for the population. As it is likely to require additional allocations to meet the Consent Decree requirements and the standard of care, those additional allocations should be sought through the budgetary and contract process.
3. Next, a process review is again recommended. This should include all entities or at least supervisors with ACH and JPS to identify how RNs can more accurately complete the screens and make appropriate and timely referrals to providers, particularly prescribers so that there are timely orders of essential medications without missed doses. There were significant numbers of patients interviewed during the site visit who complained about the difficulty in seeing psychiatric providers and receiving medication timely. Some described having medication discontinued without seeing the psychiatric provider because they had stopped taking it due to side effects

despite repeatedly requesting to see the provider. This was also found in for some of the medical records reviewed.

a. The staffing analysis should identify the number of psychiatric providers required to adhere to referral timelines and conduct timely face-to-face medication evaluations.

4. Monitor the utilization of ROIs as a part of the CQI process. There were patients whose records included outside records, but it was not consistent.

Treatment planning: (*IV.D.8.a-g below*)

a) The County shall ensure that each prisoner on the mental health caseload receives a comprehensive, individualized treatment plan based on the input of the Multi-Disciplinary Treatment Team (MDT). The MDT shall include multiple clinical disciplines with appropriate custody and counseling staff involvement.

b) The treatment plan shall reflect individual clinical need, and the County shall ensure that all clinically indicated services are available and provided.

c) The treatment plan shall include, at a minimum, the frequency of follow-up for clinical evaluation and adjustment of treatment modality, the type and frequency of diagnostic testing and therapeutic regimens (which may include clinical contacts more frequent than the minimum intervals described herein), and instructions about adaptation to the correctional environment.

d) This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.

e) Custody staff shall be informed of a patient's treatment plan where appropriate to ensure coordination and cooperation in the ongoing care of the patient.

f) The County shall, in consultation with Plaintiffs' counsel, develop and implement a Treatment Plan Form that will be used to select and document individualized services for prisoners who require mental health treatment.

g) *The County shall implement guidelines and timelines for the initiation and review of individual treatment plans, consistent with the JPS Psychiatric Services overview.*

FINDING/DISCUSSION:

Non-Compliant. (IV.D.8.a-g) This area remains problematic due to the lack of full implementation of actual multidisciplinary treatment teams. The IOPs were closest to having MDTs, but psychiatric providers were rarely present. Only the primary clinician and a deputy (Sergeant during the site visit) were present. JPS has acknowledged an inability to fully meet the Consent Decree requirements in this area despite continued efforts including staff training, policy development and form revision. The treatment plan form itself remains problematic and

does not allow for sufficient specificity and individualization. Treatment plans were not sufficiently individualized nor did they incorporate evidence-based treatment interventions (e.g., cases 1-4, 8).

Recommendations. This remains an area that remains ripe for consultation with SMEs to address treatment planning, necessary participants, and documentation of the same.

1. It is recommended that the requirement for MDT meetings be fully implemented and that tracking include identification of staff present and required staff who were absent.
2. It is recommended that the treatment plan form be further modified to identify required staff present and have them electronically sign to indicate their presence. In the rare occasion when an MDT team meeting is still held without required staff (i.e., primary clinician, psychiatric provider, custody representative at minimum), the MDT should document why it was held without that participant and the reason for their absence.
    a. The treatment plan should also include prompts and space for clinical interventions and staff responsible.
3. It is recommended that peer review or clinical supervision focused on the quality of treatment plans occur with results provided during the next monitoring round. This data can then be used to further refine treatment plan training that would be provided to all clinical staff.

MENTAL HEALTH CARE

Medication Administration and Monitoring *(IV.E.1.a-c below)*

1. *The County shall develop and implement policies and procedures to ensure that all medications are appropriately prescribed, stored, controlled, dispensed, and administered in accordance with all applicable laws and through the following:*
    a) *The County shall ensure that initial doses of prescribed medications are delivered to inmates within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner;*
    b) *The County shall make best efforts to verify a patient's prescribed medications and current treatment needs at intake, including outreach to pharmacies and community providers to request prescriptions and other health care records relating to ongoing care needs. The policy shall ensure that any ongoing medication, or a clinically appropriate alternative, shall be provided within 48 hours of verification of the prescription or from a determination by a physician that the medication is medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple prescribers, shall be referred to a health care provider for reconciliation or verification the next clinic day after*

booking.

c) *The County shall ensure that medical staff who administer medications to inmates document in the inmate's Medical Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, and (3) the date and time for any refusal of medication.*

2. *Qualified mental health professionals shall, for each individual patient, establish targets for treatment with respect to the use of psychotropic medication and shall assess and document progress toward those targets at each clinical visit.(IV.E.2)*
3. *Qualified mental health professionals shall, for each individual patient, monitor and document the following with respect to psychotropic mediations: (1) levels of medications, (2) adverse impacts (including through renal and liver function tests where indicated), (3) side effects, and (4) efficacy. (IV.E.3)*
4. *Qualified mental health professionals shall, for each individual patient, conduct and document baseline studies, including ECG, blood, urine, and other studies, as clinically appropriate, prior to the initiation of treatment. (IV.E.4)*
5. *The County shall provide sufficient nursing and custody staffing to ensure timely delivery and administration of medication. (IV.E.5)*
6. *Medication adherence checks that serve a clinical function shall be conducted by nursing staff, not custody staff. Custody staff shall conduct mouth checks when necessary to ensure institutional safety and security.(IV.E.6)*
7. *Psychiatric prescribers shall consider clinically indicated considerations and conduct an in-person consultation, with the patient prior to changing or initiating medications. In the event there is no in-person consultation before prescribing or changing medications the psychiatric prescriber shall note and document the reasons for why there was not an in-person consultation with the patient. (IV.E.7)*

FINDING/DISCUSSION:

Partially compliant. (IV.E.1-7) Medication Management remained a challenging and problematic area. It was difficult to maintain timely appointments with psychiatric providers, particularly the same provider to facilitate continuity of occur at least within the same program. Treatment continuity is accepted as a standard of care[33] and interviewed patients complained about having to repeat complaints and history because of a lack of continuity. Patients

[33] NCCHC (2015). Essential standard MH-E-09.

acknowledged that they have not provided all providers with important aspects of their symptoms and functioning due to their self-described fatigue with having to repeat themselves. This is clearly problematic and negatively impacts the ability to provide adequate care.

Some patients were frequently moved within and between facilities which also had a negative impact on appointment completion and continuity of care. Psychiatric providers were noted to order medications at intake as part of the medication verification process and without a face-to-face evaluation of the patient. This occurred in eight of ten new arrivals reviewed. Face-to-face medication and psychiatric evaluations are a critical component to providing adequate care because the provider must conduct an assessment of the patient. If patients repeatedly refuse such contacts, it is expected that the treatment plan be modified to include interventions to address this critical component to mental health treatment. Psychotropic medications continued to be prescribed without documentation of treatment targets including diagnostic symptoms and/or functional impairments. Psychotropic medications were discontinued or modified without face-to-face contact based on patient complaint and record review. Laboratory studies were not always ordered when indicated. Documentation did note that patients refused medication and labs because of the inappropriate times of administration and/or blood draw. For example, patients were approached at midnight and beyond for laboratory draws.

Recommendations.

1. Complete psychiatric staffing analysis and identify needed allocations to meet all psychiatric provider responsibilities as part of the Consent Decree/Remedial Plan (to include attendance at MDT in addition to providing crisis services and ongoing medication evaluation, monitoring, and prescribing).
2. Patients have complained about the timing of medication administration and laboratory testing at the MJ since the first monitoring period. Medications and laboratory draws must occur at timely and reasonable hours. Noncompliance with such psychiatric orders can create unnecessary clinical crises due to the inability to monitor a patient (lab draws) or missed medication doses. If this is also a matter of staffing as Defendants have stated at times, then the staffing analysis should be prioritized and address these areas. Identified necessary staffing allocations would then be identified and positions sought.
3. Peer review for psychiatric providers should be implemented as a priority and findings reported to All Parties and in response to the next monitoring round document request.
4. Ongoing QI audits of psychiatric providers should be completed to ensure compliance with the Consent Decree (IV.E.7) when changing or initiating medication.

MENTAL HEALTH CARE

Placement, Conditions, Privileges, and Programming *(IV.F.1.a-e below)*

1. *Placement:*
   a) *It shall be the policy of the County to place and treat all prisoners on the mental health caseload in the least restrictive setting appropriate to their needs.*
   b) *Placement in and discharge from Designated Mental*

Health Units shall be determined by qualified mental health professionals, with consultation with custody staff as appropriate.

c) *Absent emergency circumstances, the County shall obtain the assent of qualified mental health professionals before transferring prisoners with SMI into or out of Designated Mental Health Units.*

d) *It shall be the policy of the County to place prisoners with SMI in appropriate settings that ensure provision of mental health services, patient safety, and the facilitation of appropriate programs, activities, and out-of-cell time. Co-housing with other populations shall be avoided to the extent that such a practice prevents or hinders any of the above.*

e) *All patients requiring placement in a Designated Mental Health Unit shall be provided access to such placement and care based on current clinical need and without any requirement for director-level approval.*

FINDINGS/DISCUSSION:

Partially Compliant[34]. (IV.F) There remained at least 74 caseload inmates identified as seriously mentally ill who were housed in restrictive housing (8W) at the time of the site visit (April 2022) with 54 being classified as ADSEG1, ADSEG2, MAX, or DISC. Some of these patients were awaiting transfer to the JBCT or state hospital having been found incompetent to stand trial. The implementation of the high security IOP was seen by All Parties to result in an improvement in moving patients from the restrictive housing setting to a more appropriate mental health treatment setting. While improvement is recognized, it appears likely that need for those beds shall outpace availability. The high security IOP and ongoing need shall be reviewed as part of the next monitoring period.

The placement of SMI patients in restricted housing remains a significant concern and direct violation of the Consent Decree/Remedial Plan. This SME identified at least one patient (case 2) who was clearly acutely mentally ill who was inappropriately placed in restrictive housing for a lengthy stay before getting moved.

There also continued to be issues with delays in transfer to a DMHU once referred. It was unclear from the medical record if all delays were due to waitlists or if there were some obstacles to timely transfer due to custody staff.

Recommendations:

1. It is recommended that MDTs be held responsible for identifying the least restrictive treatment environment. Since a custody representative should be present in the MDT, they can facilitate rapid transfer when the appropriate placement/treatment bed is available.

[34] While the data provided for this report occurred before full activation of the high security IOP, All Parties agree that activation of those beds has resulted in improvement.

2. Patients who are in segregation or other functionally restrictive settings should be reviewed by MDT with specific focus on referrals to higher levels of care to stabilize the patients in the least restrictive setting where they can receive adequate care.
3. It is recommended that if patients cannot be housed in less restrictive environments than a high security DMHU, treatment plans must include goals and interventions to specifically address the underlying reasons for the more restrictive placement and/or repeated or lengthy placements in restricted housing.
4. It is recommended that lengths of stay be tracked for patients in anything but the least restrictive treatment environment and reported as part of the QI and monitoring process.
5. It is recommended that segregation mental health reviews not be conducted cellside since they will not meet Consent Decree and standard of care requirements. These reviews should be structured so that they are meaningful and designed to facilitate patient movement to less restrictive environments.
6. It is recommended that MDTs be implemented as a priority in restrictive housing and functionally restrictive settings as a priority. Fully attendance should be prioritized and treatment planning should focus on addressing the underlying cause for restrictive settings and facilitating movement to a less restrictive setting with clinically appropriate treatment.

MENTAL HEALTH CARE

Programming and Privileges *(IV.F.2.a-e below)*

a. *All Designated Mental Health Units shall offer a minimum of 7 hours of unstructured out-of-cell time per week and 10 hours of structured out- of-cell time per week for each prisoner. While out-of-cell hours per prisoner may vary from day to day, each prisoner will be offered some amount of out-of-cell time every day of the week. All treatment and out- of-cell time shall be documented for each prisoner, and reviewed as part of Quality Assurance procedures.*
b. *The County shall ensure that prisoners on the mental health caseload have access and opportunity to participate in jail programming, work opportunities, and education programs, consistent with individual clinical input.*
c. *The County shall develop and implement, in the 2P inpatient unit and the IOP unit, a program for progressive privileges (including time out of cell, property allowances, etc.) for patients as they demonstrate behavioral progress. A patient's level of privileges and restrictions shall be based on both clinical and custody input regarding current individual needs. The County shall ensure a process to review custody classification factors when necessary, so that placement, privileges, and restrictions match current*

individual circumstances and needs.

d. *Individuals on a mental health caseload shall receive, at minimum, privileges consistent with their classification levels, absent specific, documented factors which necessitate the withholding of such privileges. Clinical staff shall be informed of the withholding of privileges and the reasons for the withdrawal shall be documented and regularly reviewed by clinical and custody staff. The restoration of privileges shall occur at the earliest time appropriate based on individual factors.*
e. *Where a prisoner in a Designated Mental Health Unit is subject to any restrictions of property, privileges, or out-of-cell time, the mental health treatment provider and Multi-Disciplinary Treatment Team will, on a weekly basis, assess and discuss with the prisoner progress and compliance with the prisoner's individual case plan. This process will include clinical contact in a private, face-to-face, out-of-cell setting. The Multi-Disciplinary Treatment Team will provide input to classification staff regarding the prisoner's mental health and appropriateness for removal of imposed restrictions. Classification staff will follow the recommendation of the Multi-Disciplinary Treatment Team to remove restrictions unless there is a clear, documented security reason to maintain the restriction.*

FINDING/DISCUSSION:

Non-Compliant. (IV.F.2 a-e) This may be a proof of practice matter for Defendants. Custody began tracking out of cell activity and was able to provide data for the prior review period but such data were not provided for this monitoring period. While many logs and raw data was provided for mental health service delivery, the weekly averages of treatment offered and treatment attended could not be calculated. Medical records noted that patients in IOP were offered anywhere from two to four groups per day. However, detailed review of the group progress notes indicated that groups were started late and stopped early due primarily to custody staff or security occurrences. This occurred primarily at the MJ with it impacting RCCC less often based on the data they provided and record review.

The APU in 2P continued to restrict detainees out-of-cell time due to the physical plant and custody limitations. The unit was functionally a restrictive housing unit most of the time with occasional treatment groups offered in a non-confidential setting. As mentioned previously, those groups were often canceled "due to staffing" though it was unclear if it was due to mental health staffing, custody staffing or both based on medical record review.

Other DMHUs that were not high security were reportedly less restrictive. However, patients complained at the MJ that inadequate custody staffing and medication administration interfered with their out of cell time including treatment and recreation and often resulted in being released to group tardy.

Recommendations:

1. Custody staffing and assignment of custody escorts needs to be prioritized. A custody staffing analysis should identify how many positions should be allocated to allow for proper access currently with the acknowledgement that this will likely change over time with space and clinical staffing modifications.

2. In the interim, it is again recommended that each facility charter a QIT that includes SSO, ACH, and JPS staff to focus on identifying ways to increase out of cell time and provide normalizing experiences for the SMI detainees such as group dining, games, yard, exercise, and other activities at both the RCCC and MJ mental health units including the acute inpatient program.
    a. If acute psychiatric patients cannot be provided with these or alternative out-of-cell services, additional opportunities for placement in the community should be identified.

MENTAL HEALTH CARE

Conditions: *(IV.F.3)*

- *Staff shall provide prisoners in Designated Mental Health Units with the opportunity to maintain cell cleanliness and the opportunity to meet their hygiene needs. Custody and clinical staff shall provide assistance to prisoners on these matters, as appropriate to individual patient needs;(IV.F.3.a)*
- *The County shall ensure uniformity of practice with respect to cell searches, such that searches are not done for punitive or harassment reasons. The County shall monitor whether cell search practices may be serving as a disincentive for prisoners in Designated Mental Health Units to leave their cells for treatment or other out-of-cell activities, and shall take steps to address the issue as appropriate. (IV.F.3.b)*

FINDING/DISCUSSION:

Partially Compliant. While some patients did complain during the site visit about the ability to get all allowable cleaning materials to maintain their cells, the IOPs had an "ADL program" to assist patients in maintaining the critical activities of daily living (ADLs) that were difficult for many mental health patients. It is possible that patients could not fully clean their living areas due to the poor preventive maintenance and ongoing cleanliness issues as identified by Ms. Skipworth in her Environment of Care report. Significant problems with cleanliness and upkeep were identified for both MJ and RCCC.

Recommendations:

1. Implement the recommendations identified in the Environment of Care report.
2. It is recommended that a tracking system be created for each DMHU to record when patients are offered hygiene supplies/opportunities and cleaning supplies. If a patient requests such supplies but they are not provided, the tracking system should note the request and reason for denying the patient such supplies.
    a. Assistance with hygiene and cleanliness should be available for all patients in DMHUs. This should be a component of the treatment plan with all members of the treatment team (e.g., primary clinician, psychiatric provider, custody and in the APU nursing) developing and implementing effective interventions.

MENTAL HEALTH CARE

Bed planning: *(IV.F.4)*

- *The County shall provide a sufficient number of beds in Designated Mental Health Unit, at all necessary levels of clinical care and levels of security, to meet the needs of the population of prisoners with SMI. (IV.F.4.a)*
- *The County shall conduct a bed needs assessment, to be updated as appropriate, in order to determine demand for each category of Designated Mental Health Unit beds and shall ensure timely access to all levels of mental health care, consistent with individual treatment needs .(IV.F.4.b)*
- *The County shall establish mental health programming for women that ensures timely access to all levels of care and is equivalent to the range of services offered to men. (IV.F.4.c)*

FINDING/DISCUSSION:

Partially Compliant. (IV.F.4) Defendants did complete two feasibility studies during the monitoring period. Bed planning specifically has not been initiated but as Defendants have acknowledged, population reduction is necessary to approach compliance with the Consent Decree and that expansion of DMHUs is necessary based on lengthy waitlists. A bed needs assessment is essential in determining what must be done for construction and space needs. The same is true for detainees with SMI who are placed in restrictive housing but actually require mental health treatment in an appropriate therapeutic setting.

Recommendations:

1. Continue to pursue space and population management recommendations by Nacht & Lewis and Mr. O'Connell.
2. Complete a bed need assessment to identify how many beds at each level of care will be required to be compliant with the Consent Decree and share findings with All Parties. This assessment must address the entire detainee population.

MENTAL HEALTH CARE

Access to Care *(IV.F.6)*

- *The County shall designate and make available custody escorts for mental health staff in order to facilitate timely completion of appointments and any other clinical contacts or treatment-related events. (IV.F.6.a)*
- *The County shall ensure sufficient and suitable treatment and office space for mental health care services, including the Triage Navigator Program and other mental health-related services provided on site at the Jail. (IV.F.6.b)*
- *Locations shall be arranged in advance for all scheduled clinical encounters. (IV.F.6.c)*
- *The County shall track and document all completed, delayed, and canceled mental health appointments, including reasons for delays and cancelations.*

Such documentation shall be reviewed as part of the Quality Assurance process. (IV.F.6.d)

KNOWLEDGE/DISCUSSION:

Partially Compliant. (IV.F.6.a-d) Defendants had developed a reporting feature that tracked canceled treatment groups and the reason for cancellation. The same was true for treatment group attendance. However, these reports were of limited value in that they did not provide summary data on cancellations, group attendance, treatment groups delayed or terminated early. No custody escorts have yet been identified and many mental health appointments were noted to have been canceled or resulted in cellside visits due to a lack of custody staff. (See previous sections on space, staffing and treatment for additional detail.)

The County did relocate mental health staff from the MJ to increase availability of confidential space. Despite this, medical records revealed that staff repeatedly saw patients in non-confidential space in the IOP, EOP, restrictive housing, intake, and outpatient areas because of a "lack of available confidential space."

Recommendations:

1. Supervisors should monitor availability and utilization of confidential space.
2. It is recommended that despite significant custody staffing challenges, custody supervisors should work to identify if a small contingent of escort officer could be identified and piloted at each facility. Recommendations for further escort cadres would be developed from the pilot program findings.
3. It is recommended that further refinement of tracking and reporting features occur with County IT staff and EHR vendor to provide Defendants with reports that are helpful for managers and also provide proof of practice.
4. Staffing recommendations specified above should be implemented.

Referrals and triage: *(IV.F.6.e.i and ii below)*

- *The County shall maintain a staff referral process (custody and medical) and a kite systemfor prisoners to request mental health services. Referrals by staff or prisoners must be triaged within 24 hours.*
- *Referrals and requests for mental health services shall be handled in accordance with the following timeframes, and based on the definitions and guidance in Exhibit A-2:*
- *Prisoners with "Must See" (Emergent) mental health needs shall be seen for assessment or treatment by a qualified mental health professional as soon as possible, and within six hours. Prisoners with emergent mental health needs shall be monitored through continuous observation untilevaluated by a mental health professional.*
- *Prisoners with Priority (Urgent) mental health needs shall be seen for assessment or treatment by a qualified mentalhealth professional within 36 hours.*
- *Prisoners with Routine mental health needs shall be seen for assessment or*

treatment by a qualified mental health professional within two (2) weeks;

- *Prisoners whose requests do not require formal clinical assessment or intervention shall be issued a written response, with steps taken to ensure effective communication.*

FINDINGS/DISCUSSION:

Non-compliant. The referral system continued to be problematic. Patients continued to report and complain of submitted HSR requests and not timely receiving a response to requested mental health care. They resubmit the same request, sometimes several times out of fear that it's been lost or that they are being ignored. There continued to be detainees during the site visit who reported that they will submit a request daily in an effort to be seen. Because of their fear, lack of feedback from staff, and past experience, these patients flood the referral system with duplicate requests in an effort to receive care. If the triage nurse would simply timely see patients following receipt of a referral, then the workload in processing referrals would actually decrease because fewer duplicative referrals would be submitted. Medical record review supported patient report of repeated referrals except in the area of emergent referrals. Emergent or "must see" mental health referrals did appear to occur timely. Despite the medical record including documentation that patients were provided confirmation of receipt of their request, there was no data verifying that the patient was handed that receipt confirmation. Based on patient interviews, detainees continue to have no trust in the referral system and cope by flooding the system.

Recommendations.

1. Audits of the HSR process be prioritized and look at the entire process, from picking up HSRs to completion of appointment. Staff referrals should also be part of this audit. Defendants reported that the HSR process was modified in early 2023. The specific changes, workflows or other specific details should be provided to All Parties (to include all SMEs).
2. Audits that the audit process identify what occurs when referrals are emergent, urgent, or routine and the quality of triage (e.g., accuracy of prioritization or urgency of referral).
3. Audits should include a component that confirms the patient has received the receipt confirmation timely.

Medico-Legal Practices *(IV.G)*

1. *The County shall provide access to appropriate inpatient psychiatric beds to all patients who meet WIC § 5150 commitment criteria. At the time a patient's need for inpatient care is identified, commitment paperwork shall be initiated immediately. Placement in an inpatient unit shall occur at the earliest possible time, and in all cases within 24 hours. For individual prisoners placed on a pre-admit or wait list for inpatient placement, affirmative steps to process and place them shall begin immediately. (IV.G.1)*
2. *The County shall not discharge patients from the LPS unit and*

immediately re- admit them for the purpose of circumventing LPS Act requirements. For patients with continuing need for LPS commitment, the County shall follow all required procedures under the LPS Act. (IV.G.2)

3. *The County shall review all County and JPS policies and procedures for PREA compliance, and revise them as necessary to address all mental health-related requirements. (IV.G.3)*

FINDING/DISCUSSION:

Partially compliant. (IV.F.G) The County continues to maintain extensive policies and forms to address the forensic aspects of inpatient care including Welfare and Institutions Code 5150 commitment criteria across various timeframes, the LPS commitment paperwork, notification and other forms, firearms restrictions forms following commitment, forms to try to get your right to possess firearms back, involuntary medication orders (e.g., Sell orders) for certain populations. This is one area that was quite well covered by JPS. It is partially compliant because this section includes the element of providing access to appropriate inpatient psychiatric beds and the jail maintains a steady waitlist of patients waiting for a bed in the acute inpatient unit. There are others on the waitlist for DSH (state hospital) or the JBCT who likely should be in an inpatient bed as well. This aspect of this item will likely not be fully compliant until there are adequate inpatient beds (number and service delivery) available, whether through accessing community inpatient treatment or construction of an appropriate inpatient unit in the jail.

Recommendations.

1. It is recommended that the County implement recommendations from consultants in this area.
2. It is also recommended that the County make efforts to secure appropriate inpatient psychiatric access in the community, through the identification and use of inpatient beds outside of the jail facilities to ensure that the clinical needs of the jail patient population are met.

<u>Clinical Restraints and Seclusion</u> (*IV.H)*

Generally: (IV.H.1.a-g below)

a. It is the policy of the County to employ restraints and seclusion only when necessary and to remove restraints and seclusion as soon as possible.

b. It is the policy of the County to employ clinical restraints and seclusion only when less restrictive alternative methods are not sufficient to protect the inmate-patient or others from injury. Clinical restraint and seclusion shall not be used as punishment, in place of treatment, or for the convenience of staff.

c. The placement of a prisoner in clinical restraint or seclusion shall trigger an "emergent" mental health referral, and a qualified mental health professional shall evaluate the prisoner to assess immediate and/or long- term mental health treatment needs.

d. When clinical restraints or seclusion are used, Jail staff will document

justification for their application and the times of application and removal of restraints.

e. *There shall be no "as needed" or "standing" orders for clinical restraint or seclusion.*
f. *Individuals in clinical restraints or on seclusion shall be on constant watch, or on constant video monitoring with direct visualization every 15 minutes. All checks will be documented.*
g. *Fluids shall be offered at least every four hours and at meal times.*

Clinical Restraints (IV.H.2.a-c below)

a. *The opinion of a qualified health care professional or qualified mental health professional on placement and retention in restraints will be obtained within one hour from the time of placement.*
b. *A thorough clinical assessment shall be conducted by qualified health care professional or qualified mental health professional every four hours to determine the need for continued restraint.*
c. *Individuals in restraints shall be checked every two hours by a nurse for vital signs, neurovascular assessment, and limb range, and offered an opportunity for toileting.*

FINDINGS/DISCUSSION:

Partially compliant. (IV.H.1&2) Clinical restraints are those restraints that are initiated by a mental health provider who is qualified and allowed by license to order a patient to be restrained. In the JPS system, that would be psychiatrist primarily. California does not allow social workers to order restraints. There was no proof of practice provided during this monitoring round in this area.

There was a report by Defendants that clinical restraints were not used during this monitoring round and none of the inpatient records reviewed indicated the use of clinical restraints. JPS and ACH policies on restraints were reviewed and found to be generally acceptable.

Recommendations.

1. It is recommended that tracking of custodial restraints including the reason for restraint be continued and provided to All Parties and as part of document production.
2. Audits of custodial restraints should occur monthly to identify if custody is initiating restraints that should be clinically initiated in a medical setting. It is possible that physical plant limitations may result in custody initiating what should be clinical restraints.
3. It is recommended that any time custodial restraints (e.g. the WRAP) are used on mental health patients, an emergent referral should be sent to the mental health provider who should also be given an opportunity to deescalate the patient whenever possible and at the earliest possible time, with close coordination with custody staff.. All mental health staff should receive training

on clinical restraints as well as the standards for non-clinical restraints[35].

4. Finally, it is recommended that restraint use, clinical and custodial, be closely monitored because of the risk involved and potential for harm.

MENTAL HEALTH CARE

Reentry Services *(IV.H.3.a-d below)*

a. The County shall provide a 30-day supply of current psychotropic medications to inmates on the mental health caseload, who have been sentenced and have a scheduled released date, immediately upon release.

b. Within 24 hours of release of any inmate who is on the mental health caseload and classified as pre-sentence, the County shall transmit to a designated County facility a prescription for a 30-day supply of the inmate's current psychotropic medications.

c. The County, in consultation with Plaintiffs' counsel, develop and implement a reentry services policy governing the provision of assistance to prisoners on the mental health caseload, including outpatient referrals and appointments, public benefits, medical insurance, housing, substance abuse treatment, parenting andfamily services, inpatient treatment, and other reentry services.

d. The County agrees that, during the course of the implementation of the Remedial Plans contained in this agreement, it will consider Plaintiffs' input on measures to prevent unnecessary or avoidable incarceration of individuals with serious mental illness.

FINDING/DISCUSSION: (IV.H.3)

Partially compliant. Defendants have developed release planning policies and mental health staff have documented their efforts in cases reviewed. It could not be determined from data provided that all areas of this element were met. Specifically, proof of practice for items a and b was not provided. No documentation could be identified in the medical record indicating that the releasing detainee had or had not received discharge medications.

Recommendations:

1. It is recommended that there be a form created for the medical record that will be clearly labeled and used to document provision of discharge/release psychotropic (and other) medication.
2. It is recommended that a report then be constructed to provide proof of practice or that regular audits be conducted.

MENTAL HEALTH CARE

Training (IV.I)

1. The County shall develop and implement, in collaboration with Plaintiffs' counsel, training curricula and schedules in accordance with the following:

[35] Defendants reported that this system has been implemented, but no proof of practice was provided as part of this report. It is likely that was due to timing and it is expected that Defendants will be able to provide such proof of practice during the next review period, allowing this suggestion to be moved to the progress/accomplishment section.

(IV.I.1)

a. *All jail custody staff shall receive formal training in mental health, which shall encompass mental health policies, critical incident response, crisis intervention techniques, recognizing different types of mental illness, interacting with prisoners with mental illness, appropriate referral practices, suicide and self-harm detection and preventions, relevant bias and cultural competency issues, and confidentiality standards. Training shall be received every two years, at minimum. (IV.I.1.a)*
b. *Custody staff working in Designated Mental Health Units shall receive additional training, including additional information on mental illness, special medico-legal considerations, de-escalation techniques, working with individuals with mental health needs, relevant bias and cultural competency issues, and the jail's mental health treatment programs. (IV.I.1.b)*
c. *Mental health staff shall receive training on the correctional mental health system, correctional mental health policies, suicide assessment and intervention, relevant bias and cultural competency issues, and treatment modalities to be offered in the jails. (IV.I.1.c)*

FINDING/DISCUSSION:
Partially compliant. (IV.I) JPS provided numerous training materials, some for all staff and some just for mental health staff. There were signed attendance sheets provided as well. However, it could not be determined from available data the percentage compliance with specific training modules.
Recommendations:

1. As was recommended during the prior monitoring periods, Defendants need to track who is required to attend specific training sessions and then indicate whether those staff did attend the required training. This should be reported in documentation production as summary data including percentages of compliance (include number required and number attended) across disciplines/job classes.

DISCIPLINARY MEASURES AND USE OF FORCE FOR PRISONERS WITH MENTAL HEALTH OR INTELLECTUAL DISABILITIES *(Section V)*

Role of Mental Health Staff in Disciplinary Process *(V.A)*

1. *The County's policies and procedures shall require meaningful consideration of the relationship of a prisoner's behavior to any mental health or intellectual disability, the efficacy of disciplinary measures versus alternative interventions, and the impact of disciplinary measures on the health and well- being of prisoners with disabilities. (V.A.1)*
2. *Prisoners who are alleged to have committed a rules violation shall be reviewed by a qualified mental health professional if any of the following apply: (V.A.2)*
    a) *Prisoner is housed in any Designated Mental Health Unit;*
    b) *Jail staff have reason to believe the prisoner's behavior was unusual, uncharacteristic, or a possible manifestation of mental illness;*
    c) *Prisoner is on the mental health caseload and may lose good time credit as a consequence of the disciplinary infraction with which he or she is charged.*
3. *If any of the above criteria is met, the qualified mental health professional shall complete the appropriate form and indicate: (V.A.3)*
    a) *Whether or not the reported behavior was related to mental illness, adaptive functioning deficits, or other disability;*
    b) *Whether the prisoner's behavior is, or may be, connected to any of the following circumstances:*
        i. *An act of self-harm or attempted suicide*
        ii. *A cell extraction related to transfer to a medical/mental health unit or provision of involuntary treatment*
        iii. *Placement in clinical restraints or seclusion.*
    c) *Any other mitigating factors regarding the prisoner's behavior, disability, and/or circumstances that should be considered and whether certain sanctions should be avoided in light of the prisoner's mental health disability or intellectual disability, treatment plan, or adaptive support needs.*

FINDINGS/DISCUSSION:

Partially-compliant. (V.A) JPS has completed extensive efforts toward compliance in this area. Policy has been completed and approved, forms created, training provided, and tracking created. Unfortunately tracking did not include the disposition. This made it difficult to determine if custody staff understood that when mental health staff found a relationship (nexus between behavior and mental illness/intellectual disability) in 9 of 10 cases where mental health findings were reported that alternative sanctions should be considered or mitigated. In light of the large number of caseload patients in restrictive housing it could not be determined if every patient required to have a mental health assessment did receive one.

While staff reported that there were times when custody staff (in DMHUs) spoke to them about a patient's behavior and the patient did not receive a formal disciplinary action, there was no evidence (proof of practice) that could identify how many patients may have been positively impacted by alternative interventions. Defendants should track these occurrences to

receive commendation for a culture where people experiencing mental health symptoms, particularly to the degree that they must be housed in a DMHU, benefit from a more clinical than punitive approach.

Recommendations:

1. Refine proof of practice to include referral indicated, date sent to mental health, custodial disposition. There may need to be parallel tracking measures between mental health and custody or a log on a shared drive where each can complete their sections. If there is a nexus between the individual's mental health and the behavior, or if there are mental health considerations regarding appropriate sanctions, custody should provide documentation of the rationale for disposition or the hearing documentation should be provided.
2. Develop a QI process that audits this element for compliance and includes disposition.

DISCIPLINARY MEASURES AND USE OF FORCE FOR PRISONERS WITH MENTAL HEALTH OR INTELLECTUAL DISABILITIES

Consideration of Mental Health Input and Other Disability Information in Disciplinary Process (V.B.1-7 below)

1. *The County shall designate one Chief Disciplinary Hearing Officer for each jail facility, who shall be responsible for ensuring consistency in disciplinary practices and procedures.*
2. *The Disciplinary Hearing Officer shall ensure that prisoners are not disciplined for conduct that is related to their mental health or intellectual disability.*
3. *The Disciplinary Hearing Officer shall consider the qualified mental health professional's findings and any other available disability information when deciding what, if any, disciplinary action should be imposed.*
4. *The Disciplinary Hearing Officer shall consider the qualified mental health professional's input on minimizing the deleterious effect of disciplinary measures on the prisoner in view of his or her mental health or adaptive support needs.*
5. *If the Disciplinary Hearing Officer does not follow the mental health staff's input regarding whether the behavior was related to symptoms of mental illness or intellectual disability, whether any mitigating factors should be considered, and whether certain sanctions should be avoided, the Disciplinary Hearing Officer shall explain in writing why it was not followed.*
6. *Prisoners will not be subjected to discipline which prevents the delivery of mental health treatment or adaptive support needs, unless necessary for institutional safety.*
7. *Prisoners shall not be subject to discipline for refusing treatment or medications, or for engaging in self-injurious behavior or threats of self- injurious behavior.*

FINDINGS/DISCUSSION:

See findings on page 55 above. **Non-compliant.** (V.B.1-7)

Recommendations:

1. Tracking must include a complete picture of the disciplinary process. Custody staff should work with mental health to refine tracking and proof of practice efforts.
2. Review existing policy to identify if custody staff feel empowered to engage in alternative interventions as part of the multidisciplinary treatment team in DMHUs.

DISCIPLINARY MEASURES AND USE OF FORCE FOR PRISONERS WITH MENTAL HEALTH OR INTELLECTUAL DISABILITIES

Accommodations for Prisoners with Mental Health or Intellectual Disabilities During the Disciplinary Process (V.C)

1. *The County shall provide reasonable accommodations during the hearing process for prisoners with mental health or intellectual disabilities. (V.C.1)*
2. *The County shall take reasonable steps to ensure the provision of effective communication and necessary assistance to prisoners with disabilities at all stages of the disciplinary process. (V.C.2)*

FINDINGS/DISCUSSION:

Non-compliant. (V.C) There was no proof of practice suggesting this. While mental health evaluators found a nexus between the patient's mental illness and behavior in 9 of 10 cases identified, they did not attend the hearing nor did they document the need or lack of need for reasonable accomodation during the hearing process.

Recommendations:

1. Further refine existing mental health disciplinary assessment tracking with a feedback loop from custody staff to mental health or a shared CQI process to document and track the need for reasonable accommodation and ***provision*** of such.

Use of Force for Prisoners with Mental Health or Intellectual Disabilities (V.D.1-7 below)

1. *The County's Correctional Services Operations Orders shall include language that ensures meaningful consideration of whether a prisoner's behavior is a manifestation of mental health or intellectual disability.*
2. *For prisoners with a known mental health or intellectual disability, and absent an imminent threat to safety, staff shall employ de-escalation methods that take into account the individual's mental health or adaptive support needs.*
3. *The County's Correctional Services Use of Force policies shall include a definition and a protocol for a planned Use of Force that provides appropriate guidance for a planned Use of Force that involves a prisoner with mental health or intellectual disability.*
4. *Prior to any planned Use of Force, such as a cell extraction, against a prisoner with mental health or intellectual disabilities, there will be a "cooling down period," consistent with safety and security needs. This period includes a structured attempt by mental health staff (and other staff if appropriate), to de- escalate the situation and to reach a resolution without Use of Force. Such efforts, including the use of adaptive supports, will be documented in writing. Medical and/or mental health staff should*

be consulted if the purpose of the cell extraction is related to the delivery of treatment.

5. *The County shall require video documentation for any planned Use of Force, absent exigent circumstances. Jail staff shall endeavor to record the specific actions, behavior, or threats leading to the need for Use of Force, as well as efforts to resolve the situation without Use of Force.*
6. *The County shall ensure the completion of supervisory review of Use of Force incidents, including video (for any planned Use of Force), interviews, and written incident documentation, in order to ensure appropriateness of Use of Force practices including de-escalation efforts. The County shall take corrective action when necessary.*
7. *The County shall review and amend as appropriate its policies on Use of Force, including its policies on Custody Emergency Response Team (CERT) and Cell Extraction Procedures.*

FINDINGS/DISCUSSION:

Partially-compliant. (V.D) JPS provided a policy for mental health staffs' role in UOF and deescalation. They created a template for documentation by mental health staff in the medical record and developed an extensive training for mental health. This training was well-developed and approved with some revisions. It was to have been implemented. In addition, Defendants' Fifth Status Report noted that certain areas noted above were their standard practice (e.g., video documentation for planned UOF). However, that same status report noted that policy development was ongoing and had been delayed due to staffing challenges. Policy development had been contracted with a company that was an effective strategy to reach compliance with policy development requirements of the Consent Decree. Defendants also acknowledged in the Fifth Status Report that they had not completed training in this area but that supervisors would focus on that in 2023.

Recommendations.

1. It is recommended that a QI process be developed for all elements of this item. Findings should be reported to All Parties as part of the documentation process.

TRAINING AND QUALITY ASSURANCE *(V.E)*

1. *All custody staff, and mental health staff, shall be trained on the policies and procedures outlined herein that are relevant to their job and classification requirements. Custody staff will receive periodic training on identifying behaviors that may be manifestations of mental illness and other situations warranting a referral to mental health staff, including for a Rules Violation Mental Health Review or other mental health assessment.(V.E.1)*
2. *All custody staff shall be trained on the identification of symptoms of mental illness, the provision of adaptive supports, and the use of de-escalation methods appropriate for prisoners with mental health or intellectual disabilities. (V.E.2)*
3. *The County shall track the outcomes of all disciplinary hearings for prisoners who are on the mental health caseload or who have intellectual disabilities, including whether the recommendation of the mental health professional was followed. (V.E.3)*
4. *The County shall track all Uses of Force (planned and reactive) involving prisoners who are on the mental health caseload or who*

have intellectual disabilities, including the number of Uses of Force and the number of cell extractions by facility. (V.E.4)

5. *The County shall implement a continuous quality assurance/quality improvement plan to periodically audit disciplinary and Use of Force practices as they apply to prisoners who are on the mental health caseload or who have intellectual disabilities. (V.E.5)*

FINDINGS/DISCUSSION:

Partially Compliant. (V.E) The County has an existing training program and CQI process. Defendants have added quality improvement staff, though it is unclear if there is sufficient staff to maintain a CQI program the size required to monitor compliance with policy, standards of care, and the Consent Decree in the jails. The Quality Improvement Committee meets quarterly and reviews various types of data such as any audits conducted and grievances. Training in quality assurance was completed but again, percentage of compliance by required discipline/job class was not provided. The third audit of disabilities, accommodation and effective communication was completed in October 2021 and demonstrated improvement in documentation of such over time. There were multiple mental health committees and subcommittees where at least one agenda/minutes was provided for the initial document request. The Mental Health Quality Improvement Subcommittee appeared to meet quarterly while other subcommittees met monthly. There was also proof of practice provided for several QI studies including a study of EOP outcomes/effectiveness.

This area was developing with progress noted, but further improvement was needed. Increased utilization of audits and QI studies was needed across disciplines.

Recommendations:

1. Increase utilization of data reports, audits, and QI studies to evaluate compliance with policy, standards of care, and all elements of the Consent Decree.
    a. It is recommended that areas be identified based on risk prioritization and frequency for review of data/reports/audit findings would be appropriate to the degree of risk and prioritization.
2. As part of document production, only agendas and minutes for meetings held were included, making it difficult to determine if quorum was met and what disciplines were present. Defendants should consider including a scanned copy of the attendance sign in sheet by required position/attendee for each committee and subcommittee.

MENTAL HEALTH FUNCTIONS IN SEGREGATION UNITS

Segregation Placement Mental Health Review *(VIII.C.1.a-e below)*

a) All prisoners placed in a non-disciplinary Segregation housing unit and all prisoners housed in a Disciplinary Detention unit shall be assessed by a qualified mental health professional within 24 hours of placement to determine whether such placement is contraindicated. All prisoners subjected to Disciplinary Segregation conditions for 72 hours in their general population housing unit (i.e., confined to cell 23 hours per day) shall also be assessed by a qualified mental health professional no later than the fourth day of such placement.

b) Any decision to place prisoners with Serious Mental Illness in Segregation shall include the input of a qualified mental health

professional who has conducted a clinical evaluation of the prisoner in a private and confidential setting (absent a specific current risk that necessitates the presence of custody staff), is familiar with the details of the available clinical history, and has considered the prisoner's mental health needs and history.

c) *Mental Health Staff shall consider each prisoner's age and cognitive functioning as part of the Segregation Placement review. Staff shall receive training regarding the features of youth and brain development of young adults (i.e., 24 years old and younger) and the needs of individuals with intellectual disabilities.*

d) *If mental health or medical staff find that a prisoner has a Serious Mental Illness or has other contraindications to Segregation, that prisoner shall be removed from Segregation absent exceptional and exigent circumstances.*

e) *The County shall document and retain records of all Segregation Placement mental health evaluations, as described above. The County shall consult with Plaintiffs regarding such documentation, including the development of new forms where necessary.*

FINDINGS/DISCUSSION: (VIII.C)

Non-compliant. This has remained a challenging area for Defendants. Mental health staff have documented repeatedly conducting these reviews cell front even when there is no objective evidence presented regarding current behavioral risk. They most frequently cite the cause as being "behavioral/unpredictable" but do not provide individualized assessment to support this reason and they do not document alternative settings considered. For example, the patient could be seen in a confidential space with a deputy present or in an attorney booth. There is not sufficient documentation regarding retaining the patient in segregation or if such would be contraindicated. There were cases of patients who were found incompetent to stand trial with forced medication orders or acutely mentally ill people retained in segregation (e.g., Case 2, 43). Mental health staff did not appear to have any greater understanding of this process during this round or the importance of confidentiality and comprehensive documentation of findings and clinical rationale for finding[36].

Recommendations:

1. Further training in this area is recommended for all mental health staff.
2. It is recommended that a tracking system be developed to monitor compliance with all elements of this process.
3. It is recommended that clinical supervision include audits or peer review of the mental health review of the patient's placement.

Segregation Rounds and Clinical Contacts *(VIII.C.2)*

- *A qualified mental health or medical professional shall conduct check-ins at least once a week, to assess and document the health status of all prisoners in Segregation, and shall make referrals as necessary. The*

[36] As mentioned previously, audits of the confidential contacts were submitted with the comments for the draft report. While the frequency of confidential contacts in restricted housing increased, they remained non-compliant.

check-in shall include a brief conversation with each prisoner, a visual observation of the cell, and an inquiry into whether the prisoner would like to request a confidential meeting with a mental health or medical provider. Steps shall be taken to ensure effective communication, as well as auditory privacy consistent with security needs. When a prisoner in Segregation requests a confidential meeting with a mental health or medical provider, or the medical or mental health professional identifies a mental health or medical need, staff shall make appropriate arrangements to include triage, examination and treatment in an appropriate clinical setting. In such cases, staff shall give the prisoner the opportunity to complete a health care request but will otherwise initiate a referral without requiring the prisoner to complete a request form.(VIII.C.2.b)

Response to Decompensation in Segregation *(VIII.C.3)*

- *If a prisoner in Segregation develops signs or symptoms of mental illness where such signs or symptoms had not previously been identified, suffers deterioration in his or her mental health, engages in self-harm, or develops a heightened risk of suicide, the prisoner shall immediately be referred for appropriate assessment and treatment from a qualified mental health professional who will recommend appropriate housing and/or programming. (VIII.C.3.a)*
- *Jail staff shall follow a mental health recommendation to remove a prisoner from Segregation unless such removal poses a current safety risk that is documented. In such a case, the Commander or management-level designee shall be notified and staff shall work to remove the prisoner from Segregation and secure a placement in an appropriate treatment setting at the earliest possible time. (VIII.C.3.b)*

FINDINGS/DISCUSSION:

Partially compliant. It did appear that detainees were receiving clinical rounds in segregation but there were cases where that did not occur weekly. It was unclear if it was due to staffing issues but this seemed likely.

Recommendations:

1. Assign mental health staff for weekly restrictive housing rounds.
2. It is recommended that once item 1 above is completed, audits of compliance begin.
3. It is also recommended that the mental health supervisor assigned to restrictive housing also complete rounds to monitor the clinician's accuracy in identifying patients who need confidential contacts and/or are decompensating and require a move to another setting.

Placement of Prisoners with Serious Mental Illness in Segregation (VIII.D)

1. *Prisoners with a mental health condition meeting criteria for placement in a Designated Mental Health Unit (2P, IOP, OPP) will not be placed in Segregation, but rather will be placed in an appropriate treatment setting – specifically, the inpatient unit or other Designated Mental Health Unit providing programming as by JPS in their program services booklet. (VIII.D.1)*
2. *In rare cases where a prisoner with a mental health condition meeting criteria for placement in a Designated Mental Health Unit presents an*

immediate danger or significant disruption to the therapeutic milieu, and there is no reasonable alternative, such a prisoner may be housed separately for the briefest period of time necessary to address the issue, subject to the following: (VIII.D.2)

a) The prisoner shall receive commensurate out-of-cell time and programming as described in Exhibit A-2 (including for IOP and OPP, 10 hours/week of group treatment/structured activities, 7 hours/week unstructured out-of-cell time, weekly individual clinical contact) with graduated programming subject to an individualized Alternative Treatment Program.

b) The prisoner shall receive the following:

i. As part of the weekly confidential clinical contact, the clinician shall assess and document the prisoner's mental health status and the effect of the current placement on his or her mental health, and determine whether the prisoner has decompensated or is at risk of decompensation.

ii. The weekly check-ins described in Section VIII.C.2.b shall supplement, and not be a substitute for, the weekly treatment session described herein.

iii. Treatment provided in the least restrictive setting thatis appropriate based on the prisoner's circumstances.

iv. Privileges commensurate with the Designated Mental Health Unit program, unless modified in an Alternative Treatment Program based on individual case factors that are regularly reviewed.

v. Daily opportunity to shower.

FINDINGS/DISCUSSION:

Partially compliant. Significant concern continued with this author as to the high number of patients with SMI in restrictive housing as outlined earlier. Seventy-four patients were housed in restrictive housing and 54 were identified as ADSEG, MAX, or DISC (as of 4/25/22).

Recommendations

1. Improve quality of segregation reviews and audit for completion in a confidential setting.
2. Provide documented clinical supervision to designated restricted housing mental health staff member to support the staff member and ensure appropriate application of clinical expectations and compliance with the Consent Decree. Because of the workload of existing supervisors, peer review may also be considered to assist the clinical supervisor.
3. Complete audits of all elements as part of QI and provide findings as part of document production.

3. A prisoner with Serious Mental Illness requiring restraints (e.g., handcuffs, belly chains, etc.) shall not be denied clinically indicated group or individual treatment due to security factors, absent exceptional circumstances thatare documented. Prisoners with Serious Mental Illness housed in Segregation who require restraints when out of cell shall have

the opportunity to work their way out of restraints through graduated programming subject to an individualized Alternative Treatment Program. (VIII.D.3)

FINDINGS/DISCUSSION:

Noncompliant. Not only did a large number of patients continue to be placed in segregation/restrictive housing despite a diagnosis of serious mental illness, they continued to be seen in nonconfidential settings due to "behavioral/unpredictable" reasons and "custody request" without specific clinical justification documented in the progress note and suggesting it was based on prior behavior or standard language used to excuse a cell front visit. This creates access problems for patients. While the alternative treatment plan/program (ATP) was incorporated into the treatment policy, data on patients in segregation with ATPs was not provided this monitoring round. Based on discussions during policy development, it suggested that it was still utilized. However, patients with lengthy stays or repeated restrictive housing stays (e.g., case 2, 11) did not appear to have an ATP.

Recommendations:

1. Identify patients with repeated or long lengths of stay in restrictive housing and patients with SMI who require restraints out of cell. It is recommended that mental health staff then review those cases for movement to another setting or consideration of an ATP to allow the patient to work their way out of restraints.
2. Provide this data as part of document production.
3. Complete regular QI studies/audits of the process.

QUALITY ASSURANCE, MENTAL HEALTH CARE

1. *The JPS Medical Director, the JPS Program Manager, jail administrators, and the medical psychiatric, dental, and nursing directors, or appropriate designees, will attend and participate in this process at a minimum of every quarter. Formal minutes will be taken and maintained whenever the committee convenes.*
2. *The mental health care quality assurance plan shall include, but is not limited to, the following:*
    a) *Intake processing;*
    b) *Medication services;*
    c) *Screening and assessments;*
    d) *Use of psychotropic medications;*
    e) *Crisis response;*
    f) *Case management;*
    g) *Out-of-cell time;*
    h) *Timeliness of clinical contacts;*
    i) *Provision of mental health evaluation and treatment in confidential settings;*
    j) *Housing of inmates with SMI, including timeliness of placements in higher levels of care and length of stay in various units;*
    k) *Number of commitments pursuant to Welf. & Inst. Code § 5150, et seq.;*
    l) *Use of restraint and seclusion;*
    m) *Tracking and trending of agreed upon data on a quarterly basis;*

n) *Clinical and custody staffing;*
o) *Morbidity and mortality reviews with critical analyses of causes or contributing factors, recommendations, and corrective action plans with timelines for completion; and*
p) *Corrective action plans with timelines for completion to address problems that arise during the implementation of this Remedial Plan and prevent those problems from reoccurring.*

3. *The County will conduct peer and supervisory reviews of all mental health staff and professionals at least annually to assess compliance with policies and procedures and professional standards of care.*

FINDING/DISCUSSION:

Partial Compliance. Mental health reestablished its subcommittee during the prior monitoring period. Document production for this review period provided only one MH QI Subcommittee agenda/minutes with the first document request but suggested that the meeting occurred quarterly. Two additional agendas/minutes were included with the updated document request in August 2022. Further proof of practice is needed to include required members and signature sheets for members. Peer review had not been established. There had been audits completed of processes such as referrals but data was not provided. There was at least one QI study of EOP outcomes.

Recommendations.

1. All proof of practice for completed mental health-related meetings should be provided as part of document production.
2. It is recommended that QI studies established and/or completed during the monitoring round be provided as part of data production.
3. It is recommended that the MH QI Subcommittee prioritize the above required quality assurance areas with frequency of audits occurring consistent with the prioritization level. These should be tracked to monitor compliance with completion.
4. It is recommended that continued data tracking and reporting systems be developed in conjunction with County IT staff and medical record vendor.

CONCLUSION

The Defendants have made progress in specific areas related to mental health treatment since the Consent Decree was entered by the Court. Their progress is severely limited by physical plant limitations and staffing challenges. Improvement has been noted where evidence through SME analysis and proof of practice. It should be noted that JPS has done a significant amount of work on policy development, training, and implementation on aspects of the Consent Decree.

This is a large project that will take time and extensive investment of resources to provide staff with an opportunity for success in compliance with the Consent Decree. There may have been more areas where Defendants had made progress, but the limitations with data production continue to hamstring Defendants in providing proof of practice. Defendants are *strongly* encouraged to identify necessary resources and focus on data reports and tracking that demonstrate progress and/or compliance with Consent Decree requirements.

The utilization of consultants has been a positive move in developing data driven problem-solving. Unfortunately, the findings of the feasibility studies revealed that the MJ cannot achieve full compliance with the Consent Decree given its physical plant limitations and deficiencies, and that both physical plants (MJ and RCCC) require extensive cleaning, maintenance, and ongoing preventive maintenance to be acceptable environments of care for

medical and mental health patients.

Defendants had many staff who appeared committed to providing quality care for those in their custody. Utilizing the energy and knowledge of these staff to drive improvements and solutions seems to have the greatest potential positive impact. That can occur through the utilization of QI studies to provide line staff with input into problem-solving and implementation of those solutions.

APPENDIX A

Mays v. County of Sacramento

MENTAL HEALTH and SUICIDE PREVENTION CONSENT DECREE PROVISIONS

Document Request: Please provide each item in its own file clearly labeled with the name of the contents (e.g., Suicide Prevention Policy). Any folders containing multiple similar items should also be labeled clearly (e.g., Suicide Prevention, Restrictive Housing, Treatment Teams) and should not merely be labeled with the section number. Please note that mental health services include medication management. If there are no applicable documents for an item, please provide a single page that clearly indicates "no applicable documents for this item" on a word document for that file. It is possible that as a result of the documents received, additional documents may be requested.

There are several items whose production will be necessary to facilitate the upcoming site visit. These items should be easy to produce because they should exist and be regularly updated as part of the regular operations of JPS/mental health and the jails. These items are described in request numbers 8, 17, and 19. If there are any concerns about producing these items, please contact the subject matter experts immediately. The request is that items 17 and 19 be provided by 1/7/22 to facilitate visit planning while item 8 can be provided at arrival during the entrance meeting.

Requested due date: we are respectfully requesting that these documents all be provided by January 31, 2022. If any documents cannot be provided by that due date, at your earliest convenience please provide a table listing the items that will not be available by that date and the actual date for production of documents.

NOTE:

A. Please provide a narrative description of the mental health program, improvements since the last monitoring report that have been implemented, have target dates, or are simply "in process"). Please identify any barriers to care as well as accomplishments since the last monitoring report.

1) **Table of Contents** for any updated policies provided for the Sacramento County Sheriff's Department (SCSD) Policy and Procedure Manual (e.g., policies, local operating procedures, operations memoranda);

2) Any updated SCSD and Adult Correctional Health P**olicies**, procedures, and directives relevant to suicide prevention, mental health services, and detainees/inmates receiving mental health services (e.g., disciplinary, use of force, restrictive housing, clinical documentation, tracking). Please include all new policies that have been implemented following approval from *Mays* defense/plaintiffs counsel and subject matter experts. These should be consistent with the Table of Contents in item 1;

3) Any updated Jail Psychiatric Services **Policies**, procedures, and directives relevant to suicide prevention and mental health services. Please include all new policies that have been implemented following approval from Mays defense/plaintiffs counsel and subject matter experts. These should be in individual files titled according to the policy, procedure, and/or directive title;

4) Any updated and DRAFT intake screening, health evaluation, mental health assessment, treatment planning and any other **Forms** utilized for the identification and treatment of suicide risk, developmental/cognitive disabilities, and mental illness including release planning;

5) Any new or updated **Training Curricula** (include draft training) regarding pre-service and in-service staff training, as well as curricula, handouts, etc. regarding suicide prevention, mental illness, and mental health services (since the last review report);

5a) Training **Compliance** for the monitoring period reported in raw numbers by discipline/staff category and course as follows (excludes non-specialized Suicide Prevention training, see No. 12 below):

STAFF TITLE (Sgt, psychiatrist, etc)	COURSE	REQUIRED ATTENDEES (number)	NUMBER ATTENDED*	% compliant

*this figure should include only the number of required attendees who were present throughout the training.

A. Indicate whether training was in-person (e.g., in a training space with attendees present), virtual interactive (e.g., virtual but presence is monitored live and attendees can ask questions), on-the-job (e.g., shift briefing, staff meeting), or on their own (e.g., staff instructed to review policies or other training materials and submit signed form).

6) Any new or updated training curriculum (including DRAFT) regarding additional suicide prevention and mental health training provided to custody officers assigned to the **Designated Mental Health Units**;

6a) Training compliance for the monitoring period reported in raw numbers by discipline/staff category and course (additional training for MH designated unit correctional staff) as follows:

STAFF TITLE (Sgt, officer, etc)	COURSE	REQUIRED ATTENDEES (number)	NUMBER ATTENDED*	% compliant

*this figure should include only the number of required attendees who were present throughout the training.

7) Any new or updated **Training Curriculum** (including DRAFT) regarding additional training provided to medical and mental health staff regarding development of **Suicide Risk Assessments and Treatment Plans** for suicidal inmates specifically and mental health caseload inmates generally;

7a) **Training Compliance** for the monitoring period reported in raw numbers by discipline/staff category and course (additional training for MH designated unit medical/MH staff) as follows:

STAFF TITLE (nurses, clinicians, etc)	COURSE	REQUIRED ATTENDEES (number)	NUMBER ATTENDED*	% compliant

*this figure should include only the number of required attendees who were present throughout the training.

7b) Indicate whether the staff are **Licensed**. If not licensed, please indicate who the clinical supervisor is in each case. This can be provided in a separate document if that eases the burden

8) **Census** of all detainee/inmates. These should be broken down by level of care. The date the data was pulled should be noted on each document. ***[NOTE: For the site visit 1/12-1/14/22 please provide a census of caseload patients by facility (Main Jail and RCCC). Provide total numbers at each facility and then break down by specific levels of care. Also include a census of anyone on suicide watch at either facility, pre-admit inpatient waitlist, and census of caseload patients housed in segregation/RHUs and TSEP by facility. This census lists should have detainee name, X reference number, booking date, level of care, and housing location. These will be used for the site visit.]***

8a) Census for each facility. Total numbers at Main Jail and RCCC on the day that this request is completed.

8b) Next, please list the total numbers in any specialized custodial unit (e.g., segregated/restricted housing, protective custody, TSEP, programming units, mental health units (e.g., unit 2, IOPs). If possible, please break down those on mental health caseload;

8c) Any modified, PROPOSED or changes in locations of all designated areas utilized to house inmates on suicide precautions and mental health designated units (current and proposed);

8d) **Roster** by level of care (acute, IOP, etc.) and alpha order; this should include detainee name, X number, and level of care at a minimum.

9) Any new or updated policies, procedures, directives (including DRAFT) related to Q**uality Assurance and Continuous Quality Improvement** in the delivery of mental health services and suicide prevention;

10) **Minutes** from Mental Health Continuous Quality Improvement and Suicide Prevention Subcommittee, as well as any other regularly scheduled multidisciplinary meetings related to suicide prevention (such as the newly enacted Suicide Precautions Meeting), mental health and quality assurance for July 2021 to the present.

10a) Include minutes and audit results from Mental Health Action Plan item F.1.

10b) Include minutes and audit results for any studies, audits, or quality improvement teams initiated since July 2021.

11) Documentation of overall staff completion rates for Suicide Prevention [**only Provision VII. B)1 and B)2]** and First Aid/CPR according to the following format:

_____ % of all officers received suicide prevention training during previous 12 months.
_____ % of all medical staff received suicide prevention training during previous 12 months
_____ % of all mental health staff received suicide prevention training during previous 12 months
_____ % of all officers currently certified in CPR
_____ % of all medical staff currently certified in CPR

12) Entire **Case Files** (jail, medical, and mental health), investigative reports, and mortality reviews of all inmate suicides from January 2021 to present;

13) Total number of **Serious Suicide Attempts** (incidents resulting in medical treatment and/or hospitalization) for the period of January 2021 to present, as well as all documentation of such incidents by the Suicide Prevention Task Force;

14) **Listing** of inmates on **Suicide Precautions** from September, 2021 to the present;

15) **Listing** of all inmates confined in **Safety and Ad Seg Cells** for each month for July through December **2021** (include **Length of Stay**).

16) **Listing** of current inmates receiving **Mental Health Services** by level of care, FOSS level, housing, and diagnosis (can provide one spreadsheet that incorporates all of these aspects);

17) **Mental Health Treatment Schedules** by unit and facility [**NOTE:** For the site visit a daily schedule of clinical activities will need to be provided in advance, by 1/5/22 at the latest);

17a) Calendar or tracking of groups canceled since the first monitoring period report and reason for cancellation.

17b) Any reports tracking or documenting the amount of structured therapeutic activity provided at each level of care scheduled, offered, and attended treatment.

18) Current **Mental Health Staffing** allocations and any proposed additions:

A. Provide current mental health staffing in grid form by program. Example:

EXAMPLE:	Allocated	Licensed (Y/N)	Filled	% time in this area (half time in IOP would be reflected as .5 filled	Functional Vacancy (divide unfilled positions by allocated positions and that is your functional vacancy rate)
IOP - psychiatrist					
IOP – psychologist					
IOP – social worker					
IOP – psychiatric nurse practitioner					
IOP – other					
Unit 2 – psychiatrist					
Unit 2 - psychologist					
Unit 2 – nursing staff					
Continue on until all programs and mental health staff are included					

19) **Schedule** (weekly/monthly/quarterly) of **multidisciplinary Treatment Team meetings** provided to inmates receiving mental health services by unit or level of care;

19a) calendar and/or chronological listing of MDTs canceled and reason for cancellation.

20) The Defendants' *Fourth* Status Report in Mays v. County of Sacramento;

21) Any Suicide Prevention Action Item Tools subsequent to May 24, 2021and any Mental Health Action Item Tools subsequent to December 1, 2021

22) Any **Audits**, logs, tracking or reports on **Mental Health Compliance** with the remedial plan for individual and group treatment, referral tracking and compliance.

23) A copy of the M**ental Health Tracking Log/Report** for referrals to mental health. This log should include whether the referral was emergent, urgent, or routine, detainee name and number, date of referral and date seen.

24) Any **Audits**, logs, reports, or meeting minutes from **Medication Management**, specifically psychotropic mediations.

2a) list of all detainees who have been on psychotropic medication for at least three months.

2b) list of all detainees who have been under forced medication orders due to mental health reasons.

25) Any **Logs**, audits, or minutes from quality management meetings regarding **Release Planning** services offered.

26) **Minutes** from any **Therapeutic Space Meetings**; documentation (e.g., sign in sheets) to provide proof of practice for attendance.

27) In Response to Mental Health Action Tool ():

a. Provide update on Group Progress Note testing stage and findings (See A.2.)
b. Provide Policy and Proof of Compliance as indicated for Provision B (See B.1 and B.2)
c. Provide Lesson Plan and Proof of Compliance for Provision C (see C.1 through C.3)
d. Provide Proof of Compliance for Provision E (See E.1)
e. Provide Lesson Plan and Proof of Compliance for Provision G.1

28) Use of Force (UOF):

a. Provide all incident reports and UOF packages and any supporting additional documentation from security, medical, and/or mental health staff related to the incident.

29) Disciplinary Actions:

a. Provide a log of all misconduct disciplinary reports written since 9/1/21 (to present) for caseload patients. This log should include detainee name, X reference number, location of misconduct (facility and unit/area), date of misconduct at minimum but preferably include outcome of write-up (e.g., placed in RHU for 33 days, found guilty and given loss of visits);

b. Once the log has been provided, there will be a sample selected for SSO to provide:

1. Disciplinary write up,
2. Mental health input,
3. Supporting documentation include disciplinary hearing officer's documentation and disposition.

Submitted on January 1, 2022

FOLLOW-UP QUESTIONS/REQUESTS
POST-SITE VISIT
July 1, 2021
Unless stated specifically, the monitoring round shall be 1/1/21 to 6/1/21.

1. Use of Force (UOF)
    a. Total number of UOF incidents for the period of January 1, 2021 to June 1, 2021. Separate incident total by facility (e.g., MJ reported 125 UOF incidents while RCCC reported 200 incidents).
    b. For each facility, report the total number of UOF incidents broken down by those receiving mental health services and those not receiving mental health services.
    c. Select 10 detainees receiving mental health services from each facility (for a total of 20) and send the incident/UOF packages.
        i. Selection for the 10 detainees where the UOF incident occurred at THAT facility. The current location of the detainee is irrelevant for this item.
        ii. Use the following random numbers to select cases:

	RCCC	MJ
Random selection based on random number generator	8, 16, 25, 36, 39, 54, 57, 76, 89, 95	6, 13, 16, 21, 31 77, 83, 94, 95, 98

        iii. With these tables, a RCCC would pull incident package 8, incident package 16 and so on. The entire packet should be scanned (if reports cannot simply be downloaded) and placed on the shared drive with a notification to me.
        iv. As with RCCC above, MJ would provide complete package for case 6, case 13, and so on.

2. Out of cell time data reports for all IOP detainees (male and female) for the months of April and May 2021, and for 2P inpatient patients. The report should be separated by facility.

UOF	MJ	RCCC	Comments
Male IOP			
Female IOP			
Comparison data from non-MH unit, if possible (note unit(s) used)			
Male/female inpatient		**n/a**	

3. Schedules for available treatment space. During the site visit I was told that the available confidential space (e.g., classrooms) was so problematic that they had to schedule contacts in that space. Please provide the schedules for each unit, regardless of unit function.
4. Revised patient lists. The lists were not to include duplicates but each detainee is included at least 3 times. You do not have to correct the old list as it may be easier to generate new lists/reports

and ensure that there is no redundance. (this refers to #9). Please just clarify the date of the data in the various items.

APPENDIX B

Mental Health Program Narrative

Acute Psychiatric Unit

The Acute Psychiatric Unit is a locked psychiatric facility at the Main Jail (MJ) for patients who have been evaluated to be a danger to themselves, danger to others, or gravely disabled as a result of a mental health disorder.

Intensive Outpatient (IOP)

IOP (35 beds - MJ and 24 beds – Rio Consumes Correctional Center (RCCC)) is a designated mental health housing and program unit for patients diagnosed with a serious mental illness. IOP provides individual and group treatment and therapeutic recreation activities.

Outpatient Psychiatric Program (OPP)

OPP provides case management and individual therapy to patients diagnosed with a serious mental illness. OPP patients are housed in designated mental health housing units.

General Population-Case Management

Case Management services are provided to patients who have been diagnosed with a mental illness, but are able to independently house and program in the general population.

Jail Based Competency Treatment Program

JBCT is a contracted program between the Sacramento Sheriff and the Department of State Hospital where mental health professionals will provided restoration treatment to incarcerated individuals who were found incompetent to stand trial. This regional program treats individuals from every county in California with the goal of having them restored back to competency or transferred to the state hospitals within 90 days.

Mental Health
Program Update
JPS/ACMH
January 2022

Opportunities

- Submitted staffing plan and space request to ACH.
- EOP staff augmentation may help support providing groups in OPP and IOP on evenings and on weekends.
- Created workflows and custody communication documents that will highlight need for more custody support.
- Provide consistent Training for custody assigned to MH programs – Mental Health Conditions: *Evaluating and Responding to Psychiatric Symptoms in our Inmate Population*.
- Scheduled Mental Health Conditions: *Evaluating and Responding to Psychiatric Symptoms in our Inmate Population* training with IOP & JBCT deputies at the Branch on February 2, 2022, and Main Jail IOP and APU on February 7, 17 and 23, 2022.
- Continue to address space limitations on Acute Psychiatric Unit with ACH and SSO – MH considers this a high priority issue.
- Identified and in process of contracting with expert to develop LGBTQ+ /Transgender training to comply with WPATH training requirements.
- Identified and in process of contracting with expert to develop Use of Force and de-escalation training for MH staff.
- If receive staff augmentation for MH RVR and Ad Seg program increase the number of rules violation reviews.
- Collaborate with SSO on referral process and coordination to ensure MHs involvement in planned Use of Force incidences.

Challenges/Barriers

- No mechanism for Constant Observation. SITHU decommissioned and no female SITHU.
- Lack of sufficient custody staff to support programming/patient care in MH units, MDTs and groups in OPP and APU.
- Lack of confidential space to conduct MH interviews and group programming.
- Unable to fully implement MDTs for most patients on MH caseload until full staffing augmentations are in place. Currently, titrating services based on staffing.
- Unable to implement comprehensive treatment planning for most patients on MH caseload until full staffing augmentations are in place. Currently, titrating services based on staffing.
- MH RVR and Administrative Segregations reviews will be more fully implemented once staffing augmentations are in place. Currently providing MH RV reviews in IOP, APU and Administrative Segregation utilizing current IOP and OP staff. Require staffing augmentation to fully support this function.
- Do not have staff to provide constant observation for patients on suicide precautions.
- Redirected outpatient LCSWs to support Administrative Segregation assessments and provide groups/support on APU. Staffing is inconsistent due to high acuity and crisis intervention needs in Outpatient program.

- Difficulty recruiting sufficient staff to fill vacant positions.

APPENDIX C

(From: EXHIBIT B: JOINT STATUS REPORT NOTICE OF DISPUTE AND MOA)

MEMORANDUM OF AGREEMENT

Mental Health and Suicide Prevention Remedial Measures Implementation
Mays v. County of Sacramento (Case No. 2:18-cv-02081-TLN-KJN)

Whereas, Plaintiffs' Class Counsel and Defendant County of Sacramento (the "Parties") reached a settlement agreement in *Mays v. County of Sacramento* (Case No. 2:18-cv-02081-TLN-KJN), with a Consent Decree approved by the Court on January 13, 2020; and

Whereas, in the first round monitoring reports (filed Jan. 20, 2021), the *Mays* court-appointed experts found that the County was not in compliance with Mental Health Care and Suicide Prevention provisions of the Consent Decree; and

Whereas, to assist the County in the task of implementation, the court-appointed experts identified "focus areas" in the first round monitoring reports – that is, issues that are urgent to class member well-being, are of critical importance to broader compliance efforts, and in many cases would be relatively easy to resolve with sufficient attention; and

Whereas, the second round monitoring reports (filed Oct. 4, 2021) documented insufficient progress on the identified "focus areas"; and

Whereas, the County is responsible for provision of a Sacramento County Jail ("Jail") Mental Health Care and Suicide Prevention system consistent with legal and constitutional requirements and the Remedial Plan measures set forth in the *Mays* Consent Decree, and as such, must ensure appropriate resources, services, oversight, performance expectations, and consequences for deficiencies in the delivery of Mental Health Care services, including by its contracted provider (UCD Department of Psychiatry & Behavioral Sciences); and

Whereas, Class Counsel sent written correspondence (the "Dispute Notice," attached as **Exhibit A**), dated October 29, 2021, demanding that the County take immediate, affirmative steps to implement foundational "focus area" remedial provisions regarding Mental Health Care and Suicide Prevention; and

Whereas, consistent with the Dispute Resolution provisions set forth in the Consent Decree, the parties notified by written correspondence the designated Dispute Resolution mediator, the Hon. Nathanael Cousins, about the dispute; and

Whereas, the Parties and court-appointed experts on Mental Health Care (Mary Perrien Ph.D.) and Suicide Prevention (Lindsay Hayes) participated in a video conference with Counsel for the Parties as well as representatives from the County Executive, Sheriff's Department, and Adult Correctional Health including Mental Health representatives on November 9, 2021, as part of the Dispute Resolution process; and

Whereas, the County provided additional information regarding its response to the issues raised in the Dispute Notice on November 15, November 22, December 6, December 27, 2021, February 8, 2022; and

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Whereas, the Parties have had several additional communications to discuss specific policy revisions and staff training that are necessary to address "focus area" remedial provisions discussed in Class Counsel's October 29, 2021 Dispute Notice; and

Whereas, the Parties agree that Jail population-related stressors impose substantial barriers to implementation of certain "focus area" remedial provisions discussed in Class Counsel's October 29, 2021 Dispute Notice, including as related to inadequate staffing and physical plant deficiencies; and

Whereas, the Parties have previously agreed that "population reduction of the jails will facilitate compliance with th[e] Remedial Plan;" and

Whereas, the Parties have further agreed that if the "County is not fulfilling the provisions of this Remedial Plan due to staffing deficiencies, the parties will meet and confer regarding what steps to take to reduce the population of the jail, including available resources to facilitate population reduction;" and

Whereas, the County has acknowledged that "there is insufficient staff and space to support requirements within the remedial plan," County Remedial Plan Status Report at 8 of 130 (Dkt. 152, Jan. 20, 2022); and

Whereas, Sacramento County is currently overseeing two assessments relevant to Jail population-related and physical plant deficiencies that are barriers to implementation of the Remedial Plan, as follows:

First, the County is overseeing an assessment of the Sacramento County Main Jail facility and the practicability of implementation of all *Mays* Consent Decree requirements (the "Facilities Report"). This assessment will include an analysis of the maximum incarcerated population that the Main Jail can support while meeting the terms of the Consent Decree;

Second, the County is overseeing a jail population assessment that will include policy and program recommendations to reduce the incarcerated population through lowering lengths of stay, bookings, and future jail reoccurrence, including through implementation of community programs (the "Jail Population Report"); and

Whereas, the findings from these two assessment reports will be publicly available when completed, and will inform the County's efforts towards implementation of the *Mays* Consent Decree;

Whereas, the Parties agree that the County currently does not have a plan for reaching compliance with Consent Decree requirements related to the following issues raised in Class Counsel's October 29, 2021 Dispute Notice: (1) remediation of physical plant deficiencies that prevent delivery of adequate health care services; (2) provision of

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adequate staffing to deliver adequate mental health care services; (3) provision of adequate acute mental health level of care services at a capacity to meet class member needs; and (4) provision of adequate Intensive Outpatient Program mental health level of care services at a capacity to meet class member needs;

Now therefore, the Parties enter into this Memorandum of Agreement with the following terms:

PROVISIONS RESOLVING ISSUES RAISED IN THE OCTOBER 29, 2021 DISPUTE NOTICE

MENTAL HEALTH CARE

Mental Health Treatment Delivery (EOP and Levels of Care System) (Focus Area #3)

1. **Enhanced Outpatient Program (EOP).** The County has implemented and will expand a new Enhanced Outpatient Program (EOP) level of care, to serve more *Mays* class members with serious mental illness. The EOP level of care is designed to reduce disciplinary write-ups, emergent incidents, and need for acute or IOP levels of care. EOP level of care services include regular clinical contact from an assigned case manager, care coordination with treatment partners, mental health treatment planning, crisis intervention, psychoeducation, and increased collaboration with custody to address housing, discipline or other issues that arise. The County will ensure that EOP services are adequate and that EOP capacity is sufficient to meet class member needs consistent with Consent Decree requirements. The Subject Matter Experts will monitor EOP programming, services, and capacity in all future monitoring activities.

2. **Levels of Care System.** The County has revised its mental health levels of care system to align with Consent Decree requirements. It has ceased to utilize, and will not utilize, Frequency of Service Study (FOSS) levels for purposes of the Jail's mental health levels of care system.

a. The Mental Health Care Subject Matter Expert has found that the historically-used FOSS levels "do not map well onto the acuity of a patient nor onto existing treatment programs," and "do not address treatment planning" or "levels of mental health care which have specific timelines and expectations associated with them" in the Consent Decree.

b. On December 30, 2021, with input from the Subject Matter Expert and Class Counsel, the County finalized a revised Mental Health Policy No. 04-02, which establishes that "FOSS levels are not used to determine level of [mental health] services of or timelines for care." Instead, "level of and timelines for patient care will be determined by patient needs, clinical assessments, and assigned care location – Acute Psychiatric Unit (APU).

Intensive Outpatient Program (IOP), or Enhanced Outpatient Program (EOP)."

c. The revised policy clarifies that the Jail may use FOSS levels solely for data collection and analysis purposes.
d. The County will ensure that the system for assigning appropriate levels of care is accurate, effective, and consistent with Consent Decree requirements. The Subject Matter Experts will monitor this matter in all future monitoring activities.

Use of Force Policies and Practices, Class Members with Disabilities (Focus Area #4)

3. On February 4, 2022, the County, with input from the Subject Matter Expert and Class Counsel, completed revision of its Mental Health Policy No. 07-05 regarding Mental Health-Planned Uses of Force policy.
a. This policy is necessary to implement Remedial Plan requirements to employ de-escalation methods that take into account a class member's mental health or adaptive support needs, utilize mental health staff involvement whenever possible prior to utilizing planned use of force, and requiring video documentation and supervisory review of Use of Force incidents.
b. Mental health staff will receive de-escalation and use of force training starting in late April/early May 2022, which will include training on relevant *Mays* Consent Decree provisions.
c. Adequacy of ACH Mental Health Policy No. 07-05 implementation, training and compliance with Consent Decree requirements regarding Use of Force practices will be monitored by the Subject Matter Experts.
4. The County will modify the Sheriff's Office's Operations Order *Use of the WRAP Restraint Device*, including based on input from the Subject Matter Experts and Class Counsel, to ensure compliance with all relevant Remedial Plan provisions. Use of force incidents, including all uses of the WRAP Restraint Device, will be monitored by the Subject Matter Experts.

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SUICIDE PREVENTION

Suicide Prevention Policies (Focus Area #1)

5. Adult Correctional Health, with input from the Subject Matter Experts and Class Counsel, completed revision of its Suicide Prevention policies (Policy No. 01-15 and 02-05) in September 2021.
a. Adult Correctional Health provided a two-hour suicide prevention training to health care staff on several dates between December 2021 and February 2022. Training of custody staff rolled out in March 2022.
b. In February 2022, the County finalized a 4-6 hour suicide prevention training that covers essential aspects of the Remedial Plan as to suicide prevention. The County will utilize a multidisciplinary team to deliver this training to all newly hired mental health, medical, and custody staff.

Such training will begin in June 2022 and will be provided on an ongoing basis as staff members are onboarded.
c. The County will adapt the new-staff suicide prevention training referenced in Paragraph (b), above, to cover all essential suicide prevention aspects of the Remedial Plan, including requirements set forth in this Agreement, to be delivered to all current mental health, medical, and custody staff who have not received the new-staff training. The training was reviewed and approved by the Subject Matter Experts. Training has begun and will continue until all staff members are trained.
6. The County will complete revision of the Sheriff's Office's Suicide Prevention policy, procedure, and training, including based on input from the Subject Matter Experts and Class Counsel, to ensure compliance with all relevant Remedial Plan provisions. The County's Suicide Prevention policies, procedures, and trainings will require the following, with appropriate documentation to show proof of practice:
a. Staff will offer patients on suicide precautions a shower at least daily, and upon reasonable request.
b. Staff will provide prompt assistance with hygiene and cleaning to patients on suicide precautions whenever circumstances warrant.
c. Staff will affirmatively offer patients on suicide precautions water at least every two hours, and upon request.
d. Staff will affirmatively offer patients on suicide precautions food at least consistent with normal daily meal provisions, and upon request (*e.g.*, if

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they missed a meal due to their mental health or suicide observation status).
e. Staff will provide patients on suicide precautions and held in a cell that does not have a toilet access to a toilet promptly upon request.

Addressing Overuse and Unnecessary Use of Safety Smocks (Focus Area #2)

7. Adult Correctional Health shall, with input from the Subject Matter Experts and Class Counsel, has finalized revisions to its suicide prevention policies, including to clarify that (a) decisions about the removal of clothing and the issuance of a safety smock to class members on suicide precautions will be under mental health staff authority based on the clinical judgement of a licensed clinician, (b) class members will have clothing restored prior to discharge from suicide precautions and as soon as clinically appropriate while on suicide precautions, and (c) mental health staff will conduct at least daily assessments of a patient's readiness for restoration of clothing and shall document reasons for continued use when indicated.
8. The Sheriff's Department's Suicide Prevention policy and procedure will be

revised to align with Adult Correctional Health policy regarding use of safety smocks.

9. Staff compliance with safety smock policies to prevent overuse and/or unnecessary use of safety smocks will be subject to a documented quality assurance process for at least 12 months from the date of this Memorandum of Agreement, with quality assurance review at the monthly Suicide Prevention Subcommittee meetings.

a. Health care and custody supervisors will conduct at least weekly reviews of safety smock use to ensure proper implementation, with corrective action taken when warranted.

b. The Mental Health and Suicide Prevention Subject Matter Experts will monitor safety smock policy implementation and the quality assurance process to ensure compliance with relevant Consent Decree requirements.

Patient Confidentiality for Suicide Risk Assessments, Mental Health Clinical Encounters (Focus Area #3)

10. The County has fixed the inoperable telephone inside the designated mental health Interview Room in the Main Jail's intake area, and will take additional steps to improve confidentiality in the Main Jail intake screening area to the greatest extent possible given the deficient physical plant. The Subject Matter Experts will review and assess these modifications on future monitoring visits.

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11. As an interim measure to mitigate physical plant deficiencies impacting delivery of care, the County is utilizing two confidential attorney visit booths on the Main Jail's third floor, to improve confidentiality of mental health appointments. These interim measures, along with other measures to address deficiencies in the confidentiality of mental health contacts, will be reviewed by the Subject Matter Experts during on-site monitoring.

12. As an interim measure to mitigate physical plant deficiencies impacting delivery of care, the County will relocate (i) staff currently using Main Jail office space and (ii) storage space to a nearby off-site location, to free up rooms and the Main Jail 3-West classroom that has been used as office space. These spaces will be repurposed for confidential individual treatment and group therapy for people in the Intensive Outpatient Program or otherwise requiring mental health treatment. The Subject Matter Experts will assess the adequacy of these spaces during upcoming monitoring visits.

13. The County acknowledges that above-identified interim steps will not be sufficient to facilitate full remediation of the legal and constitutional deficiencies identified in the *Mays* case and addressed in the Consent Decree. Issues regarding provision of patient confidentiality for suicide risk assessments and mental health clinical contacts will be addressed through continued Dispute Resolution processes related

to physical plant and staffing deficiencies, as set forth on Pages 10-13, below.

Direct Observation of Class Members on Suicide Precautions (Focus Area #4)

14. On November 15, 2021, ACH ordered an end to use of Closed Circuit TV (CCTV) for purposes of observing class members on suicide precautions. The Mental Health Medical Director followed up with all psychiatry staff.

15. Adult Correctional Health, with input from the Subject Matter Experts and Class Counsel, finalized Policy No. 02-05 – Suicide Prevention Program on November 16, 2021, which removes CCTV observation and provides for direct observation consistent with Consent Decree requirements.

16. The Subject Matter Experts will evaluate implementation of suicide precaution observation practices during upcoming monitoring visits.

Appropriate Provision of Privileges and Property for Class Members on Suicide Precautions (Focus Area #5)

17. Adult Correctional Health shall, with input from the Subject Matter Experts and Class Counsel, finalized revisions to its suicide prevention policies to reflect Remedial Plan requirements regarding privileges and property for patients on suicide precautions. The Sheriff's Office's Suicide Prevention policy and procedure will be revised to align with Adult Correctional Health policy regarding

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privileges and property for patients on suicide precautions. These policies specifically shall provide:

a. Mental health staff shall have primary responsibility to determine, based on clinical judgment and on a case-by-case basis and in consultation with custody staff, the provision of:

• Routine privileges (*e.g.*, visits, telephone calls, recreation) that are otherwise permitted based on a person's classification security level

• Clothing and possessions (*e.g.*, books, slippers/sandals, eyeglasses) that are otherwise permitted based on a person's classification security level

b. Patients placed on suicide precautions shall be re-evaluated at least daily to assess clinical readiness for personal and jail-issued possessions, clothing, and privileges.

c. Placement on suicide precautions shall *not* preclude patients from receiving timely and regular access to (i) meals, (ii) liquids, (iii) prescribed medication, (iv) toilets, and (v) showers.

d. The County shall ensure full implementation of the requirements as set forth in Paragraph 6, above.

e. Class members on suicide precautions shall be allowed to attend scheduled court proceedings unless the clinician, based upon clinical

judgment and in consultation with security staff, determines that transportation to court would adversely impact the individual's condition.
f. The removal of property and/or privileges shall be documented with clinical justification in the patient's medical/mental health record and reviewed on a regular basis. Cancellation of privileges should be avoided whenever possible and utilized only as a last resort.
g. Cell window coverings shall not be used on cells holding any class member on suicide precautions or awaiting an inpatient bed, unless there is a specific security need and then for only a period of time necessary to address such security need, consistent with Remedial Plan Section VII.J.
i. Placement of a patient in an opposite gender area (*e.g.*, male placed in suicide precautions cell in female intake area) does not constitute a "security need" for purposes of this remedial provision.

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h. The County will provide tear-resistant mattresses for all patients at the acute level of mental health care, in the SITHU, or on suicide precautions for more than four hours (and consistent with Remedial Plan Section VII.O.1).

18. Staff compliance with the protocols set forth above will be subject to a documented quality assurance process for at least 12 months from the date of this Memorandum of Agreement, with quality assurance review at the monthly Suicide Prevention Subcommittee meeting.
a. ACH, mental health, and custody supervisors will conduct at least weekly reviews to ensure proper implementation, with corrective action taken when warranted.
b. The Mental Health and Suicide Prevention Subject Matter experts will monitor policy implementation and the quality assurance process to ensure compliance with relevant Consent Decree requirements.

ISSUES SET FORTH IN THE OCTOBER 29, 2021 DISPUTE NOTICE THAT ARE NOT RESOLVED BY THIS MEMORANDUM OF AGREEMENT AND WILL BE ADDRESSED IN CONTINUED DISPUTE RESOLUTION PROCESSES AND, IF NECESSARY, THROUGH ENFORCEMENT PROCEEDINGS BEFORE THE *MAYS* COURT

The Parties recognize that the County does not currently have a plan for reaching compliance with Consent Decree requirements related to the following issues set forth in the October 29, 2021 Dispute Notice:
(1) remediation of physical plant deficiencies that prevent delivery of adequate health care services;
(2) provision of adequate staffing to deliver adequate mental health care services;

(3) provision of adequate acute mental health level of care services at a capacity to meet class member needs; and
(4) provision of adequate Intensive Outpatient Program mental health level of care services at a capacity to meet class member needs.
This Memorandum of Agreement thus does not resolve the October 29, 2021 Dispute Notice with respect to these four issues. Rather, this Memorandum of Agreement provides a structure for the County to develop and present its plan and timeline for addressing the systemic deficiencies underlying these four issues. The Parties agree to continue with dispute resolution procedures, as set forth in Consent

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Decree Paragraphs 32-34. Class Counsel retains their right to pursue enforcement proceedings on these issues should dispute resolution procedures not lead to a supplemental memorandum of agreement or stipulation resolving any or all of these four issues. The parties nonetheless agree to the following:

MENTAL HEALTH CARE

Physical Plant Deficiencies Impeding Remedial Plan Implementation (Focus Area #1)

1. The County does not currently have a plan for remediation of physical plant deficiencies that prevent delivery of adequate health care services, among other essential components of the Remedial Plan (*e.g.*, ADA/Disability accessibility and program access requirements).
2. The County will take interim steps to mitigate physical plant deficiencies that adversely impact mental health care delivery, including as set forth in this Memorandum of Agreement (*e.g.*, *Patient Confidentiality for Suicide Prevention Assessments, Mental Health Clinical Encounters*, Pages 6-7, above).
3. The County will, by no later than December 1, 2022, develop a plan for remedying physical plant deficiencies that impede Consent Decree implementation, with input from relevant community stakeholders.
4. The Parties agree that a plan to remediate physical plant deficiencies must be paired with a plan containing jail population reduction measures, developed with input from relevant community stakeholders, as necessary to facilitate timely, cost-effective implementation of the Consent Decree. The County will, by no later than October 15, 2022 and with input from relevant community stakeholders, develop a plan for jail population reduction measures, to include funding and an implementation schedule for such measures.
5. Upon completion of the above-referenced plans, the Parties shall meet and confer, with the assistance of the Subject Matter Experts and the designated Dispute Resolution mediator, as appropriate, to discuss the adequacy and timeliness of the plan. The Parties may then enter into a supplemental memorandum of agreement on the matter or, if a dispute remains, may seek appropriate relief from the *Mays* court.

Staffing Deficiencies that Impede Remedial Plan Implementation (Focus Area #2)

6. The County does not currently have a plan for provision of adequate staffing to deliver adequate mental health care services, among other essential components of the Remedial Plan.

7. The Jail's Mental Health leadership was restructured in early December to more effectively complete Remedial Plan work and address mental health program

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needs. The Mental Health Program Director position was eliminated and replaced by a Mental Health Manager who oversees two new supervisors, a Clinical Operations Supervisor and an Administrative Operations Supervisor.

8. *Mental Health/Disability Input in the Disciplinary Process* Requirements. The Parties agree that remedial provisions regarding Mental Health evaluations for the Jail disciplinary process are foundational to Consent Decree implementation, including as to requirements to generally exclude class members with serious mental illness from restrictive housing, to prevent class members from being punished for behavior related to a mental health or intellectual disability, and to avoid disciplinary measures that adversely impact the health and well-being of people with disabilities. Accordingly:

a. Mental Health Rules Violation Review procedures have been implemented on a limited basis at RCCC and Main Jail, with further mental health staffing allocated in the FY 2022/23 budget for implementation of this remedial plan provision.

b. The County shall fully implement Mental Health Policy No. 07-06 (Mental Health Rules Violation Review), with appropriate staffing, no later than September 1, 2022.

c. The County issued a Post Order designating the position of Chief Disciplinary Hearing Officer at each Jail facility in November 2021. The Chief Disciplinary Hearing Officer shall be in charge of reviewing all disciplinary write-ups and ensure consistency in disciplinary practices and procedures, with a primary focus being on issues related to mental healthrelated issues.

d. The Subject Matter Experts and Plaintiffs' counsel will monitor Mental Health Rules Violation Review policy implementation and related quality assurance processes to ensure compliance with relevant Consent Decree requirements.

9. *Intensive Outpatient Program* Requirements. The Parties agree that remedial provisions regarding implementation of the Intensive Outpatient Program (IOP) are foundational to Consent Decree implementation, including as to access to such level of care for class members who have higher security/classification factors, are who are women, and/or who are LGBTQI, as required by Remedial Plan Sections

IV.F.4. and VII.F.2.and/or are women. Accordingly:
a. The County shall, no later than June 1, 2022, activate a new high-security classification female IOP program with a capacity of eight (8) class members who meet IOP criteria.

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b. The County shall, no later than September 1, 2022, activate a new highsecurity classification male IOP program with a capacity of twenty-four (24) class members who meet IOP criteria.
c. The County will continue to assess IOP need among the class member population, including for women, LGBTQI, and/or high-security classification individuals, and will take appropriate steps to provide IOP level of care for those who meet IOP criteria.
10. After Class Counsel sent its Dispute Notice on Mental Health/Suicide Prevention deficiencies, the County completed a staffing analysis that identifies the need for an additional 79 staff members to deliver mental health services at the Jail consistent with the Mental Health Care and Suicide Prevention requirements of the Consent Decree. The County's analysis acknowledges that prospective jail population "reduction programs could reduce the average daily population and associated staffing needs." The County will provide staffing plan updates to the Subject Matter Experts and class counsel regularly, and upon request.
11. Upon completion of the above-referenced plans regarding physical plant deficiencies and jail population reduction measures, the Parties shall meet and confer, with the assistance of the Subject Matter Experts and the designated Dispute Resolution mediator, as appropriate, to discuss the adequacy and timeliness of the County's staffing plan. The Parties may then enter into a supplemental memorandum of agreement on the matter or, if a dispute remains, may seek appropriate relief from the *Mays* court.

Mental Health Treatment Delivery (Acute and IOP Treatment Programs)
Acute Psychiatric Unit (APU) (Focus Area #3)

12. The County does not currently have a plan for provision of adequate acute level of care mental health services at the Jail.
13. The Subject Matter Experts have found, and the Parties agree, that continued use of the Main Jail 2P unit as the Acute Psychiatric Unit makes impossible provision of acute level of care in an adequate therapeutic milieu with appropriate treatment space, consistent with relevant Consent Decree requirements. The County will examine all possible methods to deliver acute psychiatric care to *Mays* class members, including in community facilities.
14. No later than June 1, 2022, the County will complete a feasibility analysis regarding the use of alternative space in existing County Jail facilities to provide Acute Psychiatric level of care to class members, to address – in whole or in part –

the Jail's current Acute Psychiatric Unit deficiencies – specifically, (1) the lack of

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adequate group therapy, (2) the lack of confidential individual treatment space, and (3) the persistent waitlist for admission.

15. Upon completion of the feasibility analysis, the Parties shall meet and confer, with the assistance of the Subject Matter Experts and the designated Dispute Resolution mediator, as appropriate, to discuss the County's plan to provide acute level of care to meet class member patient need, including with an adequate therapeutic milieu and appropriate treatment space, consistent with relevant Consent Decree requirements. The Parties may then enter into a supplemental memorandum of agreement on the matter or, if a dispute remains, may seek appropriate relief from the *Mays* court.

16. The County will discontinue use of beds with attachment points of any kind (including the existing beds with "handles" designed for restraint brackets) for Acute Psychiatric Unit (APU) patients.

a. As soon as feasible, and in any case no later than September 30, 2022, the County will safely eliminate the "handles" from at least 16 of the 17 existing Acute Psychiatric Unit patient rooms in the Main Jail 2P unit. If the County chooses to retain one Main Jail 2P APU room with restraint brackets, it will ensure that no patient who is "danger-to-self" or at risk of suicide is held in that room (except in cases where clinical restraints are being applied).

b. As part of the County's forthcoming plan to discontinue the Main Jail 2P unit as the APU, the County will ensure that *all* new APU beds are suicide-resistant and free of attachment points. The County may elect to install an anti-ligature restraint bed in the APU, after conferring with class counsel and the Subject Matter Experts to ensure appropriate measures against suicide.

Intensive Outpatient Program (IOP)

17. The County does not currently have a plan for provision of adequate IOP level of care mental health services at the Jail.

18. The County will produce a plan, by no later than July 1, 2022, to timely address IOP deficiencies – specifically, (1) the lack of treatment space for group therapy, structured activities, and confidential clinical contacts, and (2) the current lack of program capacity to meet the need. The County's plan shall include necessary steps (consistent with Paragraph 9, above) to ensure access to this level of care to class members who are women, are LGBTQI, and/or have higher security/classification factors, as required by Remedial Plan Sections IV.F.4. and VII.F.2.

MEMORANDUM OF AGREEMENT
Mental Health Care & Suicide Prevention - Core Remedial P]an Measures
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19. Upon completion of the plan, the Parties shall meet and confer, with the assistance of the Subject Matter Experts and the designated Dispute Resolution mediator, as appropriate, to discuss the adequacy and timeliness of the plan. The Parties may then enter into a supplemental memorandum of agreement on the matter or, if a dispute remains, may seek appropriate relief from the *Mays* court.

CONCLUSION

The provisions of this Memorandum of Agreement are designed to ensure compliance with the terms of the Remedial Plan in the *Mays* Consent Decree. The Parties agree that the relief contained herein is narrowly drawn, extends no further than necessary to ensure the protection of the federal rights of *Mays* class members, and is the least intrusive means necessary to accomplish those objectives.

The terms of this Memorandum of Agreement are subject to the monitoring and enforcement provisions set forth in the *Mays* Consent Decree.

This Agreement shall be deemed fully executed and effective when all Parties have executed it by signature.

[Signed by all parties]

APPENDIX D

(This file could not be attached to this report due to the technical difficulties of duplication. The report, Sacramento County Main Jail 300 West Pod JPS Conversion Feasibility Study, Nacht & Lewis, May 27, 2022, is available at PDF pg. 622 of the December 7, 2022 County Board of Supervisors Meeting Agenda Packet, here on the Sacramento County web site.)

Appendix E

Mental Health Contract Augmentation		
Fiscal Year	Program Additions	Staff Augmentation
FY 2017/18	20 Intensive Outpatient Program (IOP) Beds (male) – MJ	LCSW Supervisor (1.0) SW1 (4.0) Psychologist II (1.0) Psychiatrist/NP (10%)
FY 2018/19 (Midyear)	24/7 Licensed Clinical Social Worker (LCSW) Coverage - MJ	LCSW Supervisor (1) LCSW (4)
FY 2019/20	15 IOP Beds (female) - MJ	LCSW Supervisor (.40) Psychologist II (.20) LCSW (.50) SW 1 (3) NP/Psychiatrist (.40)
	24 IOP Beds (male) - RCCC	LCSW Supervisor (.50) Psychologist II (.20) LCSW (2.0) SWI (2.5) HUSC (1.0) NP/Psychiatrist (.80)
	24/7 LCSW Coverage - RCCC	LCSW Supervisor (1.0) LCSW (3.0)
FY 2020/21 (Midyear)	Enhanced Outpatient Mental Health Services for the Outpatient Psychiatric Pod. Includes mental health services, medication evaluation and monitoring, case management, and discharge planning. Adds a new level of service. Will serve approx. 125 patients at any given time.	LCSW Supervisor (1.0) LCSW (2.0) SWI (2.5)
FY 2021/22	Enhanced outpatient (EOP) mental health services in the Outpatient Psychiatric Pod (OPP) expansion to provide services to an additional 150 patients requiring intensive services. This expansion will increase services to 275 patients with a total EOP service provision of 400 patients.	LCSW Supervisor (1.0) LCSW (3.0) SWI (8.0) RN (.50)

Mental Health Contract Augmentation		
Fiscal Year	Program Additions	Staff Augmentation
FY 2022/23 *Budget approved 06/09/22*	Contract augmentation includes additional staffing to: 1) complete reviews and recommendations for patients with mental illness pending discipline and/or administrative segregation, 2) expand mental health services for patients in the Acute Psychiatric Unit, and 3) additional staffing for constant observation of patients on suicide precautions.	LCSW Supervisor (2.0) LCSW (8.0) SWI (5.0) MH Worker (16.0)

Mental Health Vacancies as of 06/07/22	
Area	***Vacancies***
Main Jail	
Outpatient	4
Enhanced Outpatient Program (EOP)	6
Intensive Outpatient Program (IOP)	0
Acute Psychiatric Unit (APU)	0
RCCC	
Outpatient	1
EOP	1
IOP	1
Jail Based Competency	2
Total	15

APPENDIX F

August 1, 2022 Mental Health Staffing

Mental Health Staff	**Allocated**	**Licensed (Y/N)**	**Vacancies**	% time in this area (half time in IOP would be reflected as .5 filled	Functional Vacancy (divide unfilled positions by allocated positions and that is your functional vacancy rate)
APU MD	1	Y	0	1.0	0
APU AN II Supervisor	1	Y	0	1.0	0
APU CN II	4	Y	0	1.0	0
APU Sr. LVN	6	Y	0	1.0	0
APU MA I	1	N	1	1.0	1
MJ IOP LCSW Supervisor	1	Y	0	1.0	0
MJ IOP LCSW	2	Y	0	1.0	0
MJ IOP MSW	5	N	0	1.0	0
MJ/RCCC OP Discharge Planner	1	N	0	1.0	0
MJ OP LCSW	13	Y	2	1.0	.15
MJ OP MSW	3	N	0	1.0	0
MJ HUSC	2	N	0	1.0	0
MJ OP NP II	3	Y	0	1.0	0
MJ OP LCSW Supervisor	2	Y	1	1.0	.5
RCCC IOP/OP LCSW Supervisor	1	Y	0	1.0	0
RCCC IOP LCSW	2	Y	0	1.0	0
RCCC IOP MSW	2	N	0	1.0	0
RCCC OP LCSW	3	Y	1	1.0	.33
RCCC OP NP II	1	Y	0	1.0	0
JBCT Beh Health Psych Supv II	1	Y	0	1.0	0
JBCT Psychologist II	3	Y	1	1.0	.33
JBCT Psychologist I (unlicensed)	2	N	0	1.0	0
JBCT LCSW	2	Y	0	1.0	0
JBCT MSW	2	N	0	1.0	0
JBCT CN II	1	Y	0	1.0	0
JBCT MD	.65	Y	.65	1.0	0
JBCT Admin Assistant III	1	N	0	1.0	0
EOP LCSW Supervisor	2	Y	0	1.0	0
EOP LCSW	2	Y	0	1.0	2
EOP MSW	9.5	N	5	1.0	.53
Outpatient MD	3.25	Y	0	1.0	0
Medical Director	1	Y	0	1.0	0

MH Manager	1	Y	0	1.0	0
Clinical Ops Supervisor	1	Y	0	1.0	0
Administration Ops Supervisor	1	Y	0	1.0	0
Administration Psychologist II	1	Y	0	1.0	0
Administration Program Service Coordinator	1	N	0	1.0	0
Administration Admin Assistant III	1	N	1	1.0	1
Asst. Clin Ops LCSW Supervisor	1	Y	0	1.0	0
QA & Training Coordinator LCSW Supervisor	1	Y	0	1.0	0
APU LCSW – 22/23 augmentation	3	Y	3	1.0	3
Pt Safety & Pt Support LCSW Supervisor – 22/23 augmentation	1	Y	1	1.0	1
Pt Safety & Pt Support Patient Navigators – 22/23 augmentation	16	N	16	1.0	16
MJ/RCCC MH RVR & Ad Seg LCSW Supervisor – 22/23 augmentation					
MJ MH RVR & Ad Seg LCSW – 22/23 augmentation	4	Y	1	1.0	.25
MJ MH RVR & Ad Seg MSW – 22/23 augmentation	4	N	4	1.0	4
RCCC MH RVR & Ad Seg LCSW – 22/23 augmentation	1	Y	1	1.0	1
RCCC MH RVR & Ad Seg MSW – 22/23 augmentation	1	N	1	1.0	1

Appendix G

Acute Psychiatric Unit (10/25/22)	
Days on Waitlist	Patients
0	2
1	1
2	2
3	2
4	1
5	4
6	2
7	1
10	2
15	1
20	1
45	1
49*	1

*the patient with the 49 day wait for acute psychiatric treatment may have had medical issues as there was a note that read, “back from hospital” and date. That date was used for the waitlist calculation.

IOP Waitlist

- This information was provided for June through December 2021 as raw data with referrals that did include information regarding subsequent program placement, if placed into IOP and data of placement for approximately 190 people.
- The data could not be analyzed to calculate length of stay on the waitlist and a current waitlist for IOP was not provided.

CASE STUDIES
SACRAMENTO COUNTY (MAYS v SACRAMENTO COUNTY)

PATIENT 1

This case was reviewed at the request of plaintiffs' attorneys. The patient had written multiple letters to them and they were concerned regarding what appeared to be un- or under-treated mental illness and ongoing suicidality. A review of the medical record revealed that the patient was on the pre-admit list for the acute psychiatric unit (APU) for danger to self, FOSS I, and had the following issues identified on the problem list: pending request for documentation regarding adult seizures with treatment pending, danger to self, serious mental illness (SMI), Post-Traumatic Stress Disorder (PTSD), with moderate level of case management services from mental health. He had previously been diagnosed with an Adjustment Disorder that had remitted and Antisocial Personality Disorder (ASPD) "per MD" as well as a history of a suicide attempt and Depression, unspecified, stable in 2019. The patient was prescribed no psychiatric medication in 2022.

The patient had remained in the jail for at least three years. According to several pieces of mental health documentation, the patient was facing serious charges and a possible lengthy prison sentence. This same documentation reported that the patient had numerous enemies at the main jail. The patient was noted to have a history of suicide attempts and a history of seizure after head injury per patient report.

In 2022, the patient reported that he was on a hunger strike to nursing who confirmed with custody he had not accepted meals for the past two days. The patient had been seen in medical (2356 hours) because of a custody referral due to the patient having been visualized attempting to cut his wrist. At 0006 hours the next day an order was placed for an emergent or "must see" mental health order. The patient was not seen until 0825 hours, clearly beyond the emergent referral timeline. During that contact, a SRA was completed cell front because the patient reportedly refused to leave his cell. During this contact, the mental health clinician still attempted sensitive mental health questions in a non-confidential setting (male booking). The patient admitted cutting his wrist with a broken spoon but was "unwilling" to show his wrist to the clinician or engage further in the non-confidential assessment. The assessment of risk was completed using prior completed SRAs and the patient was placed on watch. The patient had been seen in medical prior to the SRA and the nurse documented that the patient's skin was not broken though there were "superficial" scratches to the left forearm.

The patient had previously had a completed SRA in a confidential setting as a follow up assessment. That SRA indicated that the patient was at low acute risk because he had not submitted a HSR alleging suicide as had been reported. It should be noted that this SRA determination of low acute risk appeared based exclusively on the patient's self-report and denial, despite the possibility of the patient minimizing risk due to actual intent, an effort to please the clinician, or a host of other reasons. The acute risk determination appeared to minimize actual risk, particularly with this patient's history, impulsive behavior, and reported serious charges.

Before this, the patient had been seen crying in his cell and referred to mental health. It was not clear if mental health or nursing observed the patient or if he was referred by custody as that information was not documented in the record or the assessment completed, not allowing for an evaluation of timeliness of an emergent referral. However, this SRA more accurately

characterized the patient's acute suicide risk and current stressors, though the safety reduction plan was not clinically sound.

Mental health completed a treatment plan for the patient. The treatment plan included the goals 1)improve overall mood and manage paranoia without specific clinical interventions; and 2) reduce future risk of suicide and reestablish hope for self and future, again without empirically-based clinical goals. The treatment plan also referenced command auditory hallucinations that were not elsewhere referenced or noted in the patient's diagnosis.

Mental health documentation reviewed was consistent with the patient having frequent placements on suicide watch, engaging in behaviors that were self-injurious or suicidal gestures, demonstrated poor coping in the face of multiple significant stressors, and an inability to tolerate the regular stresses of incarceration despite prior placements. The patient was clearly lacking in coping skills based on a review of mental health documentation but even with enhanced contacts, mental health failed to document actual implementation of any type of evidence-based clinical intervention. Contacts were primarily information gathering though the patient did receive some supportive counseling through those contacts.

ASSESSMENT: This patient had an elevated suicide risk and clinical picture that was not adequately addressed through treatment planning or documented clinical interventions during clinical contacts. The patient had been receiving enhanced case management through the EOP though at the time of review the patient was on the pre-admit waitlist for the acute program due to danger to self. Clinical staff did regularly place the patient on suicide watch and refer him to the acute program, in keeping with his elevated risk and multiple major external stressors and risk factors. Unfortunately, the patient was often removed from the waitlist and suicide watch prior to admission to the acute unit despite the fact that he would have still benefitted from inpatient treatment. It appeared that the standard for *involuntary* commitment was used rather than considering *voluntary* treatment in an inpatient setting. Because of the patient's frequent placements, sometimes only days apart, he required an updated treatment plan that included discussion of consideration for that voluntary placement in the acute inpatient unit and an individualized behavioral plan. The patient's referral to the acute inpatient program at the time of review was appropriate and clinically sound.

PATIENT 2

This case was reviewed at the request of plaintiffs' attorneys due to concerns regarding the patient's extensive time in segregation (otherwise referred to as restrictive housing) during a previous incarceration and return to segregation upon his return to the jail despite his mental health history having reportedly been well known to all staff. The patient had an alert entered by medical staff that indicated the patient was to be seen with custody present due to "hostile and threatening towards medical staff."

The patient had been released and readmitted within seven months. The patient was determined to be incompetent to stand trial without an associated forced medication or Sell order. He was identified as having been diagnosed in the past with Schizoaffective Disorder, bipolar type. At his most recent admission to the jail, he was identified as Foss II with serious mental illness and a history of methamphetamine abuse. He had previously participated in the Jail-Based Competency Program. He had been placed in the high security IOP at RCCC in 2022.

This case was updated due to the delay in report submission and he remained in the IOP in 2023. However, he appeared to be refusing much of his mental health contact and

psychotropic medication (Zyprexa Zydis 15mg) (it should also be noted that this medication was prescribed for one year, an inappropriate amount of time for a psychiatric medication for someone in custody who has been found so severely and acutely mentally ill as to be incompetent to stand trial; this does not meet the prevailing community standard). In addition, a recent problem of "weight loss" was added to the patient problem list. Despite the lengthy order, the patient did appear to have been seen often by psychiatry though it appeared that those contacts were driven more by the patient's instability and lack of medication compliance than a routine psychiatric practice. The patient was most recently seen by a psychiatrist on during the month reviewed and was properly evaluated by the psychiatrist at that time, but stated that he was "against" psychiatric medication, was trying to be sober (seeming to conflate psychotropic medication compliance with illicit substance use), and declined psychotropic medications. While the patient was documented to be experiencing acute symptoms, he did not meet LPS criteria per the psychiatrist for involuntary medication. The patient would likely refuse admission to the acute inpatient program due to his extreme lack of insight. The psychiatrist indicated that the patient was being monitored closely for decompensation that would possibly meet criteria for LPS hold. Appropriately, the patient's psychiatric prescription was not discontinued, and the psychiatrist's plan included continuing to offer and encourage medication compliance.

The patient was seen by his treatment team upon admission to the IOP as well as in 2023. Unfortunately, due in part to the treatment plan form itself, the treatment plan was inadequate to meet the acute psychiatric needs of this patient. For example, one treatment goal was to successfully program in the IOP. There were measurable goals that contained more detail, but there were no specified clinical interventions for how the treatment team would achieve this goal. There were also no goals to address the specific psychiatric symptoms documented regarding tangential thinking, disorganized thought process and paranoid delusions.

ASSESSMENT:

This seriously mentally ill patient should not be held in segregation within the jail, consistent with the Consent Decree, particularly while psychiatrically unstable. If the patient was to engage in some kind of rule violating behavior necessitating a stay in segregation in compliance with the Consent Decree (e.g., rare situation), he should quickly be moved to the designated mental health unit (DMHU) as a psychiatric alternative unit to segregation as segregation placement would likely exacerbate his mental illness. While it did appear that the move to high security IOP was intended to do this, this movement was not sufficiently timely as to comply with the Consent Decree. The patient remained housed in the "high security" IOP at the time of review pending placement in a competency restoration program though he appeared to meet criteria for inpatient treatment. While the patient was delusional and lacked insight into his mental illness, the treatment team did not document consideration of a voluntary placement into the acute inpatient program and discussion of such with the patient. The patient's psychiatric care was adequate but treatment planning by the treatment team was inadequate. The patient would benefit from a revised treatment plan that included referral to inpatient care for stabilization, consultation with supervisor's regarding the possibility of involuntary treatment, and development of incentives for participation and treatment compliance.

PATIENT 3

This patient was selected as an example of mental health treatment. The patient had been in the Sacramento County Jail (SCJ) system for several years. He was identified as FOSS II or

FOSS III (conflicting documentation), seriously mentally ill, and noted to have a primary diagnosis of Antisocial Personality Disorder with a secondary diagnosis of Schizophrenia, per history, no symptoms as well as "aggressive behavior." Clearly the accuracy of the patient's self-reported mental health symptoms was in question by mental health based on the identified problem list and medical record. The diagnosis of Schizophrenia specifically was in question; hence, the use of "per history" and "no symptoms." This implies that no objective symptoms of Schizophrenia were observed. However, the nurse practitioner offered the patient risperidone during a cell front visit. This medication is typically used to treat Bipolar I Disorder, Schizophrenia, and symptoms associated with Tourette's Disorder[1] further complicating the patient's diagnostic picture.

This patient had two alerts indicating that he had assaulted a member of the medical staff in 2018 that recommended not only having an officer in the room but to consider having the patient handcuffed. In addition, a second more current alert noted that daily requests by the patient for Toradol were to be refused and would be refused in the future, referencing the reader to the provider note. That note indicated the medical concerns regarding possible kidney failure from daily Toradol shots. The provider documented extended efforts to educate the patient about the renal impact of the medication. The provider noted that the patient indicated that he "did not care." Subsequent contacts with medical staff documented that staff reminded the patient of renal concerns and encouraged him to seek alternative pain relief.

Documentation noted that the patient was seen repeatedly by mental health staff at cell front due to safety and security, behavior problems and being unpredictable without consistent behavioral descriptions of the patient to support the clinical assessment and conclusion. It should be noted that even the alert identified other options as mentioned including having an officer present in a confidential space with the staff member and using mechanical restraints if necessary. It did not appear that all mental health staff followed the same procedures with the patient as some saw the patient in a confidential space. No updated documentation could be found that specifically addressed the patient's ongoing volatility and risk. Alerts that can be interpreted as barriers to care/treatment are problematic and must be justified in an ongoing and regular manner on a case-by-case and event-by-event basis. While documentation suggested that the patient was a high-need, high-resource utilizer, it did not support that he could not be seen in a confidential environment with appropriate precautions. Mental health staff did document that the patient *reported* engaging in violent or aggressive (e.g., kicked a deputy, broke a window) behavior, though the patient was seeking alternative placement (at one point requested being housed in "OPP") or specific psychotropic medication (e.g., Wellbutrin) at the time of those reports. Mental health staff did not properly document verification of those incidents or ongoing verification of unpredictable aggressive behavior toward staff in a consistent manner. Because only wellness checks can occur cell front and not segregation review assessments or clinical contacts, there should have been documentation of efforts made to see the patient confidentially. There was one progress note that indicated custody staff had asked the clinician to see the patient cell front, presumably due to security concerns though the rationale was not documented. If mental health staff were seeing the patient cell front due to custody requests, that should have been clearly documented. There was some minimal documentation by mental health that the patient was indirectly threatening (e.g., "patient requested for cell door to remain closed" between patient and clinician), but it typically occurred in the situations described above.

[1] https://www.pdr.net/drug-summary/Risperdal-risperidone-977

In comparison to cell front ongoing segregation "contacts," the rule violation report mental health assessment did occur in a confidential setting (e.g., attorney booth) by the non-primary clinician. This caused the expert to further question the necessity of the ongoing case management contacts occurring cell front in a non-confidential setting in segregation rather than in the attorney booth if security concerns remained. This patient was not seen by his treatment team as those meetings had not yet been implemented at lower levels of care. There was no evidence that the patient had an individualized behavior plan, targeted treatment plan, or incentive plan despite concerns regarding his behavior and possible lack of a major mental illness.

ASSESSMENT: This patient was frequently seen cell side, limiting the ability to properly assess his mental status and diagnosis. He was maintained in the mental health program despite apparent concerns regarding the patient's self-report, though a proper diagnostic evaluation and/or psychological testing did not occur. This patient would benefit from a thorough diagnostic evaluation with psychological testing as needed and a treatment plan, whether the goal would be to ultimately discharge the patient from the caseload or to provide specific interventions to target his limited functioning within the correctional environment and mental status. The patient did not receive adequate care in light of these limitations.

Patient 4

This case was selected as an example of treatment and at plaintiffs' attorney request. He was last booked into the SCJ in early 2022and noted to be FOSS II with diagnoses of Schizoaffective Disorder, bipolar, additional problems of Adult Antisocial Behavior and SMI. The patient has been placed in many mental health related housing and treatment programs including 2P pre-admit waitlist, 2P/acute psychiatric treatment program, IOP, moderate case management, and intensive case management. Plaintiffs' attorneys received unsolicited correspondence from other mental health patients housed with this patient on 8W who had concerns and noted this patient had been screaming, crying, and banging on his door.

The patient had been moved to the IOP at the time of the expert's site visit. He had a history of poor compliance with his psychiatric medications including refusing medication and "cheeking" or pretending to take Seroquel only to hoard the medication per documentation. The patient did participate in treatment groups *when offered* and indoor and outdoor recreation time based on documentation in the medical record. The structured out of cell time documented in the record was impacted by custody availability, but there were typically four groups scheduled per day though not all were scheduled for a full 60 minutes. Treatment scheduled included both recreational type activity such as creative arts as well as clinical treatment groups (e.g., substance abuse, dialectical thinking, trauma-informed groups, social skills).

Mental health staff documented weekly clinical contacts, typically in a confidential setting, where the patient reported auditory hallucinations without commands as well as symptoms of anxiety and depression. The patient also reported feeling as though "things hop in and out of his body." There was no further detail to identify if this was due to tactile hallucinations, delusional beliefs, or some other process. The patient did not appear to have a strong support system based on documentation. In addition, he had several medical complaints related to hunger and stomach pain.

The patient's initial treatment plan was reviewed with the patient prior to the initial treatment team meeting. The treatment plan was similar to other patients' treatment plans in that

it did contain treatment objectives but no clinical intervention or staff responsible for each intervention was included. There were also no implementation or reassessment dates for clinical interventions. The treatment plan was instead focused on things that the patient would do such as report any medication concerns to the treatment team (medication compliance), attend one out of four treatment groups, and reduce the number of suicidal thoughts to zero per day by utilizing effective coping techniques. Specific, empirically-based clinical interventions were needed in the treatment plan so that mental health staff could implement interventions likely to meet the treatment goals. For example, the patient has a history of medication noncompliance so simply stating that the patient will be compliant with his psychiatric medications 80% of the time may not be realistic and does not indicate how the patient will get to that point when compliance has been an ongoing issue. This is a critical issue because mental health staff also documented that the patient would decompensate when not medication compliant.

The patient attended the initial treatment team with the clinician and unit deputy. The psychiatrist/NP had been unable to attend based on documentation but the clinician noted reviewing the last psychiatry progress note. The multidisciplinary treatment (MDT) team did not document that they reviewed the patient's status and treatment plan during team, though the clinician had documented reviewing the plan with the patient in advance. This was consistent with observations of treatment team at the time of the site visit. Treatment documentation indicated that the patient had a history of suicidal ideation and engaging in self-harm through behaviors that have included head banging. While the treatment plan noted the patient's poor coping skills, there were no evidence-based clinical interventions identified and/or implemented to address the patient's level of risk and ongoing mental health symptoms. Progress note review indicated that the clinical contacts were more like "check ins" to monitor the patient (e.g., medication compliance, activities of daily living) rather than to provide actual therapeutic intervention. He continued to report symptoms throughout his mental health contacts for Spring that included excessive crying and the complaint that things were "jumping in and out" of his body.

The patient's chart was reviewed for an update. He had been discharged from IOP in summer and reportedly agreed with that discharge. His compliance with treatment had become erratic and while he stated that he had acquired coping skills, it was unclear that was accurate. The patient was placed on a suicide watch and the 2P pre-admit waiting list at least once following that discharge and was made EOP in the Fall. The patient was also repeatedly moved around the MJ, to RCCC, and back to the MJ due to physical plant issues and flooding per his report to mental health during a two-month period. Prior to the multiple movements, he had been getting seen fairly regularly though not always by the same clinicians or NPs creating issues with continuity of care.

ASSESSMENT:

This patient was not adequately treated. While he improved initially when admitted to the IOP due to being removed from restrictive housing and having more opportunities to leave his cell for treatment, there did not appear to be adequate individualized treatment planning focused on his mental status. The patient was not as consistent in attending treatment and even left at least one treatment group during the session. The patient continued to demonstrate a low frustration tolerance resulting in self-injurious behavior at times, most commonly banging his head. He continued to fluctuate in his mental health level of care, requiring placement on suicide watch and referral to acute psychiatric treatment resulting in placement on the 2P pre-admit wait

list. This patient would benefit from intensive, individualized treatment with assignment to group treatment that is based on his individual needs and mental health status. The patient would also benefit from an effort to further identify the basis for his statements that something it felt as though things were jumping in and out of his body.

Patient 5

This case was selected as an example of mental health treatment within the jail. The patient had remained in the SCJ system for at least one year and had been placed at multiple levels of care including the IOP and EOP. The patient had been diagnosed with Schizophrenia and Cannabis Abuse, FOSS II, and having SMI. He had an alert that was nearly one year old that he had been aggressive with medical staff and "must" be seen with custody. The associated progress note indicated that this patient had become very aggressive at pill call, refusing medication, insisting medication be placed on the food port and that he would take the medication when he wanted. At that time the patient had been prescribed Zyprexa Zydis 10mg in the morning and 15mg in the evening. The patient was "tempout" from the jail since summer, having gone to the state hospital. While no court orders or related documents could be located and there was not a specific problem, it appeared that the patient may have been transferred to state hospital as part of a conservatorship. There was reference by the psychiatrist to a Riese order, suggesting conservatorship via the Lanterman-Petris-Short (LPS) Act. This appeared most consistent with his "tempout" status in the updated medical record review.

The patient had been seen monthly by the IOP treatment team until discharge from IOP in Winter 2022. There were intermittent treatment plan updates as an IOP patient. The patient's discharge from IOP was documented as due to refusal of medications, lack of participation in treatment and treatment planning, ability to maintain ADLs without medication and treatment, and preference to remain in his cell all day. The last treatment plan in the record, occurred as the patient was seen by the EOP treatment team and maintained medication compliance, personal hygiene, and engagement with mental health services as treatment goals. The patient was to meet with a clinician twice monthly but there were no specific treatment interventions identified for any of the treatment goals.

The patient was seen more often than twice monthly, though typically in nonconfidential settings due to space unavailability, insufficient custody staff, and refusals. Consequently, these were just "check ins" rather than actual clinical contacts. The patient did not improve and was ultimately placed in the acute psychiatric unit for approximately one month due to "altered thought processes" and grave disability. The patient had been disorganized, hypersexual, openly masturbating, muttering inaudibly with mood lability and not engaging appropriately with staff. After discharge, the patient was seen by mental health at 48-hour intervals for follow-up where he complained that he had submitted multiple HSRs to be seen by dental as he needed dentures but was not seen. The patient remained easily angered (e.g., note: patient stated he just took a shower, went back to bed, and was then called out for meeting so he was angry…I don't want meetings every day). Other than being irritable, he denied symptoms and was assessed as not exhibiting evidence of a thought disorder. He was seen within one week of discharge by the psychiatric provider (PNP) who noted that the patient was prescribed Inderal 20mg twice daily, Zyprexa Zydis 30mg in the evening, and Depakene 250mg per 5ml in the evening with snack.

The patient was next seen by an unlicensed provider who mischaracterized the nonconfidential area outside control as confidential (also occurred in another progress note). That contact was for an intake into the EOP case management level of care. It was unclear why

the patient was not discharged from acute inpatient treatment to IOP level of care. A progress note by the PNP noted that the patient was on a hold for the state hospital. An abnormal involuntary movement scale (AIMS) was completed during that contact though the patient was seen cell side because "safety and security; behavior problems/unpredictable" though the patient had met the social worker without incident outside of the cell. The patient was seen by the social worker two weeks before he was transferred to state hospital.

ASSESSMENT:

This patient would have benefitted from an individualized behavior plan or individualized incentive program when he was being treated in the IOP prior to being discharged for noncompliance with treatment. Behavioral treatment is evidence-based and can be quite effective with individuals like this patient. The reason for the patient's transfer to state hospital was unclear, unlike other patients, as was who initiated such treatment. If the defendants initiated the patient's ultimate placement in the state hospital, that would be commendable. Regardless of who initiated, that pending placement should have been part of the patient's treatment plan. No treatment plan was found for the patient's time at the acute inpatient level of care. It was concerning that a patient ill enough to require a state hospital hold was discharged from acute treatment lasting nearly one month to EOP case management rather than IOP level of care. If mental health staff believed that he had improved enough to be discharged from acute care, the patient should have been provided an opportunity to receive IOP treatment. In light of what is known about this case, the patient did not receive adequate treatment. He was frequently seen in nonconfidential spaces that further limited the ability to provide the patient with treatment that was consistent with his level of acuity.

Patient 6

This patient was selected as an example of treatment and at plaintiffs' attorney request. He had spent approximately one year in the SCJ system. The patient was diagnosed with Unspecified Schizophrenia and was identified as receiving case management while in segregation, FOSS II, SMI, assault risk, and grave disability.

The patient was requested for review by plaintiffs' attorneys because he had been housed on 8W following multiple placements on 2P. The patient had been identified due to his placement in 8W, behavior within the system, and his report to staff regarding his reasoning for a disciplinary incident.

The patient was placed in the acute treatment program for approximately two weeks in 2021, at which time he was referred to the IOP. The patient was on an alternative treatment plan due to a history of assaultive behavior. He remained in the IOP at RCCC for approximately one year, and reported that he had enjoyed the program, found it helpful, but had "graduated." Once returned to the MJ, he was placed into segregation despite significant mental illness. This was classified as an outpatient setting in some progress notes. While in segregation at the MJ following his placement there, the patient was seen cell side. All that was documented was "custody concern – not disclosed" or behavior problem/unpredictable. It was unclear why the patient could not be seen with appropriate accommodations (e.g., deputy present) or in the attorney booth. This was troubling since true clinical follow-up, case management, and segregation reviews cannot occur cell side. Contacts on the tier also do not allow mental health staff to assess patient risk including to others to identify the need for higher level of care and help custody to safely manage patients. The patient remained in segregation for at least six

months when he was sent to the IOP at RCCC. Mental health staff did document unsolicited statements from the patient that were consistent with continued delusion beliefs (e.g., I am going to get out today)

Treatment plans were quite limited. For example, the initial treatment plan addressed medication evaluation and medication management (by implication). The patient was to learn triggers and coping skills suggesting that there may have been poor frustration tolerance or something similar implied in the treatment plan. The next treatment plan was finalized during the initial MDT held at RCCC and identified that the patient was on an alternative treatment plan (ATP), though it did not specify in the treatment plan format the specific components of the ATP (e.g., when patient engages in X positive/replacement behavior, staff will respond immediately with Y intervention). While the goal was for the patient to move off of ATP, it was unclear beyond providing coping strategies how mental health staff would do that. In addition to that global goal, specific treatment interventions (e.g., use or thought logs, exploring underlying beliefs) should have been specified in the treatment plan. The summaries included in the patient's treatment plans helped to clarify treatment beyond the limited goal/objective format. The patient received an updated treatment plan when his ATP was discontinued due to a lack of aggressive or assaultive behavior. A subsequent treatment plan indicated that the patient was to have "graduated" from the IOP because the patient had been mostly medication compliant, and had no disciplinary matters/assaults.

ASSESSMENT:

This patient would have benefitted from remaining in the IOP. The patient's acute symptoms were not directly addressed beyond medication noncompliance and aggression/assaultiveness. The patient seemed to experience multiple delusions that were likely the underlying cause of both of those behavioral dysfunctions. While delusions can be difficult to treat, they should have been a part of his treatment plan and a part of his housing decisions. It was not compliant with the Consent Decree to send this patient with SMI to segregation to live for months. Clearly the patient decompensated and needed to be returned to IOP prior to his transfer to prison (most recently housed at CSP-LAC).

Patient 7

This patient was selected for review as an example of care in segregation for a patient diagnosed with SMI. The patient had been booked two years earlier and remained in the MJ in 8W at the time of the record update review. He had been identified for case management in late Fall 2022, was FOSS II, an assault risk, Bipolar I Disorder, stable (at intake), Marijuana Use, and Personality Disorder, cluster B traits and prescribed Zyprexa Zydis 10mg each evening. This patient had also been identified by plaintiffs' counsel for review due to his lengthy stay in segregation. Despite having been identified as an assault risk, the patient had no associated alerts.

The patient was frequently seen cell side with reasons provided including safety and security, behavior problems/unpredictable, and refusal to leave cell. The patient was removed from psychotropic in Spring 2021 due to noncompliance and without a face-to-face visit following a nursing referral. The patient submitted a subsequent HSR received by mental health in Spring 2021. The HSR was not scanned with associated documents but a social worker documented that the patient wrote: "I was wondering if I can classify as t-sep for a single cell in psych ward." An order was placed for mental health "follow-up" rather than properly classifying

the visit by acuity (i.e., emergent, urgent, routine). The patient was not seen for two and one-half weeks following completion of the original HSR. This is not an appropriate amount of time for self-referral, especially as the HSR identified possible risks for self-harm (e.g., safety concerns) or risk to others. This should have been an urgent referral to assess the risk at the time as well as to engage in psychoeducation regarding levels of care and TSEP process. In a confidential contact, the patient reported concerns regarding his cellmate as well as two prior documented cell altercations per the medical record. The clinician did provide the patient with psychoeducation regarding levels of care and TSEP pros and cons. The patient submitted a recent HSR, indicating that he needed to be seen "asap." Despite that, mental health did not receive the HSR until two days later and the patient was seen two days after that. The mental health HSR note implied that the request was seen as routine (i.e., segregation review scheduled).

The patient was seen while housed in segregation fairly regularly (e.g., weekly to biweekly), sometimes in response to a HSR and other times for segregation review. These nonconfidential contacts typically occurred cell side because of the patient's reported behavior – behavior problems/unpredictable – rather than patient refusal and without specific detail regarding the patient's behavior to justify the clinical decision. However, the treatment record update indicated that since approximately late Fall 2022, the patient was seen confidentially unless he refused. On at least one occasion, custody told staff that the patient was assaultive/aggressive, and mental health did not see the patient at all on that date.

No treatment plans were ever completed for this patient. If he was placed on an ATP, it was not noted as part of a treatment plan. The patient was referred to the IOP due to being in segregation for two years for "assaultive" behavior. By the end of early 2023, the patient had not transferred to even the high security IOP. Segregation reviews did not assess the patient's mental status (cannot be properly assessed cell side) and risk of decompensation nor did they address that the patient was identified as SMI yet maintained in segregation contradictory to the Consent Decree.

ASSESSMENT:

This patient was not housed consistent with the Consent Decree. Because he was evaluated to have a serious mental illness, he should have been transferred from segregation to at least the high security IOP. This patient would benefit from transfer to an IOP. The patient would benefit from a comprehensive evaluation that would clarify any diagnostic issues, examine the role of the patient's mental illness in aggression and disciplinary action, and form the basis of an individualized treatment plan. If the patient continued to refuse confidential visits, an incentive plan should be developed as part of the overall treatment plan.

Patient 8

This case was selected as an example of care for a patient pending transfer to state hospital/competency program. The patient had arrived to the SCJ system in early 2022 and had transferred out by Winter 2022. He had a forced medication (Sell Order) and was prescribed Abilify, Latuda, Zyprexa, Lamictal and Effexor. Because the patient's medications were prescribed for one year, the electronic MAR had to be carefully evaluated to determine what medications were truly active in that they were being administered and prescribed at transfer. While the ability to write medication orders for one year and leave them "open" (not closed or update stop date), nursing charting was confusing as minimal information was included as to what was refused, the reason for refusal, and statements that the patient (again, on a court

ordered forced medication order) had permanently refused Invega. It was unclear that nursing understood the patient had a forced medication order. It appeared that at the time of transfer, he was actively taking Lamictal 125mg twice daily, Latuda 40mg, and Effexor 225mg in the morning, decreasing the seeming polypharmacy concerns as identified through the medication list. The patient had been diagnosed with Schizophrenia and identified as having a SMI; he was FOSS II. The patient had been on the acute inpatient pre-admit waitlist for what appeared to be several weeks in Spring 2022. He had received crisis, IOP, and EOP levels of care.

This patient was also identified by plaintiffs' counsel following a letter regarding a history of inpatient treatment (DSH), suicidal ideation, and homicidal ideation due to auditory hallucinations.

As mentioned in other cases, a patient who has been found incompetent to stand trial should be treated at the inpatient level of care while awaiting transfer to an inpatient setting. The patient should be closely monitored by psychiatry until transfer. It appeared that this patient may have been determined to be incompetent to stand trial in early Summer 2022. He had been on the 2P pre-admit waitlist twice in Spring 2022 due to suicidality and multiple custody referrals (e.g., use of emergency button in cell, complaints regarding auditory hallucinations). This patient was seen confidentially by a psychiatric provider (i.e., PNP) for initial intake, though not timely (more than 5 weeks after arrival). The patient had a second psychiatric initial evaluation two months later when placed into the IOP. Based on review of progress notes, psychiatry worked to find an agreeable and effective medication regimen prior to the forced medication order.

While being treated at the EOP level of care, the patient repeatedly reiterated to his clinician that he needed IOP level of care. He did have multiple medical needs (e.g., scabies, ear flush) but social work continued to see him primarily in the nonconfidential area outside of control, mischaracterizing that as a confidential area while the PNP typically went cell side for a variety of reasons, including quarantine and confidential space unavailable. An EOP treatment plan was completed and was adequate for the EOP level of care. The patient had previously demonstrated delusions when seen cell side and poor mood. These were not addressed in the treatment plan. Following that treatment plan the patient was seen weekly, though cell side. While these were not clinical contacts, the patient reported continued auditory hallucinations including command hallucinations and related stress. The patient was eventually referred to IOP level of care as he had decompensated due in part to continued medical quarantine.

By early Summer, the patient was told by his clinician that the patient had been accepted into IOP and would be transferred "soon." The patient was transferred to RCCC shortly thereafter. The patient was seen approximately every three weeks by the psychiatric provider though not typically in a confidential space. The patient was assigned to treatment groups and his participation was erratic. He was seen monthly by his treatment team.

While the patient was certified for assessment of competency early in 2022, it was not until Summer that the final order of "incompetent to stand trial" was made. The hearing found that the state hospital would determine the patient's ability to be medicated with antipsychotic medications, further complicating the medication management for JPS psychiatric providers. The patient was discharged from the RCCC IOP in mid-Fall and decompensated quickly. The patient's paranoid delusions, particularly toward the government appeared to be interfering with the patient's ability to work with his public defender.

ASSESSMENT:

This patient would have benefitted from IOP throughout his admission at the jail. The patient had been found incompetent to stand trial and was to go to the state hospital. Likely due to bed space, he did not go. Instead he was released to a CJSP. While housed at the jail, the patient erratically complied with treatment. He was provided an incentive program to encourage group treatment attendance while at RCCC IOP. It should be noted that those groups and assignment to them was not individualized. The patient was also erratic in his psychotropic medication compliance. The lack of a forced medication order created barriers for psychiatric providers, but it was unclear why the patient was not provided inpatient treatment, particularly as he repeatedly reported acutely psychotic behavior including auditory command hallucinations and displayed multiple delusions.

Patient 9

This case was selected as an example of mental health treatment in segregation. The patient spent nearly two years in the SCJ system. He had been identified for segregation case management while in segregation in early/Winter 2022, and had been on the acute inpatient pre-admit several times for danger to self. He was also on the pre-admit inpatient list previously for two and ten days for grave disability. The patient was diagnosed with Schizoaffective Disorder, bipolar type, Antisocial Personality Disorder, cluster B traits, and identified to have SMI and be an assault risk (spitting). He was prescribed Abilify 20mg twice daily.

Treatment plans were completed for EOP and ACMH case management with the last treatment plan completed in Summer 2021. There was no updated treatment plan or treatment team meeting for case management in segregation. This patient has repeatedly been referred to mental health by custody on at least five occasions through 2021 and Summer 2022 and by medical staff during that time. He also had completed multiple HSRs. He was moved to segregation in early 2022, and began submitting even more HSRs and mental health services "kites". The patient submitted one HSR in early 2022 that asked to see any of a multitude of people, but noted "911" and "…needed over years now…" This HSR was inappropriately classified as "MH HSR" which is not a specific prioritization. The patient was not seen until two days later for what should have been an emergent or "must see" request. The patient was not seen until at least 17 hours after mental health received the HSR, cell side, due to "safety and security." Since this patient required an assessment of risk and clarification of concerns, it required a confidential clinical visit and a clearly articulated clinical rationale to not do so that should include examples of the patient's behavior. The patient was repeatedly seen in nonconfidential settings due to the lack of confidential space or "safety and security."

A suicide risk assessment (SRA) indicated that the patient had experienced difficulty adjusting to the deprivations of confinement. There was repeated documentation of difficulty with deputies and verbal threats. The patient had a history of "gassing" (i.e., saving bodily fluids to then throw them at another person).

The patient was often seen cell side due to safety and security: behavior problems/unpredictable. This was secondary to custody referrals, responses to emergent referrals, and "clinical" contacts. There was a segregation review that occurred in a confidential setting that noted that the patient was hypomanic with pressured speech, tangential with disorganized thought process, but easily redirectable and logical. However, this contact clearly noted acute mental health symptoms for a patient with SMI who should have been referred to a DMHU.

ASSESSMENT:

When staff identify a barrier to care (cell side contact) that is due to "safety and security" and/or "behavior problems/unpredictable," that progress note should clearly and comprehensively document the specific *current* behaviors that are a threat to safety and security. Documentation regarding a critical barrier to treatment in a high-risk, high-stress environment (segregation) was inadequate. If the patient was to return to the jail, a current individualized treatment plan should be developed that specifically addresses this area of care and the patient's symptoms that may underly any restrictions (e.g., hypomania). It should include the priority of confidential contacts. The treatment should also include treatment targets of the symptoms and behavior underlying the treatment obstacle(s). Finally, this patient was inappropriately maintained in segregation despite clearly having a serious mental illness contrary to the Consent Decree. The segregation reviews were also inadequate as they should have addressed that aspect of care and alternative placement in a DMHU.

Patient 10

This case was selected as an example of treatment in segregation and in response to plaintiffs' request. The patient had been released and rearrested within one week in Fall 2022. The patient was released to another program in late Fall 2022. It appeared that the patient may have returned from state hospital at some point as the diagnosis, Schizoaffective Disorder, bipolar type, Amphetamine Dependence, and Cannabis abuse were reportedly based on "NSH" or Napa State Hospital returnee packet. The patient had prior inpatient treatment including at the MJ. During 2022: Spring 2022 for danger to self and altered thought processes, early Fall for danger to self, mid-Fall 2022 for altered thought processes, a "quick 5150 to ER" also in mid-Fall, and shortly thereafter for danger to self (cleared after one day) and grave disability. The patient fluctuated primarily between FOSS I and FOSS II and had been identified as SMI and assaultive. He had prescribed Seroquel 300mg twice daily, Zyprexa 20mg twice daily, and Buspar 30mg twice daily at the time of his discharge.

The patient was often seen cell side, particularly in segregation, though even when on the pre-admit list. Reasons for cell side contacts included other floor activities, confidential space unavailable, outside of control (mis-identified as confidential), refusal by the patient and safety and security/potential risk to self or staff. There were multiple emergent (must-see) referrals regarding the patient and the patient became increasingly noncompliant throughout early and mid-Fall 2022. The patient was referred to the inpatient acute treatment unit for grave disability at this time and while awaiting placement in 2P, the patient was housed in "male seg 1" and "male seg 5." In mid-Fall, mental health received an emergent referral from custody because the patient had tried to attack custody when the door to his cell was opened that morning. The patient was seen timely but in a nonconfidential setting due to safety and security. The patient was identified as "quick and release" suggesting multiple fast admission and releases were due to that status. The "quick 5150 to ER" was noted in progress and linkage notes. A subsequent progress note noted that the patient had accumulated multiple disciplinary infractions and repeated placements on segregation despite having a SMI.

No treatment plan was completed for the patient in 2022 despite the various levels of care, multidisciplinary actions likely due to his mental status, and state hospital placement. The medical record included multiple intake assessments, linkage efforts, and chart reviews to restart psychotropic medication upon re-admission to the jail.

ASSESSMENT:

This patient would have benefitted from a proper treatment plan during one of his admissions to the jail. This was complicated at times by the patient's brief stay and rapid return. This negatively impacted continuity of care both within the jail system and within the community when the patient was released. The patient was not housed in a DMHU consistent with the Consent Decree. Instead of placing this extremely ill patient in segregation, all staff should have been well aware of his acute mental illness that was documented for years and instead housed him in the acute inpatient program. He was frequently placed on the waitlist, removed, and then rapidly placed back on the waitlist. The patient clearly met criteria for acute inpatient treatment through much if not all of 2022. It is hopeful that the patient has not returned since his release. Should the patient return, he should be housed in accordance with the Consent Decree and clinical needs. This patient would likely require a high level of care consistent with IOP or acute inpatient.

PATIENT 11

This patient had been reviewed before due to multiple disciplinary actions and lengths of stay in segregation. He had spent approximately 15 months in the SCJ system. The patient was diagnosed with Bipolar Disorder, unspecified. He was provided with an ATP in late Spring 2022 though the problem list suggested it was in place for only one week. The patient had been treated in IOP, intensive case management, and on the acute inpatient pre-admit list. He was identified as FOSS II. At the time of discharge, the patient was prescribed Vistaril 50mg (for sleep and anxiety) though it had last been dispensed on prior to release. He had also been prescribed Remeron, Trileptal, Abilify and diphenhydramine. A progress note approximately one month prior to release by the PNP indicated that those medications were active and that the patient believed they were helping.

The psychiatric provider (PNP) entered an alert in Fall 2021 that the patient was argumentative and volatile…requiring a "chaperone" when seen. In Winter 2021, the patient was found to have been hoarding pills. In Spring 2022, mental health management entered an alert for PNP visits to occur in the attorney booth, a more appropriate alternative to the use of a chaperone.

There were treatment plans developed since Summer 2021 for EOP, IOP and to add a treatment goal of an ATP. The ATP was discontinued in early Summer 2022 because the patient and primary clinician had discussed discontinuation. The patient reported increased insight into triggers, anger management techniques, and coping skills. A problematic peer was moved out of IOP. The patient was to transition to regular programming. Prior to that mental health staff had developed incentive plans in an effort to assist patient's functional level.

The patient had a history of multiple admissions to crisis beds and inpatient psychiatric treatment while in the California prison system. He had a well-documented history of an inability to cope with the stressors of everyday incarceration. The patient received multiple disciplinary infractions in one month in early 2022 while housed in the SITHU.

The patient did advocate for himself and used the HSR and grievance system. However, his treatment participation was erratic according to the medical record.

ASSESSMENT:

This patient was maintained in segregation beyond guidelines in the Consent Decree. He should have been moved to a DMHU. Instead, it became the norm for the patient to remain in

segregation despite SMI and documented poor frustration tolerance and coping skills. Mental health did attempt to develop incentive plans and an alternative treatment plan. This patient would have benefitted from consultation with plaintiffs' counsel and SMEs, particularly given the complexity of the case. The patient was appropriate for inpatient treatment at various points during his most recent incarceration and would have benefitted from consideration of a forced medication order.