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Via Email

October 29, 2021

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County of Sacramento

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County Executive
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Sacramento County Sheriff's Office

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Chief Administrative Officer
Psychiatry and Behavioral Sciences, UC Davis

Re: Notice of Dispute
Demand for Remedial Action: Mental Health Care, Suicide Prevention
***Mays v. County of Sacramento* (E.D. Cal., No. 2:18-cv-02081-TLN-KJN)**

Dear Mr. Heyer, Ms. Edwards, Chief Peterson, Dr. Damiano, and Mr. Elder:

As class counsel representing the people in custody in Sacramento County Jail facilities (the "Jail") in *Mays v. County of Sacramento*, we write to communicate our serious concerns regarding the County's ongoing failure to comply with critical mental health care and suicide prevention requirements of the *Mays* Consent Decree. Given the County's failures, we write pursuant to Paragraphs 32-34 of the Consent Decree to give notice of our initiation of the Dispute Resolution process.

In the first round monitoring reports (filed Jan. 20, 2021), the court-appointed experts found that the County was not in compliance with nearly all mental health care and suicide prevention provisions of the Consent Decree. To assist the County in the task of implementation, the experts identified "focus areas" – that is, issues that are urgent to class member well-being, are of "critical importance" to broader compliance efforts, and in some cases, would be "relatively easy to resolve" with sufficient attention.

The second round monitoring reports (filed Oct. 4, 2021) make clear that insufficient progress has been made on these identified focus areas.[1] Our clients face serious and unacceptable harm as a result.

[1] Mental Health Expert's Second Round Report of Findings, Mary Perrien, Ph.D., Docket 149-2 ("Mental Health Report"); Second Monitoring Report of Suicide Prevention Practices, Lindsay M. Hayes, Docket 149-3 ("Suicide Prevention Report").

We include as a recipient of this letter UC Davis, the long-time County contractor for Jail mental health services (called Jail Psychiatric Services or "JPS"). Monitoring has confirmed an "absence of [] urgency" by JPS to provide constitutionally adequate care to all people with serious mental health needs. Mental Health Report at 3-5. To date, JPS has failed to produce a coherent plan for meeting its constitutional and judicially mandated obligations to provide adequate care. This cannot continue.

While UC Davis/JPS is not currently a named defendant in the *Mays* lawsuit, they have become a substantial impediment to effective implementation of core *Mays* Consent Decree provisions. Sacramento County is responsible for compliance with the *Mays* Consent Decree and relevant constitutional and legal requirements, and it must ensure sufficient oversight of its mental health care contractor in order to meet those obligations.[2]

Affirmative steps must be taken *without delay* to implement foundational remedial provisions in the *Mays* Consent Decree. Plaintiffs' class counsel is prepared to proceed as necessary to protect the rights and well-being of *Mays* class members.

I. MENTAL HEALTH CARE

A. Focus Area #1: Address the Enormous Physical Plant Deficiencies that Impede Remedial Plan Implementation

The lack of adequate space to house and treat class members with mental health needs remains a primary obstacle to provision of constitutionally required care and Consent Decree compliance. The County must address this pervasive deficiency, both to mitigate harms now and to achieve a durable remedy in the future.

The Jail's **inpatient mental health unit** (Main Jail's "2P" unit) was never designed to provide acute mental health care and is poorly maintained, as demonstrated by the "overall lack of cleanliness and physical plant deterioration." Mental Health Report at 12-14. The 18-bed unit lacks space for group therapy or confidential individual treatment. Dr. Perrien poignantly states in her report that the unit looks and feels more like a solitary confinement unit than an inpatient treatment unit. *Id.* at 14. Adding to the problem is that there are regularly as many as 20 people on the acute care waitlist at a given time (most waiting several days for admission), an intolerable delay to access care.

[2] We are considering all available legal avenues to ensure compliance, including seeking to add UC Davis/JPS as a party in this case. *See, e.g.*, *Coleman v. Schwarzenegger* Order, Docket 1855, Case No. S-90-0520 LKK JFM (E.D. Cal. Jun. 28, 2006) (adding director of Department of Mental Health (now "DSH") as a defendant in prison class action based on Department's "critical role in creating sustainable and effective solutions for inpatient care" and its "failing to address specific court-ordered remedies," making judicial supervision necessary to "insure an effective remedy in th[e] case").

Dr. Perrien concludes unequivocally: "Achieving Consent Decree compliance will not be possible if 2P remains the inpatient service unit." *Id.* at 15.

The space available for the **Intensive Outpatient Program (IOP) unit and other mental health programs** at the Main Jail is also "quite problematic." According to Dr. Perrien, the deficiencies in space means that "actual treatment cannot be implemented," and delivery of care is "compromised by the lack of confidentiality." Mental Health Report at 16. Similar space deficiencies persist at RCCC as well. *Id.* at 18.

The space available for **mental health and suicide prevention assessments of newly booked people** is also entirely deficient, with no possibility of confidentiality for patients to disclose extremely important and sensitive health care information. Mental Health Report at 16; *see also* Suicide Prevention Report at 26 (noting that intake screening "remains dysfunctional and very problematic" and that the County "remains in Non-Compliance" due in part to space deficiencies).[3]

The space deficiencies at the Jail are well known and longstanding, and there must be a plan to remedy those deficiencies. The County has previously developed construction plans at RCCC and the Main Jail to address the deficiencies identified in the *Mays* case. In November 2019, the County abandoned a plan for facility improvements at RCCC. Plans to fund the initial design stage of a "Main Jail Annex" next to the current Main Jail facility were abandoned earlier this year. The County has represented that renovations to the current Main Jail facility would involve "very high costs" and "significant time to complete the work." 3/10/21 Agenda, *Letter to Board of Supervisors re: Workshop – Review the Design-Build Process Related to the Correctional Health and Mental Health Services Facility Project* at 2. Thus, at present, there is no clear plan or path for the County to comply with Consent Decree provisions related to the substantial physical plant deficiencies that exist.

To date, the County also has failed to implement durable jail population measures to mitigate space deficiencies in the Jail. A meaningful commitment by the County to maintain and build on the Jail population reduction that was achieved during the pandemic, for example, would create opportunities to make progress towards an adequate, cost-effective, and time-efficient remedy. As the parties jointly set forth in the Consent Decree, "population reduction of the jails will facilitate compliance with this Remedial Plan." Remedial Plan Section II.B.1. Opportunities for substantial population reduction are available. *See* The Carey Group, *Sacramento County Consultant Report on*

[3] The medical care experts have reached a similar conclusion: "We affirm that the current space at Main and Branch Jails is completely inadequate to meet the serious medical needs of the population. Lack of space has contributed to the many cell-side assessments – which compromises confidentiality and health care delivery – and likely to preventable hospitalizations and deaths." Medical Care Report at 10.

Jail Alternatives, May 29, 2020 (estimating a potential "mid-range reduction" of 20% of the incarceration rate through proposed initiatives).

We are aware that the County is currently gathering input from its consultants as to what can be done at the Main Jail to meet the terms of the Consent Decree, as well as consideration of what reduction to the present incarcerated population may be necessary to achieve compliance. We also understand that the County is gathering external input as to concrete measures to safely reduce the Jail population. This work is essential and overdue, and must be pursued expeditiously.

B. Focus Area #2: Remedy Extreme Staffing Deficiencies that Undermine Care

For years, Sacramento County Jail has been plagued with insufficient mental health staffing. As part of the Consent Decree, the County and JPS have committed to providing sufficient staff to deliver necessary mental health care and fulfill the requirements of the Remedial Plan.

While some JPS mental health care positions have been added, there remain critical and glaring gaps. These gaps include insufficient staffing (1) to provide adequate acute care to patients; (2) to provide necessary treatment to patients across the continuum of care; (3) to conduct Consent Decree-mandated treatment team meetings for patients; and (4) to complete Mental Health Evaluations for people with mental health and/or intellectual disabilities who face disciplinary measures or restrictive housing placement. Mental Health Report at 21, 42. These staffing deficiencies must be addressed.

Mental health staffing deficiencies are a barrier to implementation of key Remedial Plan provisions. As just one example, insufficient JPS staffing has prevented implementation of the Mental Health Evaluation process for the Jail disciplinary process.[4] Approximately three years ago, JPS leadership developed a protocol and form for this essential component of the Remedial Plan (Section V.A & Exhibit A-3 (JPS-Rules Violation Mental Health Review)). But JPS has not allocated staffing to implement the protocol. Meanwhile, scores of class members identified as having serious mental health needs remain in restrictive housing placements, including dozens requiring the highest levels of care. Mental Health Report at 42 (point-in-time data showing 58 class members with mental illness in Main Jail's Administrative Segregation/Disciplinary Detention unit 8W, including 33 designated at the either of the two highest levels of mental health need).

[4] The *Mays* Consent Decree requires that the County's disciplinary process "meaningful[ly] consider[] 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 wellbeing of prisoners with disabilities." Remedial Plan Section V.A.1; *see also* Section V.B.4.

The results are both predictable and unacceptable. We have observed cases in which class members with serious mental illness or intellectual disabilities have been punished – including through lengthy solitary confinement placements – for incidents such as a refusal to take a medication based on concerns about side effects, inability to keep one's cell clean, a refusal to return an extra shirt to a deputy, and a refusal to participate in a mental health contact where the deputy demanded the patient sit on the dayroom floor to receive mental health care. In short, because JPS has failed to allocate staff to fulfil this critical component of the Remedial Plan, people with mental health and intellectual disabilities are being punished for their disabilities in ways that worsen their mental health conditions.

We demand that the County complete a robust staffing analysis and ensure that there is a staffing plan sufficient to meet all Consent Decree requirements. Attention must be paid to space deficiencies that stand to impede the delivery of care even with sufficient staffing. As discussed below, there must also be sufficient custody staffing to facilitate the provision of mental health care.

C. Focus Area #3: Provide Adequate and Timely Treatment to Class Members with Mental Health Needs

1. The Long-Operating, Deficient Acute Care Program Must Be Fixed.

Until there is a durable solution to the issue of inpatient mental health capacity, space, and programming, the County will never reach compliance with the *Mays* Consent Decree. The current 18-bed "inpatient unit" (2P) is poorly maintained, physically deteriorating, and lacks space for necessary group therapy and confidential individual treatment. The unit looks and runs more like solitary confinement unit than a treatment setting. The program is entirely unequipped to provide adequate inpatient care for complex patients. For these reasons, Dr. Perrien's report concludes that "[a]chieving Consent Decree compliance will not be possible if 2P remains the inpatient service unit." Mental Health Report at 15. The County has indicated that these issues have been "looked at over the years," with no action taken. Mental Health Report at 10.

The unit not only fails to operate as a legitimate inpatient psychiatric unit, but also is far too small to meet the needs of the Jail population. There are regularly as many as 20 people on the acute care waitlist at a given time, causing an intolerable delay to access care. This shortfall is well known to the County. In 2016, the County's jail mental health consultant noted that the County needs approximately 40 certified inpatient beds to serve the Jail population. *See* Evaluation of Mental Health Services: Sacramento County Jails at 59, *Mays* Docket 1-3. Five years later, there has been no plan or action to expand the capacity of the acute care unit.

Importantly, Dr. Perrien finds that there is no alternative space at the Jail that "offer[s] a positive therapeutic milieu with appropriate confidential treatment space" to serve as a Consent Decree-compliant acute care unit. Consequently, **the current acute**

unit (2P) must be shut down and replaced with alternative methods to deliver inpatient care, including in community facilities. As noted by Dr. Perrien, the "County must seriously review what access to inpatient care may be available in the community and attempt to contract inpatient services with appropriate housing that are not inside of the jails." Mental Health Report at 19. Options can include utilizing UC Davis psychiatric facility beds through an amended contract, identifying another private facility to provide contracted mental health beds, or utilizing Sacramento County mental health beds.

We are aware that the Sacramento County Mental Health Treatment Center (SCMHTC) provides 50 inpatient beds to people requiring inpatient mental health care. The capacity was twice as large until the County's dramatic budget cuts in 2008-09. The County should seriously consider whether utilization of some bed capacity at SCMHTC (or another existing facility) could serve *Mays* class members, particularly those with a lower security profile. Such a strategy would be far more cost- and time-effective than engaging in new jail construction to meet the inpatient bed demand.[5]

It is intolerable and unconstitutional to deny people in psychiatric crisis timely access to acute levels of mental health treatment. The County must take immediate action to mitigate the harms of its longstanding inadequate acute care program at the Jail, and at the same time actively pursue a path to full and durable Consent Decree compliance.

2. The Intensive Outpatient Program (IOP) Created as Part of the Mays Settlement Must Deliver on Its Promise of Serving All Who Require IOP Level of Mental Health Care.

The creation of the Intensive Outpatient Program (IOP) was a foundational component of the Consent Decree in this case. IOP units are meant to provide an appropriate step-down unit for patients discharging from an acute level of care and to provide increased treatment to patients at risk of decompensation. Patients must receive at least ten hours of structured treatment per week, with clinical case management and robust treatment planning.

The County is not providing class members timely access to IOP level of care when clinically indicated. Dr. Perrien noted a waitlist of 19 people waiting for IOP admission. Six had been waiting for more than one month and one person had been waiting for 80 days. Mental Health Report Appx. C. (Staggeringly, another 107 people were on the waitlist for Jail-Based Competency Treatment and another 84 people were on the waitlist for transfer to a Department of State Hospitals program.)

Moreover, class members with serious mental illness are still routinely denied referral to IOP, because the existing IOP units are not designed to provide care to people

[5] Several Northern California counties provide inpatient care to jail detainees in psychiatric settings outside of the jail – for example, Alameda, Marin, San Francisco, Sutter, and Yuba.

with high security factors. This must be addressed. *See* Remedial Plan Section 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.").

Waitlists for treatment undermine the system of care. Delays to access care lead to the intolerable situation of people decompensating unnecessarily and, in particular, having restrictive housing units filled with people with serious and immediate mental health needs, a clear violation of the Consent Decree prohibition on the use of restrictive housing for this group. *See* Remedial Plan Sections IV.F.4 & 5, VIII.D.1.

IOP capacity must match the need for such care, and timely access to the IOP program is essential in order for the County to achieve compliance with the Consent Decree's prohibition on the placement of people with mental health needs in restrictive housing units.

3. The County Must Address Custody Staff Shortages Affecting Mental Health Care and Custody Interference with Treatment.

The County also must take immediate action to remedy custody-related obstacles to mental health care. The Consent Decree explicitly requires that custody staff fulfill their role to facilitate timely access to adequate care for people requiring mental health treatment. Remedial Plan Section IV.F.6.

The experts have found that custody failures undermine delivery of mental health care, identifying several examples where patients were denied confidential clinical contacts due to custody staff "unavailability" or other custody-related issues. Suicide Prevention Report at 32-33, Mental Health Report at 24.

One glimmer of progress this year – the addition of group therapy on the acute mental health unit – has been undercut by custody staffing failures. We have reviewed records showing that group treatment sessions in the acute unit have been cancelled "due to custody shortage and unavailability."

Active custody interference with treatment is also a problem that must be addressed immediately.

We have received reports from people with serious mental health needs in the restrictive housing units (again, a placement that violates the Consent Decree) regarding custody staff failing to respond to emergency requests for help when they are experiencing mental health distress. And as discussed in Part II, below, custody staff also fail to implement clinical orders regarding property and privileges to people on suicide precautions. They have also disrupted treatment by, for example, forcing a patient to sit on the floor for a clinical contact and responding punitively when the patient declined to participate.

4. JPS's Flawed Mental Health Levels of Care System Must Be Replaced.

It is well established that JPS's system for identifying patients' mental health care needs has failed and must be replaced.

JPS's "FOSS levels" have proven problematic and ineffective for Remedial Plan implementation efforts. According to Dr. Perrien, they "do not map well onto the acuity of a patient nor onto existing treatment programs. They also do not address treatment planning" or the "levels of mental health care which have specific timelines and expectations associated with them" in the Consent Decree. Mental Health Report at 38-39.

FOSS levels are not a professionally validated or recommended system, and appear to be unique to JPS's program at Sacramento County Jail. For the County and JPS to reach compliance, they will need to re-examine, and then substantially refine or replace, the FOSS levels system to ensure effective implementation of Consent Decree requirements. This too is overdue and readily achievable.

D. Focus Area #4: Reform Use of Force Policies and Practices Impacting Class Members with Disabilities to Comply with Consent Decree Requirements.

We are aware of multiple class members with serious mental health needs who have recently been subjected to uses of considerable force and full-body restraints, without adequate involvement of mental health staff before, during, or after the incident.

For example, class counsel recently highlighted a troubling use of force against a class member with serious mental illness and a history of severe self-harm and suicide attempts in custody. The incident began when the class member requested mental health care for escalating anxiety and depression. Custody staff informed him that his only option to receive mental health care was to do so while seated on the floor of the dayroom in his housing unit, in plain sight and earshot of the entire housing unit and multiple deputies. When he protested, deputies unnecessarily antagonized and threatened him. They then tore through the belongings in his cell under the auspices of a cell search while he stood cuffed against a wall watching. Once the class member returned to his cell, he refused to submit to removing his cuffs. Rather than involve mental health in de-escalation efforts or give the class member (who was alone in his cell) an opportunity to cool down, the deputies entered the cell, forcibly removed him, and placed him in a restraint device. The incident was harmful and avoidable, and it demonstrated a profound disregard of the man's mental health needs.

The County has not implemented Consent Decree requirements designed to avoid or mitigate uses of force against people with mental health or intellectual disabilities. Jail staff must utilize de-escalation methods, implement specific use-of-force protocols that account for disability needs, and use a "cooling down period." Mental health staff must

provide structured interventions to pursue de-escalation and resolutions without use of force whenever possible. Remedial Plans Sections V.D.2-7.

Adult Correctional Health (ACH) has recently provided draft Use of Force and Use of Restraint policies. We and the court-appointed experts have reviewed those drafts and are currently meeting with relevant custody and health care leadership to address concerns and chart a path forward. Resolution of this focus area will require not only substantial changes to policy but also robust staff training, culture change, and mechanisms for accountability.

Effective implementation will require the commitment of staff and leadership from the Sheriff's Department as well as from JPS and ACH.

II. SUICIDE PREVENTION

A. Focus Area #1: Develop Compliant Suicide Prevention Policies

The first focus area identified by suicide prevention expert Lindsay Hayes was revision of the Jail's suicide prevention policies. The parties have finalized the ACH suicide prevention policies; timely and effective implementation is now essential.

The monitoring experts have found repeated instances of staff – in many cases, JPS staff – not being aware of or following existing policy. Dr. Perrien noted earlier this year that a "troublesome aspect" of her monitoring was that staff was not adhering to existing policies: "Policies can be re-written, but supervisors must ensure that staff adhere to those policies." First Report of Compliance in Mental Health Services Based on Consent Decree at 7, Docket 136-2. This is a critical opportunity for JPS and Sheriff's Department staff to demonstrate their commitment to bringing their practices into compliance with the Remedial Plan and the Constitution.

B. Focus Area #2: End Overuse and Unnecessary Use of Safety Smocks

The second suicide prevention focus area addresses necessary changes to the use of "safety smocks," sometimes called "safety suits." *See* Remedial Plan Sections VII.B.5, M.2, & N.1-7.

At present, class members identified as at current risk of suicide are stripped of all clothing, including underwear, and given only a safety smock made of heavy, tear-free material fastened with straps or Velcro. The garment is open at the bottom and on the sides. While the suicide smock is a suicide prevention tool (its structure and thickness prevent it from being used as a makeshift noose), the *Mays* Consent Decree and modern practice demand that it *not* be used beyond what is clinically necessary. The safety smock leaves a person physically exposed without modesty, is uncomfortable, and provides little warmth. The unnecessary use of safety smocks is cruel, humiliating, and counterproductive; people who are suicidal will deny or refuse to report suicidal thoughts for fear of being put in a safety smock, which at the Jail can last for days at a time.

Despite the relatively discrete and critically important nature of this issue, the experts found that there has been no progress towards compliance in 2021, with continued unnecessary and deeply harmful use of the safety smock, in violation of the *Mays* Consent Decree. These failures must be addressed without any further delay.[6]

Mr. Hayes provides specific examples of safety smock misuse in the SITHU/safety cells and attributes the failure in significant part to **custody staff**. In one case (identified as Case No. 5), Mr. Hayes observed a patient on suicide precautions who had been in a safety smock for four days. Even after the clinician specifically notified custody that clothing should be restored, custody staff failed to do so. Suicide Prevention Report at 63.

Dr. Perrien found deficiencies with respect to safety smocks in the acute unit, attributing the failure in significant part to **JPS mental health staff**. She documented that people "continued to be regularly restricted to a suicide resistant smock . . . by psychiatry beyond what appeared to be clinically indicated. Progress notes did not consistently renew those orders nor were there clinical justifications for those restrictions." Mental Health Report at 45.

This issue can and must be resolved very quickly, but it will require attention, training, and quality assurance from custody, ACH, and JPS. Compliance requires, among other things, that (1) decisions about the use of a safety smock or removal of normal clothing be made by mental health staff based on individualized clinical judgment, (2) mental health staff determine a patient's need for a safety smock at the initial suicide precautions evaluation and *at least* daily thereafter, and (3) provision of regular clothing occur "as soon as clinically appropriate. Remedial Plan Section VII.N. JPS mental health staff must fulfill their duties, and custody staff cannot ignore or undermine appropriate clinical orders.

C. Focus Area #3: Address Inadequate Privacy/Confidentiality

The third suicide prevention focus area addresses the requirement for reasonable privacy and confidentiality during the intake and suicide risk assessment processes. Remedial Plan Sections C.2, D.1, K.3. The County has failed to make progress on this critical issue. As noted above, full compliance with these provisions will require substantial modifications to the Jails' physical plant. But the County has failed to implement "immediate, interim measures" to improve privacy and confidentiality. Suicide Prevention Report at 7.

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[6] Misuse of the safety smock was a core deficiency that the *Mays* lawsuit sought to remedy. *See Mays* Complaint at 106 ("Defendant uses safety suits indiscriminately and for excessively long periods of time, in some cases several months. In addition, Defendant forces some people to wear safety suits – with no other clothing, including underwear – even after they are no longer suicidal, a degrading and punitive practice.").

To the contrary, health care staff still routinely conduct non-confidential, cell-front suicide risk and related assessments. This places class members in a terrible position of having to disclose private information in front of deputies and other incarcerated people in order to seek the help they need. The County has failed to take even basic interim steps, such as fixing the inoperable telephone inside the designated JPS Interview Room in the Main Jail's booking area and developing additional privacy booths for intake nursing staff. Suicide Prevention Report at 33. These failures are inexcusable and demonstrate a lack of urgency about important issues affecting the health and well-being of class members.

D. Focus Area #4: End Reliance on CCTV Observation for Class Members on Suicide Precautions

JPS has failed to remedy longstanding defects in its practices for monitoring people on suicide precautions. In two consecutive reports, Mr. Hayes has called on the County to stop relying on CCTV surveillance in place of in-person observation. This is because too often, video feeds are not adequately watched, leading to suicides and serious suicide attempts being caught on video without timely intervention.

Although the Consent Decree requires an end to the practice and although Mr. Hayes noted that JPS "can quickly come into substantial compliance through policy revision," the problem persists. Of particular concern, JPS leadership appears to be unaware of the persistence of these bad practices; they report that the problem has been resolved despite documented examples to the contrary. *See, e.g.*, Suicide Prevention Report at 54.

The County is on clear notice that its suicide observation practices are deficient and dangerous. The failure to remedy this issue immediately violates the Consent Decree, puts class members at risk of great harm and even death, and exposes the County to significant liability in the event of an in-custody death that could have been prevented through this straightforward change to practice. The inclusion of CCTV monitoring in JPS/ACH clinical orders should cease immediately.

E. Focus Area #5: End the Improper Denial of Privileges and Property During Suicide Precautions

The fifth focus area addresses the inappropriate denial of property and privileges to people on suicide precautions. Remedial Plan Sections VII.M.1-3. The County's failure to demonstrate meaningful progress towards compliance results in severe and indefensible harms to class members every day.

The Consent Decree requires that mental health staff have the primary responsibility to determine, based on individualized clinical judgment, the removal and return of (1) routine privileges (*e.g.*, visits, telephone calls, recreation) and (2) clothing and possessions (e.g., books, slippers/sandals, eyeglasses) (M.1 & M.2). Any denial of

these privileges or property must be "documented with clinical justification" and "reviewed on a regular basis." The Remedial Plan states that "[c]ancellation of privileges should be avoided whenever possible and utilized only as a last resort" (M.3). In other words, people who are requiring mental health care should not suffer the deprivation of basic items and privileges unless strictly necessary from a clinical perspective.

Here too, the County has failed over the course of two monitoring periods to make changes that would "quickly [facilitate] substantial compliance" with the Consent Decree. Suicide Prevention Report at 7. Instead, the Jail's practices have been defined by inconsistency and dysfunction across the custodial and health care disciplines.

Mr. Hayes found that people on suicide precautions continue to be categorically denied routine **privileges**, including visits, showers, phone calls, and out-of-cell time, as well as access to the courts. Suicide Prevention Report at 58, 64. He found that all people on suicide precautions in safety or SITHU cells "were always locked down." *Id.* at 47, 59.

Staff also continue to indiscriminately deny personal **property** to people on suicide precautions, in clear violation of the Consent Decree. In one recent example, a deputy rejected out of hand a clinician's attempt to provide a book and word search game to a person on suicide precautions. Suicide Prevention Report at 61 (when JPS clinician removes patient from suicide precautions and attempts "to provide him with a book and word search game, a deputy interceded and said 'No.'"). As discussed in Part II.B, above, the blanket denial of clothing to people on suicide precautions also persists.

Mr. Hayes' report describes the resulting significant and altogether unnecessary harm to specific class members. To recount just one example, Mr. Hayes observes one man (Case No. 2) to be "very depressed, teary-eyed, and frustrated that he had been clothed in a safety smock for five days and prohibited from having a shower and shave. He was concerned about his appearance for an upcoming court hearing. The inmate complained that 'they don't let me out for anything.'" After discussion with Mr. Hayes and a JPS supervisor, the clinician found that the man was clinically ready to get his clothes back and a shower. The next day, Mr. Hayes again observed the patient, who had a "brighter affect[] than the day before" and "was grateful that he had his clothes and, although he had not yet received a shower or shave, was looking forward to his scheduled court hearing the following day." Staff reported that this was the first time in *at least three years* that a class member on suicide precautions in the SITHU was allowed clothing. Suicide Prevention Report at 59-60.

The failures lie with both custody staff and JPS mental health staff. Mr. Hayes stated that the "blanket denial of such routine privileges by deputies, as well as the lack of documentation by JPS clinicians in recommending both clothing and privileges when appropriate, continues to be very problematic." Suicide Prevention Report at 61-62.

JPS mental health staff and leadership have failed to take steps towards implementation, in terms of both training and practice. Mr. Hayes found that JPS

clinicians were unfamiliar with Consent Decree requirements on the privileges and property issue, and wrongly stated to him that "clothing issue and privileges were the sole discretion of the deputies, not JPS." Hayes Report at 59. Dr. Perrien noted that, in the acute mental health unit, "the primary issue appeared to be that the psychiatrist continued to refuse those items to the [] patients who requested their clothes back or reading materials but the psychiatrist would not allow it nor provide a clinical rationale for that decision." Mental Health Report at 45.

Custody staff and leadership have similarly failed to conform their practices to their legal and constitutional obligations. The aforementioned example of a deputy categorically and reflexively refusing to allow a class member to receive a book and word search game from a clinician is troubling. Another deputy, misinformed on Consent Decree requirements and appropriate suicide prevention practice, "freely admitted that they did not believe suicidal inmates should be permitted to attend court hearings or receive telephone privileges because such activities might result in bad news" that could cause the person to attempt suicide. (Mr. Hayes clarified that the staff had it backwards, noting that the "most ideal time to receive any potentially bad news would be while the inmate was still being observed on suicide precautions.") *Id.* at 47. These findings suggest a troubling lack of accountability and knowledge about the Consent Decree.

The County – including JPS – must develop and implement a corrective action plan to achieve compliance now, through issuance of policies and departmental memoranda, provision of targeted training across both custody staff and JPS mental health staff, and effective supervision/quality assurance procedures. Progress toward compliance must happen without delay, including as follows:

1. Class members on suicide precautions, regardless of location, must be provided routine privileges and property consistent with *individualized* clinical judgment, with custody consultation as warranted. Such privileges must include (a) social and legal visits, (b) telephone calls, and (c) out-of-cell activities (dayroom, outdoor recreation, *etc*.).
2. Property must be provided as soon as clinically appropriate, consistent with individualized security considerations, including books, games/activities, writing implements (pen/pencil and paper), tablets, clothing, slippers/sandals, eyeglasses, toothbrush, deodorant, *etc.*
3. All people on suicide precautions should be allowed to attend their court hearing unless the clinician, based upon clinical judgment and in consultation with security staff, determines that transportation to court would adversely impact the individual.
4. Health care and custody policies must be revised consistent with the above, making explicit that these requirements apply to people on suicide precautions regardless of placement (safety cells, SITHU, *etc*.).

5. JPS mental health staff must be trained and held accountable as to their role.

F. Additional Area for Immediate Remedial Action: Provide Access to Meals, Fluids, Hygiene, Shower, Prescribed Medications, and Toileting to People on Suicide Precautions

An additional area of deficiency in both policy and practice relates to the provision of the most basic of human needs to people on suicide precautions. Recent monitoring reveals shocking denials of water, hygiene, showers, and toileting, all in clear violation of the Consent Decree. *See* Remedial Plan Section H.4.

One class member recently reported that he spent approximately two days on suicide precautions in a Main Jail holding cell that had no toilet or running water.[7] Over the course of those two days, he asked both custody and mental health staff for access to a toilet so that he could defecate. His request was denied each time, with one staff member telling him to defecate on the floor in the corner of the cell. He was ultimately forced to defecate on a paper plate, leading to his getting feces on his feet. He asked repeatedly for water and supplies to clean himself, and was denied. He was forced to eat his lunch that day in this state.

Mr. Hayes's report confirms that these cruel and unacceptable practices persist: "In practice, inmates housed in safety cells continue to not be offered showers, were required to request hydration, and could only defecate into a floor grate." Suicide Prevention Report at 46; *see also id.* at 58 ("Most inmates on suicide precautions either did not receive a shower or rarely, if ever, received a shower."); *id.* at 59 (people held in SITHU were "prohibited from taking a shower" even during multi-day placements).

Progress toward compliance must happen without delay, including as follows:

1. People on suicide precautions must be offered showers at least daily, and upon reasonable request. Prompt assistance with hygiene and cleaning must be provided whenever circumstances warrant.
2. People on suicide precautions must be *affirmatively offered* water at least every two hours, and upon request.
3. People on suicide precautions must be affirmatively offered food at least consistent with normal daily meal provisions, and upon request (*e.g.*, if they missed a meal due to their mental health or suicide observation status).
4. People held in cell that does not have a toilet must be provided access to a toilet promptly upon request. No one should ever be directed or forced to defecate on the floor or through a grate on the floor.
5. Health care and custody policies must be revised consistent with the above,

[7] We note that the Consent Decree explicitly limits placement in such a cell to six hours. Remedial Plan Section H.1.

making explicit that these requirements apply to people on suicide precautions regardless of placement (safety cells, SITHU cells, *etc*.).[8]

6. JPS staff must be trained and held accountable as to their role.

The persistence of degrading, unnecessary, and harmful deprivations for people in acute mental health distress is intolerable and must be addressed with urgency.

III. CONCLUSION

We are deeply disappointed by the lack of progress on key provisions of the Consent Decree relating to mental health care and suicide prevention. The current system for providing mental health care in Sacramento County's jails is inadequate. Class members with serious mental health needs are being harmed every day as a result.

Inadequate mental health care in the Jail has been a core element of the parties' negotiations going back five years. The failure of JPS to present a clear plan for achieving compliance with the Consent Decree, including through program expansion and staff augmentation as necessary, is unacceptable.

Consistent with the Consent Decree's Dispute Resolution process, we request a meeting within the next two weeks, with appropriate County leadership and relevant staff, to discuss these important matters.[9] Absent a plan for prompt remedial action on these issues, we will proceed to protect the rights and well-being of *Mays* class members through appropriate enforcement action in court. We look forward to seeing these issues addressed.

Sincerely,

Aaron Fischer

Margot Mendelson

Cc: Hon. Nathanael Cousins
Mary Perrien, Ph.D., *Mays* Court Expert, Mental Health Care
Lindsay Hayes, *Mays* Court Expert, Suicide Prevention
Karen Saylor, M.D, FACP., *Mays* Court Expert, Medical Care
Madeline L. LaMarre, MN, FNP-BC, *Mays* Court Expert, Medical Care

[8] ACH draft Policy 04-08 (Outpatient Program – Suicide Precautions, Observation Levels & Item Restriction) (Draft date: 10/1/21) restates the remedial plan provisions but provides no guidance as to their implementation. The SSO's draft Suicide Prevention and Intervention policy (Draft date: Sept. 2021) makes no reference to this topic at all.

[9] We are providing a copy of this letter to Judge Cousins, who is designated to assist in dispute resolution processes.