

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

First Report of Compliance in Mental Health Services Based on Consent Decree

Final Submitted

January 20, 2021

Mary Perrien, Ph.D.

Introduction

The Sacramento County Jail System consists of two facilities: the Main Jail (MJ) located in downtown Sacramento and the Rio Cosumnes Correctional Center (RCCC) located in Elk Grove. The Main Jail has a current capacity for 2,396 inmates, and the RCCC has a current capacity for 2,259 inmates. As of December 7, 2020, the Mail Jail population was 1,780 inmates or 74% of capacity, while RCCC held 1,421 inmates, or 63% capacity. The reduced capacity has been the result of many special judicial and other interventions taken since the beginning of the COVID-19 pandemic to reduce the jail population to allow for reduced population within the jail to minimize exposure of detainees. The average daily intake (ADI) of new detainees to the jail system based on data collected in July 2019 was 104 detainees per day with the average daily release (ADR) of detainees at 109 detainees. The following graph provided by Sacramento Sheriff's Office (SSO) reflects the average length of stay (LOS) and "churn" or turnover on specific time measurements between 24 hours and more than three years:

Population turnover for inmates released on or after 7/22/2019 (SSO):

24H	48H	72H	7D	14D	30D	6M	1Y	3Y	3Y+
30.90%	4.58%	6.07%	13.67%	7.89%	9.23%	22.48%	3.35%	1.69%	0.13%

What this table underscores is that over half of the jail system population (55.22%) have a length of stay of seven days or less with similar numbers of new arrivals. This places a typical but heavy burden on the intake process, relying on nursing and mental health staff to accurately identify those newly arriving detainees who require urgent and emergent referrals to mental health for services such as treatment for suicide prevention and those detainees with serious mental illness (SMI) who require ongoing treatment in the least restrictive setting. When extending the time to six months, 94.82% of the population has a length of stay that is six months or less. This data reinforces the need for all mental health service providers to be quite familiar with community and prison resources as discharge planning and continuity of treatment services will need to be a focus on mental health treatment in the jails upon identification of detainees with mental illness and development of the initial treatment plan, regardless of the detainee's legal status at that time. This will be addressed further in that section of the Remedial Plan.

The MJ and RCCC are operated by the SSO. Adult Correctional Health (ACH) provides the medical services within both facilities through the Sacramento County Department of Health and contracts with Jail Psychiatric Services (JPS) through University of California (UC) Davis for mental health services. JPS also has its own nurses who work in the acute inpatient unit, 2P. All other nursing staff are ACH staff.

The Consent Decree in this case was formalized in June 2019. It included negotiated individual Remedial Plans focused on medical care, mental health services, and suicide prevention to be monitored by the court-appointed experts of Ms. Madeleine LaMarre, Dr. Mary Perrien, and Mr.

Lindsay Hayes, respectively. The remaining areas related to restricted housing and discrimination against people with disabilities would be monitored by Plaintiffs' counsel.

The mental health caseload was provided at the time of the August 2020 visit¹ by this expert to get a "first sight" of the facility and meet staff. There were a total of 1729 (~54%) detainees who had some sort of contact with mental health staff, but just 1291 (~40%) receiving ongoing mental health treatment. The breakdown by level of care as provided was as follows:

LEVEL OF CARE	MAIN JAIL	RCCC
IOP	34	21
INPATIENT/2P	18	
Total	52	21

Data was not provided for those detainees receiving enhanced outpatient services (OPP) or mental health services in the mainline outpatient program. Data was provided for the caseload by frequency of service scale (FOSS) as follows:

FOSS LEVEL	DESCRIPTION	MAIN JAIL	RCCC
I	Patients who meet criteria for W&I Code 5150 and are in inpatient unit 2P, waiting for a 2P bed, or are 2M suicidal	332	0
II	Clinical contact must be within month for a variety of reasons including inpatient discharge or cleared from 2P waitlist or suicide watch	256	69
III	Patients receptive to JPS services and ² receiving psychotropic medication the frequency of contact is clinically determined but not to exceed 90-day intervals	634	299
IV	Detainee has been assessed to not need of additional ongoing mental health services	240	198
TOTAL		1163	566

¹ Data for this was dated "as of 8/25/20." Defendants provided the August data when more current figures were requested on two separate occasions in November 2020. Because total population data are from a different point in time, percentages are presented as approximate.

² Emphasis is the author's.

FOSS levels can be problematic in understanding acuity and what to expect for frequency of mental health contacts, but this will be discussed later in the report.

The three experts 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. Because of this refining of the definitions, the Parties may find some compliance ratings to have changed. The underlying foundation of those ratings has not changed, only the consistency of the standard used to measure them. Those standards of compliance are as follows (and can be found in expert Mr. L. Hayes first compliance report 1/20/20):

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. Compliance has 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.

This report shall be structured similar to the Consent Decree sections with comments and recommendations 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 standards³.

³ This expert also relied on experience gained from over more than 25 years of working in state and federal correctional systems, including her training and work experience with the Federal Bureau of Prisons where she was

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, time (this will be discussed when discussing mental health staff documentation and clinical records), or similar. For example, a description of process for providing inpatient care to those detainees who were beyond the capabilities of the jail, such as a non-compliant high risk pregnant female detainee in need of inpatient psychiatric treatment, was requested along with any budgetary information and utilization in 2020. No response was provided though ultimately it was determined that this situation had not been considered. Given the stark nature of the 2P inpatient milieu, that was concerning. Another example involved the inability to get a current census of detainees by their level of care. Two requests were made, and the only information provided duplicated information provided in August 2020 despite the clear request for *current* information. In the first example, it appeared that no one had considered the possible need to refer to a community psychiatric hospital or state hospital for care while the second example could not be explained but was perhaps due to a recent change in leadership and a lack of familiarity with certain tasks.

It was extremely difficult to complete this review remotely for a variety of reasons. The global pandemic made everything more difficult for all parties including communication, interviews of detainees, and any observation of service delivery. People in leadership positions changed during this review period and some of those people were unfamiliar with their new positions. There were also some problems with timely responses to documentation requests though some of the obstacles were because the data was not being tracked, was being tracked in a non-standardized manner, or was done via paper logs and similar. In addition, the documentation that was completed, particularly in the electronic health record (EHR), was noted to often be problematic (e.g., vague, incomplete, missing). Simple monitoring tasks took longer or could not be completed due to these elements. The mental health progress notes were incomplete, level of care was not always clear or would be contradicted by other information that had been provided and could not be determined conclusively by reading the chart. Simple chart reviews became needlessly complex and took far longer than necessary. While a plan has been developed to address this for the next monitoring round, it resulted in far fewer charts reviewed than desired for this round.

In fairness to the defendants, most if not all staff have not been monitored before and are on a steep learning curve. This expert believes that there may be areas of at least partial compliance that have not been identified because there was no proof of practice to support such a finding. It may be helpful to hold an all-parties teleconference with relevant County officials to discuss some reports that should be produced regularly as part of the monitoring process. All existing

trained as a correctional officer first, psychologist second, and worked correctional posts, responded to multiple facility incidents, and was involved in uses of force. Her experience has included responsibility for correctional work centers, inmate movement, and participation in management reviews of staff misconduct, inmate discipline, and use of force reviews at the institutional and central office level. The expert has had to develop, request, and implement budgets and staffing plans, testify at legislative committees in support of those plans, and audit prison and jail operations.

reports could be reviewed with any modifications that may need to occur and then recommended new reports developed. Most reports and tools provided as part of external monitoring are excellent managerial tools and would likely be helpful to departmental managers, supervisors, and line staff.

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., Deputy Director of Department of Health Services and Ms. Zoe Clauson, Administrative Services Officer I for the continuous provision of information and responsiveness to requests. I would also like to express my deepest appreciation to Lieutenant Alex McCamy, SSO, and Ms. Andrea Javist, LCSW with JPS, for their time in August showing me the physical plant at both Main Jail and the Rio Cosumnes Correctional Center while also promptly providing requested information including a mental health program census and following through with other requests. Dr. Jason Roof, Medical Director for JPS, also dedicated a significant portion of his day in August to provide me with information necessary to understand the services provided by JPS and his time and effort were greatly appreciated as were Mr. Aron Brewer's. Following Ms. Javist's departure for unknown reasons around or about the second week of October 2020, Mr. Daniel Oforlea was placed into her position and has kindly worked to provide follow-up information. All staff have graciously received my requests and worked to fulfill them. Mr. Rick Heyer has been a tremendous asset in facilitating all of these different requests and his efforts have been most helpful.

Methodology

In June 2020, this mental health expert and the suicide prevention expert jointly developed a document request for defendants (the Sacramento County Sheriff's Department [SSO], the Sacramento County Adult Correctional Health Services [ACH], and the University of California, Davis Jail Psychiatric Services [JPS]). That document request can be found at the end of this report.

In anticipation of the August 2020 site visit by this expert, another information request was submitted that included a census of all mental health caseload participants by level of care with specific information as defined in the Remedial Plan included, and average amount of out-of-cell structured treatment time provided to patients in the IOP by facility and the inpatient program. Finally, on November 6, 2020, this expert requested an updated census list by level of care structured similar to the list received in August 2020. Only the outdated August data was ever provided despite clarification and a second request. The average structured therapeutic activity hours provided to patients in the IOP or acute programs was also not provided though staff acknowledged that while groups could possibly be held in the 2P inpatient program, they were not.

There was a vast amount of other information provided. For the purposes of this first monitoring report, this expert reviewed policy provided in response to the document request provided by all *three* parties: the SSO, ACH, JPS. These policies included basic healthcare functions such as intake, healthcare screening access, and health records though each entity may have its own policy that addressed the item (e.g., intake). There were specific mental health policies provided by JPS on the acute inpatient program, the intensive outpatient program (IOP), and all levels of care. In a general sense, the JPS policies were generally consistent with standards of care though less so with the Remedial Plan. When the policies were less compliant, it more likely due to omissions of important elements than the inclusion of contradictory elements. The more troublesome aspect identified during this monitoring round was not just that certain aspects of the Remedial Plan were not spoken to (i.e., 7 hours of structured therapeutic activities out of cell) but that staff did not adhere to policy (e.g., confidentiality). Policies can be re-written, but supervisors must ensure that staff adhere to those policies.

In addition to reviewing large numbers of policies provided by the SSO, JPS and a smaller number by the ACH, there were training materials provided by all three partners in the provision of care at Sacramento County Jail that were reviewed. Compliance data for training provided by JPS and SSO was reviewed. Capacity for the jails and specific units as well as specific mental health units/programs was provided and reviewed as part of this monitoring report. Program and unit schedules were provided by SSO and JPS and reviewed as part of this report.

In addition to document and data review, there were interviews of staff, particularly during the August site visit. The mental health program director and security compliance lieutenant were both a wealth of information and extremely helpful in providing clarity in explaining documents

and daily operations. Interviews of the service consumers (detainees) were also very helpful and provided directions to examine and data for the review.

Another important source of information was the defendants' 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." The Defendants have produced their second Status Report at this date and have yet to meet the criteria set forth above. While the first Status Report was utilized in this monitoring report, it did not provide substantial information. The second and third status reports will be used as the primary information source for the next monitoring report and should be viewed as such by Defendants. As we move forward toward compliance with the Consent Decree, ensuring that Defendants present a properly executed status report to the experts with sufficient time to question staff will be critical in the production of the experts' reports and in establishing that Defendants can monitor themselves.

The medical records for numerous detainees were also reviewed and provided information for this report. Ten of those records were formalized into case studies. More of the records were not formalized into case studies because it quickly became apparent that detainees were overwhelmingly seen cellside and those contacts cannot be considered a clinical contact due to the non-confidential nature of the contact and the inability to provide treatment in that setting as well as the dangers in discussing anything meaningful or of a sensitive nature in the housing unit. As a result, clinical findings would be repetitive and negative. It also became readily apparent that multidisciplinary treatment teams (MDTTs) with the detainee present were not occurring in accordance with the Remedial Plan and if there was a treatment plan in the record, it was not developed as required through an MDTT. The substance of the plans was typically inadequate, or the interventions were rarely implemented. Additional cases were reviewed, some in depth and others in targeted reviews. Targeted reviews included reviews focused on finding a treatment plan and evaluating its quality, locating an intake screen and mental health evaluation, and/or identifying the frequency of clinician contacts.

In summary, for each Remedial Plan item assessed, this expert reviewed relevant documents and data to include Defendants' first status report, 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.

A summary of compliance findings:

Substantive Area	Total Provisions ⁴	Substantial Compliance		Partial Compliance		Non-Compliance		Not Yet Assessed	
		#	%	#	%	#	%	#	%
Mental Health Services and Prisoners with Intellectual Disabilities	91	0	0%	62	68%	16	18%	13	14%

Prioritization for Future Monitoring Report

Defendants and Plaintiffs discussed the possibility of conducting a focused review for the next monitoring round. Because there have been so many significant leadership changes impacting program service delivery at the Sacramento County Jails and staff are inexperienced in being monitored by the Federal Court, it seemed advisable to help them focus on significant areas where sustained attention would prove dramatically fruitful across several additional areas. For example, resolving space issues would address treatment delivery, treatment access, bed planning, and possibly recruitment and retention. To harness the expertise of All Parties early in the Remedial Process encourages All Parties to take charge of the case rather than let the determine the Defendants plans and dictate All Parties' subsequent moves and recommendations. This process was discussed openly amongst experts, defendants and plaintiffs and all parties appeared open.

Because of the parties' willingness to participate in such an endeavor and the unique timing of it, this expert strongly recommends to the Court that the Experts be directed to conduct a focused monitoring review for the 2nd Monitoring Period. The Parties will meet to ultimately select the agreed upon areas of focus, but these are the mental health recommendations 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.

⁴ This total was computed by adding major (e.g., IV.B) and substantial sub-major (e.g. IV.A.2) areas of the Remedial Plan.

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 – 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.

CONSENT DECREE REQUIREMENTS AND FINDINGS

GENERAL PROVISIONS (Section II of Remedial Plan)

Staffing. *The County shall maintain sufficient medical, **mental health**⁵, 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) Based on the 2020-2021 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 following positions have been allocated:

⁵ Emphasis is the author's and meant to identify this expert's area of responsibility for this report.

Main Jail - outpatient

Discipline/Title	FTE	Shift
LCSW supervisor	100%	Days
LCSW supervisor	100%	NOC
LCSW	100%	Days
LCSW	100%	Days
LCSW	100%	Days
LCSW	100%	Swing
LCSW	100%	Swing
LCSW	100%	Days
LCSW	100%	Days
LCSW	100%	Days
LCSW	100%	Days
LCSW	100%	Days
HUSC	100%	Days
Psychologist II	5%	Days
SW I	100%	Days
SW I	100%	Days
SW I	100%	Days
Nurse Pract Superv	60%	Days
Nurse Practitioner	100%	Days
Fellows	60%	Days
Psychiatrist	10%	Days

17.4 FTE

RCCC – Outpatient

DISCIPLINE	FTE	SHIFT
LCSW Supervisor	10%	DAYS
LCSW Supervisor	100%	DAYS
LCSW	100%	DAYS
LCSW	100%	DAYS
LCSW	100%	DAYS
LCSW	100%	DAYS
LCSW	100%	DAYS
LCSW	100%	DAYS
Nurse Practitioner Superv	40%	DAYS
Nurse Practitioner	100%	DAYS

8.5 FTE

MAIN JAIL – IOP (20 Beds for males, 15 beds for females)

DISCIPLINE	FTE	SHIFT
LCSW Supervisor	100%	DAYS
LCSW	100%	DAYS
SW I	100%	DAYS
SW I	100%	DAYS
SW I	100%	DAYS
SW I	100%	DAYS
SW I	100%	DAYS
SW I	100%	DAYS
SW I	100%	DAYS
SW I	100%	DAYS
Psychologist II	15%	DAYS
Nurse Practitioner	50%	DAYS
Psychiatrist	50%	DAYS

RCCC IOP (24 beds for males)

DISCIPLINE	FTE	SHIFTS
LCSW Supervisor	100%	DAYS
LCSW	100%	DAYS
LCSW	100%	DAYS
SW I	100%	DAYS
SW I	100%	DAYS
HUSC	100%	DAYS
Psychologist II	15%	DAYS
Nurse Practitioner	40%	DAYS
Psychiatrist	40%	DAYS
	6.95 FTE	DAYS

MAIN JAIL – ACUTE INPATIENT (18 beds)

DISCIPLINE	NUMBER (of positions)	FTE	SHIFT(S)
AN II	1	100%	VARIABLE
CN II	2	100%	DAYS
CN II	2	100%	NOC
LVN II	2	100%	DAYS
LVN II	2	100%	SWING
LVN II	2	100%	NOC
MA	1	100%	NOC
Psychologist	1	5%	DAYS
Psychiatrist	1	15%	DAYS
Psychiatrist	1	85%	DAYS

13.1 FTE

There were also 5.80 administrative positions, all of whom work dayshifts.

When discussing the obstacles to providing adequate mental health treatment with mental health (JPS) management, the focus was on the limitations of the physical plant. Staffing was not perceived to be a significant limiting factor though additional staff were believed to be helpful, though details such as what type of staff and where they would be deployed could not be provided. However, while the physical plant does provide a significant challenge to mental health staff in the provision of adequate mental health treatment, the only solution that has been discussed has been to build the MJ Annex. SSO and mental health staff have indicated that facility is at least three years away and the impact of the current fiscal problems that all counties are facing in this global pandemic are not fully known. Therefore the MJ annex construction project may be even further away. There must be an interim plan to provide adequate treatment at all levels of care for all detainees in need

of mental health services. The interim plan may incorporate multiple elements such as retrofitting areas in the current facilities, additional staffing, and reallocation of existing staffing. It will require that all parties come together and work creatively to identify effective, acceptable solutions while awaiting the annex.

One area ripe for consideration of reallocating existing staffing involves the current use of social workers for non-clinical groups such as movement groups, art groups, and movie or recreational therapy groups. While onsite in August 2020, social workers were observed facilitating treatment groups that did not require their level of education and experience in facilitation. These groups could be provided by recreational therapists, rehabilitation therapists or licensed psychiatric technicians. In other psychiatric facilities in California, those disciplines are far more likely to be facilitating such groups, allowing social workers to focus on providing clinical treatment groups such as mood management, Dialectical Behavior Therapy, and other empirically-based (proven effective) treatments. It should be noted that recreational therapy and associated movement groups are not treatment modalities that social workers are typically trained to provide. It is also important to note that two of the unit movement groups observed had an officer present in the unit with the group. There did not appear to be a security need for the officer as the detainees and therapist were easily observable outside of the unit due to the wall being almost completely glass with enormous line of sight visibility. This officer was intruding on the clinical nature of the group, apparently at the therapist's request, and unable to attend to any other programming while observing the group.

On a positive note, Defendants have provided information that more social workers are expected to be allocated to the MJ in the first quarter of 2021. They report that services will be evaluated and reallocation across programs will be reviewed at that time.

Recommendations:

Based on this expert's experience with activating new mental health programs, modifying existing mental health programs, and evaluating existing mental health programs, there are areas in the existing mental health staffing plans that should be subject to review. For example, having all staff scheduled during day shift in the MJ IOP when there is so little space available. Staggering staff throughout the day and evening can increase access to out-of-cell treatment activities. Examining the staffing in the acute inpatient program, there are an inadequate amount of FTE psychologists or licensed master's level clinicians to facilitate a therapeutic milieu and clinical out-of-cell activity. Currently, there is only nursing, 1.0 FTE psychiatry and 5% FTE psychologist assigned to the unit. There were no nursing groups scheduled for the acute inpatient program and record review indicated that detainees remained isolated in their cells for long periods of time with staff only seeing them cell front. Acute inpatient ratios for psychiatry in California are typically 1:15, suggesting that the acute program requires additional psychiatric resources. At the RCCC, licensed clinical social workers to detainee ratios were 1:12 which was close to the JPS stated ratios of 1:10 but not compliant and the IOP at the main jail was only staffed with one (1.0) LCSW for a total of 35 detainees. The JPS appendix A-2 document did allow for inclusion of MSW and the Main Jail IOP was staffed primarily with SW Is so the ratios could likely be met but

with less sophisticated and unlicensed providers. That was concerning as this is a more complex and higher treatment need population. As mentioned above, social workers have also been tasked with providing recreation therapies that they do not typically have the training to provide which are more commonly provided by nursing staff or recreational or rehabilitation therapists. Clearly there may be a need to reallocate existing staff while awaiting construction and additional staff.

The County and its service providers have been directed by the Remedial Plan to begin tracking out of cell and therapeutic activity. Being able to accurately track completed contacts and therapeutic groups (structured therapeutic activity) and unstructured therapeutic activity (yard, recreational time) daily by detainee will be critical in demonstrating improvement in providing treatment in specific programs and compliance with the Remedial Plan (e.g. section D.6). That data will also be useful in quantifying any need for additional staff. Therefore, this data should be established first and managers from JPS and ACH should work with SSO to utilize this data to develop a revised interim staffing plan based on the Remedial Plan and expected service levels described by the Remedial Plan and JPS attachments. Once the revised interim staffing plan has been established, it should be shared with all parties and evaluated within the context of an interim space plan (to be discussed further). This interim staffing plan and subsequent monitoring reports shall be used to determine if and how many of what type of mental health or custody staff may need to be hired.

The Defendants reported that staff will develop a reporting form to complete and track treatment services to utilize for staffing needs. No target date was provided for report completion or tracking implementation.

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.1.a-c) This item was assessed primarily through review of medical records. This item was determined to be partially compliant rather than non-compliant because the County (JPS) does have a policy for identification and consultation with the Regional Center if an intellectual disability is suspected or identified. However, there was no evidence that the policy had been fully implemented nor that it had been updated to be consistent with the Remedial Plan.

Detainees' arrival process was reviewed, and the screening and assessment intake process reviewed. There was no evidence of a standardized screening for intellectual disabilities utilized by trained, qualified mental health staff to identify those detainees who have intellectual disabilities. There was also an absence of evidence that mental health staff had been identifying the adaptive support deficits and needs of those detainees identified as intellectually disabled with a formal program of monitoring, management, and accommodations provided for these detainees.

It was noted that there was a JPS policy (806) last updated in 2016 that allowed for JPS mental health staff to consult with the regional center, if still open, regarding client management if there is a detainee where intellectual disability is suspected or identified.

Recommendations: It is recommended that JPS and other related County officials meet with Plaintiffs' counsel to develop screening and assessment protocols to identify potentially intellectually disabled detainees, policy regarding the process of screening and identifying those detainees at intake, and a formal program to monitor, manage, and accommodate the needs of identified detainees.

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

2a. **Not Assessed.** This item was assessed within the area of detainees with mental health needs. Since there was no evidence that detainees with an intellectual disability were identified, there was no reason to believe that multidisciplinary treatment teams were being held for them, particularly given the findings with detainees experiencing mental illness that MDTTs rarely occurred.

2. 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.** See explanation 2a. These detainees were not regularly identified.

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 of mental 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 has worked with its vendors and providers to revise and create relevant mental health policies. While many of these policies have been provided, a large number of them were last reviewed in 2016 and require updating to be compliant with the Remedial Plan. Both parties in this litigation developed a process for policy review where revised policies are sent to Plaintiffs' attorneys for review and comment. Once those policies have completed that level of review, the policies are sent to the experts. This expert has recently received 11 related mental health policies and one form which are under review. That review shall be included in the Second Monitoring Report.

1. Written document of mental health programming. Detainees reported and showed this expert various orientation documents that addressed the range of mental health services available within both the MJ and RCCC. Detainees reported that they received these documents once they were admitted to certain mental health programs though some detainees in those same programs indicated that they had not received those information packets. All detainees denied receiving any such packets at intake. It

appeared that JPS had begun disseminating the packets but did not yet have a formal process and may not have made them available to all detainees at intake.

1a) **Recommendations:** Further information is necessary to determine substantial compliance. It is recommended that JPS track or conduct audits of dissemination of this information to new arrivals at intake and to mental health programs and restrictive housing for two quarters in 2021 and provide that data to the mental health expert and plaintiffs' attorneys for review. Defendants have committed to implementing this recommendation.

2. Referral timeframes. Detainees reported that they were not seen timely by their social worker or psychiatrist.

2a) **Non-compliant.** JPS has established timeframes for referrals for various mental health services. However, they are not compliant with the consent decree. The Remedial Plan dictates the following timeframes for emergent ("see now") referrals of a maximum within 6 hours, urgent within 36 hours, and routine within two weeks. Since the routine timeframe is generous, this expert further interprets that as 10 working days and 14 calendar days. Thirty-six hours for an urgent referral is unusual and not seen in other systems; the standard is typically 24 hours as the standard for emergent referrals is typically 4 hours. There is no distinction regarding the type of referral. However, 6 and 36 hours were established in the Remedial Plan and were used as the standard in this monitoring report. It is strongly suggested that all parties review the recommended standards of 4 hours for an urgent referral, 24 hours for an emergent referral, and 7 calendar or 5 working days for routine referral as the Defendants move toward compliance. This helps staff better identify compliance for urgent referrals and establishes timeframes more consistent with the standard in correctional healthcare.

There is no exception noted in the Remedial Plan that different types of referrals shall have different time expectations and there is no clinical justification noted for JPS' different referral times for different mental health services (e.g. emergent psychiatric evaluation in IOP is 24 hours while emergent "MH assessment" is 6 hours). These appear to possibly be due to staffing issues and availability. If that is accurate, that would be completely inappropriate. An emergent referral is an emergent referral. If it can be done within a longer period of time, it is simply not emergent, it is urgent. This helps all staff to speak the same language and know the timeframes that they all must meet based on the acuity of the matter at hand.

2b) **Recommendations:** It is recommended that JPS re-evaluate their referral policies including any policies addressing medication management, laboratory studies and related medication and detainee

monitoring, and update those policies so that they conform to the standards agreed to in the Remedial Plan. Staff should then be trained in those updated policies with continuous quality improvement studies to follow to ensure effective implementation. Defendants have committed to completing this task.

3-7) **partial compliance.** (IV.A.c-g) The County and/or its vendor, JPS, did have policies to address these areas. However, they had not been updated since the Consent Decree and should be reviewed with the Remedial Plan requirements in mind.

8) **partial compliance.** (IV.A.h) There were numerous training curricula provided for the 2019-2020 training period. This included basic training on working with people with mental health disorders for jail staff, when to make referrals, and available treatment at MJ and RCCC. There were also modules for de-escalation and planning for aggressive behavior to be presented to all staff (e.g., Pro-ACT). There were a large number of well-developed training modules available for mental health staff to implement. However, the County was found to be in partial compliance because the training log did not note required staff and attendees. Defendants have already begun working on establishing proper tracking of training.

8.a) **Recommendations.** Future training compliance should include data on 1) required training, 2) required attendees, and 3) percent compliance.

If necessary, all parties should meet and confer to review training and identify required training and a reasonable training schedule that applies to mental health staff, medical staff (including nursing), and custodial staff. Once that has been established, training records should include attendance and monitor who has not attended the required training. A goal of 85-90% compliance is recommended for this area.

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 First Status Report, the County has been in the process of revising its policies to reflect the Remedial Plan. However, these efforts have also been tempered by the enormous efforts necessary to contain COVID-19 during a global pandemic at both jail sites. It is this expert's understanding based on communication with all parties that revision of those policies continues, even with major turnover in leadership at SSO, ACH, and JPS which has also negatively impacted these efforts temporarily. The County has been doing its best to meet this expectation.

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) The County has implemented male and female IOPs at MJ and a male IOP at RCCC. This has been perceived as a positive occurrence by mental health and custodial staff as well as detainees. However, there has not been sufficient treatment provided in those programs for them to be compliant with their own policy and the Remedial Plan. Detainees are overwhelmingly seen cellside rather than in a confidential area. There were multiple incidents when the detainee would then refuse the service (e.g., Case 9, detainee self-report) due to the lack of confidentiality. Detainee participants in IOP requested additional treatment during interviews and specifically, more clinically-focused treatment. Detainees wanted to learn more about their mental illness and how they could help themselves. They wanted to spend more time learning and less time "moving" (referring to the daily movement groups).

There is a significant need for more access in mental health unit programs. This need is so great that Defendants frequently mention it, appropriately advocating for themselves and their clients. In fact, the need is so great that detainees are constantly on the waitlist, and clinicians are constantly forced to juggle their patients treatment needs. As of mid-December 2020, there were 39 inmates on the inpatient/IOP waitlist where in August there had just been 14 and there were 72 detainees in restrictive housing designated as SMI when it should have been rare that there was one person.

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:

Partially Compliant. (IV.A.4) As stated previously, there are numerous reasons why

JPS has not yet implemented its non-acute mental health programs consistent with JPS psychiatric services overview as observed onsite, reported by JPS and custodial staff, and identified in mental health record review. This will be discussed in detail later in the report. Briefly, detainees were most frequently seen at cell front instead of in a confidential space and had minimal therapeutic groups.

Recommendations: The County and JPS need to track clinical activity to develop an interim plan for treatment schedules, staffing, and space until the Annex is built.

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 these positions had apparently been constructed, all experts asked the various managers about reporting structures, how simple things like supplies would be requested and purchased (group treatment materials for example) and other inquiries attempting to assess the actual impact in this area. The experts remained uncertain about the actual lines of communication in some areas and daily operational authority. While it was clear who worked for whom, this area of the Remedial Plan appeared to be an effort to achieve some equality amongst three different entities in operations of the jail (SSO, ACH, JPS). It remained unclear if that had been achieved and operational efficacy remained based on relationships rather than the established leadership structure and team. It was also unclear to this expert if recent managerial departures would have a positive or negative impact on the leadership team. Responsibility falls to those at the highest levels to assess this area and provide all parties and experts with evidence of functional, cohesive leadership within the MJ and RCCC across disciplines.

Recommendations: Continued assessment of this area by experts in future monitoring of the Remedial Plan.

MENTAL HEALTH CARE

Patient Privacy (IV.C)

All 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 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:

Partially Compliant. (IV.C.1, 2, 5) This area is defined as partially compliant because there was policy that directed staff to hold confidential contacts and mental health management had an expectation that clinical staff would complete private

contacts whenever possible in accordance with the Remedial Plan. However, this had not been fully or properly implemented. Confidential clinical contacts are a key component to mental health care. Particularly in forensic and correctional settings, patients are often cautious, possibly paranoid, and develop trust slowly. At times their well-being in the milieu is based on keeping information about themselves hidden or secret. This is true for other detainees and other staff though this lack of trust may be at odds with receiving adequate mental health treatment. Therefore, maintaining private settings for clinical contacts is a critical element to care. While the physical plant, particularly at the MJ (more than RCCC) presents a challenge, this does not excuse staff from making every effort to maintain confidentiality.

Non-Compliant (IV.C.2, 4) This item was noted as non-compliant because it was the exception rather than the norm that mental health staff documented where clinical contacts occurred and whether they were confidential. For example, a visiting room in the main jail had reportedly been used for individual sessions, but security staff present during the August 2020 tour indicated that the door would be left at least slightly ajar. The expert asked staff to go on each side of the partition and talk with the door slightly ajar and the expert outside where an officer would stand and the conversation could be overheard. There were other examples of non-confidential settings that could not be determined just by location. Unfortunately, the majority of contacts occurred cellside and were clearly not confidential. There was rarely an explanation of the reason the contact occurred at the cell. Holding meetings at cell front or in open spaces with non-clinical staff around, inmate porters in the area, and deputies moving about or standing close by reduces the type and quality of information clinicians will obtain from detainees. Detainees repeatedly reported that their contacts were rarely private and that they withheld important mental health information due to the non-confidential nature of the setting.

This was a deeply disappointing area to find clinical staff repeatedly failed to meet compliance. While onsite in August 2020, mental health managerial staff indicated that mental health line staff were consistently using classroom space if it was available. However, once on the housing units, this was quickly observed to be an expectation of mental health management that had not manifested into an operational reality. Speaking to a mental health provider who very honestly acknowledged that at times the workload simply forces providers to do cell side interviews. Mental health management was committed to reinforce their expectation with staff regarding confidentiality but seemed surprised to observe the failure to use open classrooms and unaware of what the actual operations had been. Supervisors must complete direct observation and audits to ensure that operational and cultural changes such as the expectation for privacy for detainees were consistently happening.

These cell front contacts continued through November up to the writing of this report based on record review. There were some occasions where contacts were noted to have occurred in a confidential setting in the classroom, though when this expert had been onsite detainees had reported that even classroom contacts were not confidential

because the door would be left open and a deputy would be present whether at the MJ or RCCC. In fact, in one case reviewed from RCCC, the deputy actually interrupted the therapeutic session because he heard the detainee raise his voice with the clinician and heard the detainee curse. The unacceptable nature of that interruption cannot be stressed strongly enough. The fact that there was an informal write-up about the incident written by the deputy confirms that there is a culture in the jails where neither clinical staff nor security staff understand the professional boundaries of their respective positions and the sanctity of the therapeutic relationship. One training will not correct this culture. It should be noted that documentation by psychiatrists typically did not indicate if the detainee was seen cell front or in a private setting whereas social worker were much more likely to provide that information.

Recommendations: Mental Health staff should be repeatedly reminded about the necessity of private clinical contacts. Mental Health units should be frequently visited by correctional and mental health supervisors and managers who can observe operations and hold correctional and mental health staff to those standards. Correctional staff should never interrupt a therapeutic session unless the clinician requests it or the situation is unsafe. Deputies should receive training in recognizing an unsafe situation and clinicians should receive training on working with difficult and violent clients. The quality assurance/quality improvement team, in the course of conducting audits should review records to be sure that there is documentation to support that clinical contacts are held in private and if they are not that there is information documenting the security reasons that a private contact did not occur.

Clinical staff must be held accountable for documenting in their notes whether the contact was confidential. This holds true whether the contact is an assessment, suicide risk assessment, routine contact, or MDTT. Somewhere on that form the clinical staff must indicate that the detainee was seen cellside or in an office that was or was not private. Supervisory staff are encouraged to conduct supervisory audits on a quarterly basis to verify that staff are following policy and take appropriate action based on findings.

On a positive note, Defendants purchased white noise machines to use in treatment areas where they would enhance privacy for detainees. Defendants continue to train and work with staff about the importance of privacy during contacts and plan to monitor through the quality management process.

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, it was not clear whether JPS could actually provide a census for each level of care (OPP, IOP, acute inpatient, segregation) and each facility (MJ, RCCC). One was provided in August, though some of the records reviewed indicated that the levels of care provided for those patients were not accurate. In early November, an updated, current list was requested, particularly because of the amount of "churn" and frequency of discharge within the jail. There was a new person in the Program Director position who provided the old August 25th list. A second request for a current census was submitted but such a case list was never received. This item was scored as partially compliant because JPS was able to provide the initial list and the electronic record makes it appear that such case lists should be possible despite the recent failure to produce such a list. Defendants need to provide the experts with a straightforward response as to whether they can produce such a list and then do so on a monthly basis with date to be negotiated.

- *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 have been negatively impacted by the frequency of cell front contacts. Because detainees were frequently seen cell front, it did not appear that they were seen with the medical record based on documentation. This conclusion was based on providers not citing relevant information from prior notes/contacts in their current note (case 1). The provider clearly had not reviewed the chart. There were occasions when a detainee would ask the provider a question that would go unanswered that, had the chart been accessible, would have been easily answered. In multiple cases it appeared that prescribers were failing to review the record, resulting in multiple medication changes as each provider would simply prescribe their own regimen without regard to what the detainee was currently receiving (case 3) or in maintaining continuity of care.

- *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 policy development and implementation. Intake screening is not conducted in a confidential setting which may negatively impact the intake process. As noted by Medical Expert LaMarre, intake screening is currently limited by numerous factors. It is not compliant currently with the Remedial Plan. The new policy that should be compliant will be a phased in policy over time. Urine drug screens were not consistently implemented nor was documentation consistently present to document why they could not be completed. Ten intake screens were reviewed as part of this experts review of intake screenings where all ten detainees were later determined to have a mental health condition, eight had SMI, and all had substance abuse issues. Similar to what the Medical Expert found, the registered nurses who completed these intake screens had contradictory information where in one part of the screen the detainee was noted to not have a substance use history but in another area documented that the detainee may be under the influence. Another area of concern noted on the ten intake screens reviewed was prior medications. Only six sought ROIs signed from the detainees for prior medications or made an effort to continue current medications. Intake screening and Mental health policy needs to be updated to reflect the Remedial Plan regarding intake assessments and access to psychiatric prescribers as well as timeframes for referrals.

Recommendations. SSO, ACH, JPS must review the intake process and areas to identify what changes can be made so that nursing and mental health providers can complete intake screening and assessments in a confidential area. Next, a process review with all entities should occur, or at least with ACH and JPS to identify how RNs completing the screens can make appropriate and timely referrals to providers, particularly prescribers so that there are timely orders of essential medications without missed doses as was also discovered in mental health patients who were forced to repeatedly submit kites to request their medications. JPS should conduct its own assessment to determine the appropriate staffing for mental health

evaluation at intake with mental health providers. It would appear that at least one psychologist and one psychiatrist would be needed for evaluation of difficult cases at intake. Once policies have been updated to be compliant with the Remedial Plan, the mental health and ACH staff assigned to intake and/or float staff should receive training in those policies. Finally, an electronic tracking system that can provide staff with alerts or triggers that identify which detainees have upcoming appointments to assist clerical and clinical staff in scheduling those appointments timely so that mental health services are provided within timeframes is necessary. Mental health management reported that the current system cannot currently provide that functionality.

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 a focus under development. There was no multidisciplinary treatment team (MDTT) that was identified in any record reviewed (case studies or additional records). There were screenshots of treatment plans provided in response to a treatment plan form document request, but no adequate treatment plan and/or MDTT form was provided for review to this expert despite being requested from the County. What was typically found in detainee records who were in the IOP or acute inpatient program were some medication compliance goals or coping skills goals identified by one team member in a progress note. Progress notes did not support that any of those treatment goals were actually subjected to treatment interventions in the acute program nor were any therapeutic treatment groups assigned in the IOP based on a treatment plan. There was still extensive work to be done in the area of developing who would be members of the detainee's MDTT, the elements of an adequate individualized treatment plan, and how to document implementation of that plan through progress notes. There were expected timelines for initial MDTTs across FOSS levels, but those timelines were not in accordance with the standards of care in all cases.

FOSS levels appear problematic across this system of mental health service. There are specific levels of mental health care which have specific timelines and expectations associated with them which should be consistent with the Remedial Plan. Those timelines are not congruent with FOSS levels nor do they always imply a specific FOSS level. Two FOSS levels are centered around a specific program (inpatient care in 2P) and two of the levels could reflect a host of contact frequencies with mental health providers. For example, someone treated at FOSS levels II and III could each be seen weekly. The exact frequency was never clarified in the charts reviewed so the reviewer had no idea what was expected of the treatment team. This increases the likelihood that the detainees would be equally confused. Those detainees who were interviewed could not be sure how often they were seen, even in the IOP. The existence of policy regarding level of care services and expectations what effectively is an additional policy that impacts those same areas seems like an unnecessarily confusing way of operating a mental health program.

Recommendations. This area would benefit from consultation with at least the Suicide and Mental Health experts, possible inclusion of the Medical expert, and all parties to discuss the membership of the treatment team and the key components a truly individualized plan as well as timing for initial assessments. One aspect that ACH has communicated in several of its reports is that the population inside its jails has become increasingly complex with ever-increasingly health (medical and mental health) problems that are increasingly intertwined, as the global pandemic only makes more clear. There will need to be increased time allocated for staff to be on site or available through adequate electronic video equipment with detainees present for treatment team meetings and the training of staff in these new expectations. This is an area that may take some time to develop properly but is expected to benefit detainees and staff greatly once properly implemented.

It is strongly recommended that JPS mental health staff in consultation with the mental health and suicide prevention experts re-examine the need for FOSS levels and the way in which they would be utilized effectively in light of the Remedial Plan. The clinical utility of these levels must be clearly established if they are to be maintained and forms must be created to indicate the level at each contact, the frequency of contacts expected, and the clinical rationale for that determination. Currently, clinical staff do not appear to conceptualize cases in that manner and document such clinical conceptualizations, so this must also be reviewed as an important component of treatment and training for mental health 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 medications: (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 is an area that requires further assessment and review. There was evidence of prescribers not reviewing prior records and not maintaining treatment continuity (case 3) as a result. Of several new arrivals that were reviewed for continuity of medication, the prescribers were not provided with the referral for a bridge order or essential medication order timely to allow the detainee to continue psychotropic medications without missing a dose. Psychotropic medications were prescribed without treatment targets being identified for those medications. There was no purpose identified for the prescription (e.g., hallucinations, anxiety, depression). It was not unusual for psychotropic medications to be changed without the prescribing providers seeing the detainee in person. Laboratory studies were not always ordered when indicated. This was partially compliant because providers did not always fail to do these things but they did not consistently adhere to policy or the Remedial Plan. Detainees in the IOP, OPP, and JBCT programs at MJ complained consistently about delivery of evening medications and RCCC detainees also complained about medication pass. At MJ staff confirmed that while they had thought that they had resolved the problem, there was a problem with nursing staff delivering medications as late as 0100 to 0200 hours. Detainees reported that they would decline the medications because they did not want to wake up. This was also noted on occasion in patient records. It was most concerning for Case 3.

Recommendations. Policies should be updated to be consistent with the Remedial Plans. All staff should be trained on the revised policies. Peer review should focus the measures. The problems with medication administration must be addressed immediately. There is no reason to believe that other detainees aren't also refusing important medical and mental health medications because of the late administration. This also occurred in the acute inpatient unit. Nursing staff must resolve this with SSO staff. There was apparently a simple remedy that worked in the past and could be easily employed again. Then this must be closely monitored by supervisors and part of the QI system.

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:

Unable to properly assess. (IV.F) While the SSO reported that some of these points were part of ongoing current practices, they could not be adequately assessed through available materials and remote monitoring. It was noted that there were 72 detainees in restrictive housing who were designated as SMI and should not have been housed there based on the Remedial Plan (IV.F.5). Security staff have repeatedly stated that it was due to a lack of mental health beds and that they attempt to work detainees out of those highly restrictive settings, but detainees with mental illness and particularly serious mental illness make up a disproportionate portion of the population in the most restrictive housing settings.

MENTAL HEALTH CARE

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

- *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.*
- *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.*
- *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.*
- *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.*
- *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) While this has been negatively impacted by the global pandemic and physical plant, there must be an interim solution that provides for this out-of-cell time and structured therapeutic activity for patients. Many of the detainees with mental illness/SMI are

locked down for long periods of time, particularly if they are in the inpatient unit. It is like solitary confinement for them with long periods of time spent in their cells with no therapeutic break. The IOP detainees in the MJ were allowed to come out of their cells at times and be in their dayroom area. However, the detainees interviewed during the on-site time in August all asked for more therapeutic activity, those in the MJ and RCCC where detainees were more contained to their cell. Females in the IOP and OPP in the MJ were kept separate and fed in their cells. They all reported that they would appreciate some normality in their Mental Health unit by being allowed to eat in a communal setting in the dayroom. RCCC female detainees in the mental health programs were kept primarily in their cells as well and also had a lot of requests for additional treatment groups, more meaningful clinical groups, and expressed great appreciation for several correctional staff who would make a point to be sure that they received more yard time.

In the acute inpatient unit 2P, detainees were regularly restricted to a suicide resistant smock, tear resistant bedding and similar by psychiatry. While the progress note would identify which specific rights were being denied (e.g., right to have shoes, right to bedding), the psychiatrists did not provide a clinical rationale for the denial of rights leaving the reader to infer. These orders did not follow any kind of treatment team discussion since there was no formal MDTT in the inpatient unit. No cases were identified when custody staff were restricting privileges or property in 2P or other units nor did any inmates report custody removing their property. The primary issue involved the inpatient unit when detainees would want their clothing back or reading material to pass the day and a psychiatrist would not allow it but would not provide a clinical justification for refusing the material.

Recommendations: Each facility should charter a QIT that includes SSO, ACH, and JPS staff to focus on identifying ways to increase normalizing experiences for the detainees such as mealtimes, games, yard, exercise, and other activities at both the RCCC and MJ mental health units including the acute inpatient program. Multidisciplinary treatment team meetings should be implemented as soon as possible and patients schedules and privileges should be reviewed to be sure that they are getting out of their cells and engaged with treatment. Policies that include “denial of rights” should default to patients having their property and clothing and privileges and requiring extensive documentation of clinical justification if any of those are removed. In the cases reviewed, psychiatrists did not document clinical justifications for any DORs that were ordered.

Clinical staff and security staff must be trained on the remedial plan and educated that detainees in mental health units receive all of the property and privileges that they would have based on their classification and custody level. If security staff restrict any property or privileges of a detainee in a mental health unit, then security staff must inform mental health staff and there must be a plan to restore those privileges/property at the earliest time that would be appropriate. Until that time, the treatment team which includes at least one security representative will regularly review the restrictions on a weekly basis until they are restored.

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:

Could not Assess.

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) Bed planning is partially compliant because the County recognizes that there is a significant need for more mental health beds at the IOP, OPP, and acute inpatient levels of care at this time. There have been efforts made toward obtaining funding to design the annex, though the impact of the current pandemic and budgetary losses are not fully known to this expert. There is such a need for more mental health unit beds that managers from all entities repeat the need for such space at every opportunity, appropriately advocating for their staff and the population that they are treating. It is incredibly difficult to adequately treat people who there is insufficient space to provide that treatment. At the time of the August site visit, there were 14 people on the 2P inpatient waitlist while in early December, there were 39 people on the inpatient/IOP waitlist. That is almost a 300% increase in just four months.

Of equally great concern was the 72 detainees with SMI in restrictive housing (segregation⁶) as of December 8th, 2020. The Remedial Plan (IV.F.5) clearly states that detainees with SMI will *not* be housed in restrictive housing “...unless the detainee presents an *immediate* danger or significant disruption to the therapeutic setting and there is no reasonable alternative...” Instead, these detainees are to be housed in appropriate alternative treatment programs. These detainees make up more than half (58%, 72 of 124) of the total restrictive housing population. It is typically viewed as a sign of a problematic mental health program when detainees with mental health diagnoses are over-represented in the segregation population. Caseload detainees make up roughly 40% of the total jail population but nearly 60% of its segregated population. There must be room within alternative treatment programs such as the IOP to move those detainees out of restrictive housing and into treatment with a goal of a less restrictive environment as treatment progresses. In addition, increased treatment access

⁶ Sacramento uses administrative and disciplinary segregation and total separation to reflect the status a detainee may be in for housing when separated from others and under enhanced security measures that include increased isolation and reduced freedom of movement.

through increased bed space and increased treatment activities at all levels of care must be prioritized so that decompensation can be identified and staff can intervene before a detainee reaches the point of requiring a restrictive setting like segregation.

Because there is not currently sufficient bed space, mental health providers must juggle their patient caseloads and maintain detainees on waitlists for longer than the patient should be held in a space where the appropriate treatment cannot be provided. Again, the future MJ Annex building seems to be the answer everyone is counting on, but there needs to be an interim plan until the Annex is built and can be inhabited. Will there be an additional release plan for detainees with SMI who can be placed in a living space in the community? Is there inpatient care in the community that the County can establish a contract for placement for those detainees whose needs exceed the services that can be provided at the jail?

There are clearly only several options when there are people in custody who require services. One must build beds to provide services or release people to the community. **Recommendations.** The SSO, ACH, JPS management should include interim bed planning in their existing space, treatment and bed planning while waiting for large construction projects like the MJ Annex. It appears that smaller reconstruction efforts can make large improvements at RCCC but that it will take more at the MJ. It is not appropriate to leave class members waiting for three years or more to receive appropriate services in an appropriate setting. Therefore, while planning for those large scale projects, the County must also plan for reasonable interim steps that can provide reasonable options for adequate service delivery.

Defendants have committed to implementing a Space Committee in 2021.

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 cancellations. 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) Eight records were quickly reviewed for therapeutic groups for IOP participants in the MJ. In October and November, approximately 98 groups were scheduled but 44 (45%) were canceled due to insufficient custody staffing. The reader is reminded that the global pandemic continued during this time period and that numbers throughout California were increasing for those testing positive. Any conclusions drawn during this time should be interpreted with caution given the impact of quarantine and isolation of staff. A “growth” request had been submitted for an escort team based on the SSO First Status Report. While budgetary challenges due to the global pandemic may have made such requests uncertain, the request was made. It should also be noted that while there was a schedule for IOP, IOP must share the one classroom with the JBCT program at MJ and between men and women. There is a lot of activity that must occur in quite limited space and the JBCT programs seem to dominate with IOP being a second priority. This is likely due to the County’s requirement to provide JBCT for misdemeanants and has a contract with DSH for felony treatment. While provider contacts were tracked, they did not appear to have been fully tracked consistent with the Remedial Plan.

In fact, Defendants did note in their second status report that the current electronic health record has failed to fulfill their hopes as a tool for compliance tracking and reporting. Many of the reporting features that they had hoped for will not be realized with the current system.

Just reviewing provided treatment schedules it was easy to see that the JBCT program dominates the other mental health programs in the way that it eats up available space. Rather than divide and share limited space, JBCT is allocated a disproportionate amount of treatment space for groups and activities while IOP and

OPP have been expected to make due with space on the unit or no space at all. As a result, many of their groups get canceled and interviewed detainees reported a type of learned helplessness where they became apathetic toward groups and lose the motivation to participate because they've had so many times when they were excited to go to group only to be disappointed when it was canceled.

The acute inpatient program is even more bleak. The IOP units are larger with more activity overall that participants can watch from their cells. The inpatient unit is small with little going on. The television was not on when this expert toured the unit and there was no radio on for stimulation. No groups were offered and patients there were seen primarily by telepsychiatrists limiting their human interactions to just the nurses providing their daily care. As has been stated elsewhere in this report, the experience is much like solitary confinement in segregation where the correctional officers are nurses instead. The primary modality of treatment appears to be isolation despite its negative effects. Medication management would be the other intervention utilized with occasional success despite the bleak environmental challenges. The most ill individuals are placed into this inpatient unit yet they receive even less treatment than those who remain in the IOP.

Recommendations. The SSO and JPS are encouraged to explore the possibility of dedicated escort teams though the IOP and JBCT have assigned staff already. Other systems use mental health or healthcare escort cadres who are dedicated to make sure that this large number of contacts and activities occur, allowing housing deputies to focus on the other escorts and unit activities and programs. It is also important that provider show up on time for their appointments in their scheduled offices and areas. The Space Committee should document meetings and discussions regarding what spaces should be available to see inmates in so that more appropriate identified space can be made available for therapeutic activity.

Mental health and security management must immediately initiate a treatment tracking system for the inpatient program and IOP. The amount of actual treatment delivered out of cell needs to be documented and tracked so that weekly averages can be calculated. Detainees need to be provided with actual therapeutic interventions outside of their cells and in confidential settings. While seeking to identify confidential settings, community meetings and community activities in common areas can be utilized as out of cell activities so that detainees are not isolated in their cells for extended periods of time as currently occurs. Once a baseline of service delivery is established, the treatment teams' goals should be to include it by at least 10% each week.

Defendants have indicated that funding was approved for additional officers for pill call. This should eliminate the medication administration problems.

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 system for 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 until evaluated by a mental health professional.*
- *Prisoners with Priority (Urgent) mental health needs shall be seen for assessment or treatment by a qualified mental health 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:

Partially compliant. (IV.F.6) While JPS has implemented a referral system that includes established timelines, there are other timeframes for different types of referrals that do not reflect the Remedial Plan or Exhibit A-2. JPS must reconcile their policy so that all referrals reflect the acuity of the referral: emergent or “must see,” urgent or priority, and routine (14 calendar or 10 business days).

Recommendations. As stated previously, JPS needs to revise their Access to Care referral policy so that it conforms to the Remedial Plan. There should not be different timelines for different types of referrals. The referrals should be characterized by its acuity. If it is not necessary that the referral be done quickly, then it should be characterized as routine. Staff should then receive training so that they can be competent in the policy and learn how to appropriately categorize referrals. It is also recommended that Defendants make sure that the referral process is as streamlined as possible to minimize the number of hands a referral must pass through before it gets to the person who actually takes action.

MENTAL HEALTH CARE

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 has 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. This is one area that was quite well covered by JPS. It is partially compliant because this section includes the element of providing access and the jail maintains a steady waitlist of patients waiting for a bed in the acute inpatient unit. This aspect of this item may not be fully compliant until there are additional beds available, whether through an interim plan or MJ Annex.

Recommendations. Bed planning, space planning, treatment planning, treatment tracking, recommendations previously provided would apply in this section as well.

MENTAL HEALTH CARE

Clinical Restraints and Seclusion (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) Data was provided that restraints were not used in the last quarter for 2020 (Jul-Sep). The JPS and ACH policies on restraints were reviewed and generally were acceptable.

Recommendations. The ACH and JPS policies provided for review had not been updated but should be as part of the Remedial Plan process so that staff can rest assured that they are consistent with the Remedial Plan. The JPS Program Director indicated that mental health staff do not provide services when custody initiate correctional restraints. This should be clarified in existing policies because that was not clear in the provided policies. This would apply more to JPS than ACH as it

appeared that ACH nursing staff provide some oversight for safety and monitoring when correctional restraints are used.

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 and family 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) Met with Pharmacist who described and showed this expert the process to provide departing detainees with prescriptions and medications. Could not find documentation in medical record reviews that supported medication provided but was unsure if that was a documentation matter. This aspect will be further assessed during the next monitoring round.

MENTAL HEALTH CARE

Training (IV.I)

- I. *The County shall develop and implement, in collaboration with Plaintiffs' counsel, training curricula and schedules in accordance with the following: (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 Unit 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) SSO indicated in their First Status Report (July 2020, filed with Court October 2020) that many of the areas addressed in the Remedial Plan already. Some of those training curricula were presented and looked very good. However, compliance could not be determined because compliance materials were not presented to identify the required training and required staff in attendance to determine percentage compliant for custody and mental health staff.

Recommendations. As stated in other areas of this monitoring report, the specific staff positions (e.g., jail deputies, sergeants) (all clinical staff or specific clinical staff) and specific training modules that will be required must be identified with training module number. Training compliance must then be reported by module number and the percentage of required staff who were compliant with the training.

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 cel-19l extraction related to transfer to a medical/mentalhealth 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:

Non-compliant. (V.A) There were policies regarding Disciplinary measures and Use of Force for Prisoners with Mental Illness or Intellectual Disabilities that required revision that the SSO indicated the revision process had been slowed so that SSO staff could

assist with essential duties as part of COVID-19. JPS staff reported that they “talk with” classification staff, hearing officers and others but that it is not a formal process and that the mental health staff defer to correctional staff. This is not consistent with the intent or spirit behind the Remedial Plan. Further work will be required in this area for compliance.

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 38 above. **Non-compliant.** (V.B.1-7) More work to be done in this area. A formalized process must be developed in policy and implemented following training of both security and clinical staff.

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) See findings page 38 above. No formal process implemented at this time. Policy still in development.

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

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:

Non-compliant. (V.D) While there has been some training curriculum provided regarding deescalation, it was not presented in context or explained. There was no current policy that had been updated to be compliant with the Remedial Plan and address the needs of detainees with

mental health and or intellectual disability needs. In fact, the SSO First Status Report indicated that this area was one that had been slowed down due to the need for staff to address the essential duties as a result of the global pandemic. Because of the importance of this policy and the multiple aspects for policy, training, and review contained within this policy, it is critical that this policy be focused on soon so that staff can be trained and then monitored to ensure that the training is practiced.

Recommendations. This policy review and update should be prioritized so that it is completed within the next six months with training to occur within the four months following completion.

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. However, the Remedial Plan identifies specific items to be included in each. The County has identified that these policies are in development and expect that they will be completed soon. The policies will impact all of healthcare. It is not yet clear how QA/QI will impact correctional operations and what will be monitored. It is expected that the County will comply with the Remedial Plan and track those areas listed here.

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)

Could not be assessed. Several records were selected for review from cases that were believed to have been detainees with mental health records in segregation. However, when those medical records were reviewed, there were in fact no mental health problems identified in the chart and no mental health contacts. In mid-December Defendants did provide a log of detainees in restrictive housing who had been designated SMI, but those records could not be reviewed at that late date. It should be noted that while those detainees were to be removed from segregation

“absent exceptional and exigent circumstances,” 72 (of 124 total) remained on segregation status. (VIII.C.1.d).

MENTAL HEALTH FUNCTIONS IN SEGREGATION UNITS

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 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:

This was also difficult to assess. The records that provided that were to be segregation inmates did not have medical backgrounds. There were three referrals that were located where either medical or mental health staff referred the detainee to a provider for evaluation. In one case the detainee was moved to another cell on a different unit that did not appear to be a segregation unit though the detainee did appear to continue to spend a lot of time in his cell still. The records were very confusing, contacts were far apart and it was unclear what was happening. No FOSS

level was identified for that case. It appeared that the detainee may have been moved but was not a mental health caseload.

MENTAL HEALTH FUNCTIONS IN SEGREGATION UNITS

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 that is 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. RCCC was identified as the IOP where more violent segregation

inmates would be housed. However, the records for those inmates in IOP at RCCC were extremely difficult as the detainees were frequently moved back and forth from MJ to RCCC and back to MJ and from cell to cell to cell. The notes in the medical chart rarely or never explained these moves. There were two cases when the inmates were identified as being on an alternative treatment program (ATP) but the ATP was being used to justify cutting back on out of cell treatment for the detainee without any individualized effort to increase treatment, even when the detainee was extremely ill and likely checking medications or refusing them due to late administrations.

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 that are 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:

Could not be assessed.

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. This was still under development for mental health.

Recommendations. This should be a priority for mental health with data tracking being a top tier priority and peer review later once all of the data review systems have been established.

CONCLUSION

The defendants have made some progress in certain areas related to mental health treatment since the Remedial Plan has gone into effect. Those efforts were thwarted by the global pandemic and slowed by severe resource and physical plant limitations. However, the progress that has been made has been less than would have been hoped for at this point. It was unclear how much some of that may have been due to significant leadership changes across medical, mental health and security areas of operation.

In recognition of the new leadership and lack of experience of having been monitored by those tasked with achieving compliance, prioritizing areas of concern has been discussed amongst the experts. All experts expressed initial support for such an idea. At the same time the experts were considering such an idea, the Parties were also discussing such a plan and proposed such a recommendation to the experts. This would allow defendants to focus the bulk of their resources on those priority areas while still working to maintain at least current levels of compliance in the other remedial areas.

As there seemed to be universal agreement to this idea, it is recommended that a meeting be scheduled as soon as possible with the top managers, their representatives, plaintiffs' representatives, and the experts to discuss how this process might work and to agree on the priority areas. For example, priority areas could include maximizing utilization of the electronic health record to establish the types of tracking and reports requested that would assist in managing and monitoring healthcare services and daily operations. Another priority item would be space and staffing utilization. The annex is at least 3-4 years off under the best of circumstances and an interim plan must be developed and implemented for the adequate provision of services. With this would be an assessment of need and bed planning to evaluate how many of what types of bed would be required now and in the future for building. The same would be true for how many of what discipline of staff to provide the necessary services. Use of Force would be a priority due to the degree of risk to both detainees and staff when force is used and the benefits gained when force can be avoided. There may be a total of 8-10 items when mental health, suicide, and medical combine their priorities, but the list should not be so large that it remains unwieldy. Then the parties could utilize the experts as consultants on those priority items. Defendants have voiced a willingness to participate in this process.

It is in the best interests of those who find themselves in custody in either of the Sacramento County Jails for all parties to work together to facilitate compliance as quickly as possible.

DOCUMENT REQUEST
Mental Health and Suicide Prevention
6/20/20

- 1) Table of Contents for the Sacramento County Sheriff's Office (SCSO) Policy and Procedure Manual;
- 2) All current SCSO and Correctional Health policies, 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, tracking);
- 3) All current Jail Psychiatric Services policies, procedures, and directives relevant to suicide prevention and mental health services;
- 4) All draft policies, 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, tracking);
- 5) All current and draft intake screening, health evaluation, mental health assessment, treatment planning and any other forms utilized for the identification of suicide risk and mental illness;
- 6) Training curriculum regarding pre-service and in-service staff training, as well as curricula, handouts, etc. regarding suicide prevention, mental illness, and mental health services;
- 7) Draft training curriculum regarding pre-service and in-service staff training, as well as curricula, handouts, etc. regarding suicide prevention, mental illness, and mental health services;
- 8) Training curriculum (including draft) regarding additional suicide prevention and mental health training provided to custody officers assigned to the Designated Mental Health Units;
- 9) 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;
- 10) Location of all designated areas utilized to house inmates on suicide precautions and mental health designated units (current and proposed);
- 11) Policies, procedures, directives (including draft) related to quality assurance and continuous quality improvement in the delivery of mental health services and suicide prevention;

12) Minutes from Suicide Prevention Task Force meetings, as well as any other regularly scheduled multidisciplinary meetings related to suicide prevention, mental health and quality assurance for January 2019 to the present.

13) Documentation of overall staff completion rates for suicide prevention, first aid/CPR, and mental health training presented as follows:

_____ % of all officers received suicide prevention training-2019

_____ % of all medical staff received suicide prevention training-2019

_____ % of all mental health staff received suicide prevention training-2019

_____ % of all officers currently certified in CPR

_____ % of all medical staff currently certified in CPR

_____ % of all officers received mental health training-2019

_____ % of all medical staff received mental health training-2019

_____ % of all mental health staff received mental health training-2019

14) Entire case files (jail, medical, and mental health), investigative reports, and mortality reviews of all inmate suicides from 2019 to present;

15) Total number of serious suicide attempts (incidents resulting in medical treatment and/or hospitalization) for the period of 2019 to present, as well as all documentation of such incidents by the Suicide Prevention Task Force;

16) Listing of inmates on suicide precautions from June 1, 2020 to the present;

17) Listing of current inmates receiving mental health services and level of care;

18) Mental health treatment schedules, to the extent that those exist;

19) Census by facility and designated units within each facility including restrictive housing (please just indicate the date that the census was produced on the document)

20) Current mental health staffing and any proposed additions;

21) Schedule (weekly/monthly/quarterly) of multidisciplinary team meetings attended by the multidisciplinary treatment team for inmates receiving mental health services; and

22) Defendants' First Status Report in *Mays v. County of Sacramento*.