VIA EMAIL

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Dear Sarah, Andrea, and Tianna,

Thank you for facilitating my site visits to the Sacramento County Jails on September 4 and 5, 2024 and October 8-10, 2024. As I shared on site and during my tours, I am aware that the leadership of Adult Correctional Mental Health (ACMH) is taking steps to try to improve mental health care in the jails. I appreciate the receptiveness to my comments and feedback and value our collaborative working relationship. I don't think anything in my letter will surprise any of you though it does get more specific in terms of concerns about individual and systemic matters. I appreciate that Andrea has been brainstorming methods to correct my areas of concern within ACMH control as the Sheriff's Department and Adult Correctional Health (ACH) work on their responsibilities as well. I am submitting this letter to you now for two reasons: 1) For people incarcerated in the Sacramento County jail system, not receiving timely access to adequate mental health care is a very serious matter; for some, it may be a matter of life and death; and 2) I wanted you to have this information now so that you can act on it quickly rather than waiting for the report.

This letter sets forth the findings from my September 4 and 5, 2024 visit to the Main Jail to assess unmet mental health needs in the jail system. The letter describes my interviews with patients and outlines essential next steps to ensure the provision of adequate mental health care and avoid preventable harm and suffering in the jails.

I. Introduction

On September 4 and 5, 2024, I conducted a site visit at the Sacramento County Main Jail. Consistent with evaluations I have previously conducted for correctional systems, I met with 14 patients in confidential settings to evaluate their current mental health needs, the appropriateness of their assigned level of mental health care, and the adequacy of their treatment plans. I selected the vast majority of these patients randomly from rosters provided by ACMH and the Sacramento Sheriff's Office (SSO).[1] I was accompanied by class counsel for these interviews. Below I set forth my findings, based on my interviews and subsequent medical record reviews.

[1] ACMH and custody staff identified some patients who they believed would be helpful in our assessment. In particular, ACMH was asked to provide names of patients that they thought would demonstrate the increasing acuity of their population and the struggle to provide adequate care in the current environment. ACMH provided a list with several of these patients' names, and I randomly selected a several patients from this list to interview (i.e., people were selected "targeted randomly" from this list). The other patients who I selected, which represent most of the patients I interviewed, were randomly selected from a list of the 1,000+ people at the jail who are on the mental health caseload.

The primary finding from my assessment is that the mental health program in the Sacramento County Jail system is in grossly under-resourced and currently incapable of meeting the needs of the patient population. In my clinical judgment, every patient whom I interviewed was placed at an inadequate level of mental health care and was receiving inadequate mental health treatment in the jails. In many cases, the patients were experiencing immediate and serious harm due to the deprivation of mental health care in the jails. Several of the patients whom I interviewed are at moderate to high chronic risk of suicide or self-harm and have suffered or are likely to suffer permanent damage because of preventable mental health decompensation in the jails.

In several cases, patients disclosed serious mental health symptoms to me that are not documented or referenced anywhere in their medical records. This suggests a failure to establish sufficient clinical rapport that may result from excessively infrequent clinical contacts, the persistence of non-confidential clinical encounters, the clinical workload and related brevity of individual contacts, and inconsistent clinical staffing. The ongoing placement of patients in custodial settings that exacerbate their mental health needs may also impede the establishment of a therapeutic rapport necessary to identify patients' mental health needs and assign them to accurate levels of care. Continued challenges to access mental health care through custody staffing challenges exacerbate the preventable suffering of the patients and make it more difficult for mental health treatment providers to properly assess the patient's mental health status and need for higher level of care.

ACMH's pervasive failure to assign patients to appropriate levels of care may also reflect the absence of adequate resources to treat the patient population. At the time of each visit, there were persistent waitlists at every level of care. At nearly every level of care, the number of people on the waitlist exceeded the number of people being treated. For example, at the September site visit, 25 patients were awaiting placement in the 17-bed Acute Psychiatric Unit (APU). Thirty-seven people were awaiting placement in the Intensive Outpatient Program (IOP), several of whom had been waiting over six months for placement. Two-hundred and seventy-eight people were awaiting placement in the Enhanced Outpatient Program (EOP), which has a capacity of 240.[2] Some patients had been waiting for placement in the EOP since 2022. Based on these numbers, even doubling the capacity of these mental health care programs would be insufficient to meet current, identified demand. And since that time, the number of people on the waitlists has only grown.

In systems where demand for mental health services outstrips capacity so substantially, it is common for providers to stop making clinically indicated referrals. With 278 people on a waitlist for 240 spots in the EOP, for example, a provider may see little value in placing more patients on that waitlist, even if the patient desperately requires that level of care. The provider may prioritize some placements over others based on scarcity of bed space instead of clinical judgment. For example, referring a patient to an incorrect level of care because of the belief that

[2] This information is based on data generated on September 3, 2024, which I received at the Jail during my visit on September 4, 2024.

they won't have to wait as long to receive at least "some care." This may explain, in part, the fact that ACMH had failed to identify the appropriate level of care for each patient I interviewed.

My findings indicate that ACMH cannot, at this stage, accurately assess the degree of mental health needs in the jail system or estimate the resources necessary to provide adequate mental health care to the population. Current waitlists dramatically underestimate the level of the need in the jails by not capturing "true need[3]" and not providing validated data regarding need As detailed below, I met people at serious risk of suicide or self-harm who were not even in the EOP program or identified for the EOP waitlist. There is reason to believe that the program census and waitlists represent a significant underestimate of mental health needs in the jail population.

As a result of these findings, I recommend that ACMH conduct a comprehensive mental health needs assessment of the jail population. Such an assessment would include evaluation of the unique community resources and barriers that impact the overall need of patients with SMI at the Sacramento County jails. Once the level of need is accurately assessed, ACMH should conduct a full staffing analysis to assess the staffing needed to provide adequate mental health services to the jail population. ACMH should use that staffing analysis to generate a comprehensive staffing plan, including as to recruitment and retention needs. The challenges of the physical plant should be reviewed with the benefit of findings from a patient-based needs assessment and staffing analysis. It is noted that ACMH has been pursuing vendors for a proper staffing analysis.

II. Background

ACMH offers four primary levels of mental health care to people at the jail: (1) Outpatient Services (OPP), (2) Enhanced Outpatient Program, (EOP), (3) Intensive Outpatient Program (IOP), and (4) Acute care, which is offered in the Acute Psychiatric Unit (APU).[4] These levels of care are intended to treat people with a broad range of mental health needs, ranging from people who have relatively mild and well-managed symptoms to people who have serious mental illness and cannot manage their activities of daily living. A general description of each level of care is below:

Level of Care	Description of Program
Outpatient Program (OPP)	• Lowest level of mental health care at the Jail. • Designed to provide triage and crisis intervention services to the general population.

[3] "True need" is defined as the actual mental health treatment needs that exist in the Sacramento County jail population whether the need has been formally identified; the actual amount of needed mental health services at any given time in the jail system.

[4] The jail also provides programs that are only available after a court has determined that patients meet specific criteria (Jail-Based Competency Treatment, JBCT and Early Access and Stabilization Services, EASS).

Enhanced Outpatient Program (EOP)	• Intermediate level of care with three sub-levels. • Designed for people with a range of mental health needs, including those who have a mental health disorder but have generally well-managed symptoms (General), people who have an SMI but need moderate support with activities of daily living (ADLs) (Moderate), and people who have an SMI and have significant impairment in their ability to manage ADLs (Intensive).
Intensive Outpatient Program (IOP)	• Second-highest level of mental health care at the Jail. • A step up from GP and a step down from APU. • Designed as treatment for patients with Serious Mental Illness (SMI).
Acute Psychiatric Unit (APU)	• Highest level of mental health care at the Jail. • People are admitted to the APU when they are a danger to self, a danger to others, or "gravely disabled." • The APU has 24/7 staffing with daily psychiatrist rounds.

As indicated above, many patients have been placed on a waitlist for a higher level of mental health care. In those instances, an ACMH clinician has determined that the patient needs a higher level of care, but the patient cannot be treated at that level of care because of insufficient capacity. Currently, the waitlists are very long. For example, almost three times as many people are on the EOP waitlist than are being treated at the EOP level of care. Nearly two times as many people are awaiting acute care than are being treated at that level of care.

	Total People at this Level of Care[5]	**Waitlist for this Level of Care**
Enhanced Outpatient Program (EOP)	193	555
Intensive Outpatient Program (IOP)[6]	79	49
Acute Psychiatric Unit (APU)	17	33

Total Patients at EOP, IOP, and APU Levels of Care	**289**
Total Patients on EOP, IOP, APU Waitlists	**637**

[5] This data is from October 7, 2024.

[6] Of the 79 people at the IOP level of care, 38 are housed at RCCC in the high-security IOP unit. All of the people at the EOP and Acute levels of care are housed at Main Jail.

III. Summaries of Patient Interviews

Patient 1

Patient 1, a 48-year-old Latino male, had been at the jail since July 2023 and was housed on 8 West at the time of our interview. He was at the OPP level of care, and he was not on the waitlist for EOP, IOP, or the APU. On June 23, 2024, the patient was found to be a danger to self, placed on suicide watch, and on the APU waitlist. Several weeks earlier (6/14/24), he had been found to be a danger to others. He had been repeatedly assessed to be a danger to self and/or a danger to others since November 2023. The patient reported that he was in jail because he had killed his cellmate while housed in the California prison system. No diagnosis was listed in his problem list, but he was prescribed multiple psychotropic medications. Review of progress notes indicated that he had been diagnosed with Schizophrenia Spectrum or other Psychotic Disorders. On the day of his arrival, July 20, 2023, ACMH determined that he was a danger to others and instructed custody to house the patient on single cell status in administrative segregation. The patient was also on solo dayroom at the jail. For such a recommendation to be acceptable, this patient should have had a MDTT that agreed with placement and outlined how his access to treatment would not diminish simply because of housing.

Patient 1 had very serious mental health needs evidenced by prior inpatient treatment in CDCR and community services. He has a history of suicide attempts, and reported continued experiences of extreme paranoia and intense auditory hallucinations. During our interview, he reported that the "voices are too much to bear," and the voices tell him to hurt himself and other people. It should be noted that he reportedly killed his cellie because of the voices (i.e., command auditory hallucinations).

The patient recently was brought to suicide watch then was returned to 8 West, an inappropriate housing choice for someone so ill. The high-security IOP would have been an acceptable interim placement. The patient reported that he programmed alone for one hour a day. He had no group treatment, which was confirmed by the medical record. The patient had repeatedly reported to custody and mental health that he had command auditory hallucinations telling him to harm someone. He repeatedly stated that the medication was not helpful and could not identify any coping skills. Per progress notes in the medical record, the patient had reportedly been placed into segregation due to threats toward staff and peers, though mental health notes frequently indicated that he denied a specific identified person.

The patient was on multiple antipsychotic medications, including Clozaril and both an antidepressant and mood stabilizing medication. When the patient reported inconsistent bowel movements to his social worker, a psychiatric nurse practitioner changed his clinic appointment to urgent (on 9/6/24) due to the elevated risk of death due to constipation on Clozaril. However, the patient was not seen timely and only a chart review was completed by a different nurse practitioner on September 9, when a laxative was added; he was already prescribed a stool

softener at the time. It was not clear why a face-to-face confidential clinical contact did not occur, especially when addressing medications, their side effects, and patient concerns related to those prescriptions.

The patient was seen regularly by the social worker to monitor for side effects and complications from Clozaril. Those contacts were clearly brief check-ins without any type of therapy. The patient was seen both confidentially and at cell front, though he was most often seen non-confidentially due to his refusal. In light of the patient's frequent refusals, an incentive or behavior plan was necessary to improve treatment participation, but mental health staff did not implement such a plan.

Following chart review and clinical interview, my assessment of Patient 1 is that he currently has major unmet mental health needs despite extensive medication management efforts and is at the incorrect level of care. Patient 1 should remain at the inpatient level of care for an extended period so that he would be provided with intensive treatment in a closely monitored environment by nursing staff at minimum. The patient could then be stepped down to an intensely structured therapeutic environment without 24-hour nursing. This patient should be at the inpatient level of care, not at the OPP level of care.[7]

Patient 2

Patient 2, a 42-year-old female, had been at the jail for around two months (7/13/24) at the time of our interview and was housed on 7 West when we spoke. She was at the OPP level of care, and she was on the EOP waitlist. The patient had been diagnosed with Schizoaffective Disorder, bipolar type, an Opioid Use Disorder, "alcoholism," polysubstance abuse, methamphetamine abuse, and a seizure disorder. She reported that her seizure disorder was not well managed, and that custody staff minimized or ignored her concerns, even after reporting to them that she had experienced a seizure. Her list of medical concerns included a low blood pressure reading (8/8/24), which could also cause her to become light-headed and faint, vitamin deficiencies, self-harming behavior, and was underweight. She had been prescribed hydroxyzine, but the prescription was discontinued at her request. She was receiving medication-assisted treatment for her opioid abuse disorder. At the time of our interview, she reported taking Abilify, Buspar, and trazadone. Two of those are antidepressants; but trazadone in combination with

[7] As used in this report, inpatient care includes two levels of care. There is crisis or acute inpatient care to stabilize the patient so that they can be released safely to a lower level of care. However, there is a second category of inpatient treatment that involves increased lengths of stay, does not require that the patient be an imminent danger to self or others or that they be gravely disabled. As community mental health funding has decreased nationally, inpatient care has become more of a crisis placement. This can be seen through readmission rates and length of stay data for any agency. IOP is not a substitute for this intense, longer length care.

another antidepressant can increase the risk of a manic or hypomanic episode. Given the patient's presentation during the interview and diagnosis, her prescriptions are of concern.

Prior to our interview, the patient had recently been accepted into the IOP from OPP level of care (on August 25, 2024). But she erratically attended IOP treatment groups, and on August 27, 2024, the patient was seen confidentially by her social worker (SW) because she wanted to be discharged from IOP and move to 7W. The SW found the patient to be euthymic with no significant symptoms of SMI demonstrated. The SW discussed EOP level of care with the patient and noted that the patient was receptive. The SW concluded that the patient was appropriate to be discharge to EOP (despite the disturbingly brief admission to IOP) and did no education or otherwise tried to engage the patient in her treatment program within IOP. The patient was discharged without a multidisciplinary treatment team (MDTT) review and was moved to 7W later that day.

Treatment should always be determined by the patient's treatment team rather than an individual provider. For this patient, that was particularly critical since her presentation could vary over time and by provider. It should be noted that the patient was discharged from IOP directly to OPP level of care; not the EOP level of care. She was only on the EOP waitlist. She was seen confidentially by a prescribing provider on August 29 and had hydroxyzine discontinued because the patient felt over-sedated.

The patient presented for our interview with pressured speech, thought derailment, and was emotionally labile. She was difficult to redirect and would became increasingly emotional when she was redirected. It was clearly a challenge for the patient to manage her thoughts and emotions. She would be agitated and angry toward others, such as the detainee porter and mental health staff generally, but would rapidly cycle to tearful and distraught over thoughts of losing her dog because of her incarceration. Her dog was her primary support and preferred companion as she had endured significant trauma up to her time of arrest. Her psychomotor movement was restless, again demonstrating difficulty managing her behavior, though some of the observed behavior may have been due to past or current psychotropic medications. She reported a history of mental health care in the community, confirmed by medical record review.

During our interview, the patient described her extensive history of substance use, visual hallucinations, and auditory hallucinations. The patient's activities of daily living (ADLs) were poor. Her clothes were dirty and she was not well groomed. She explained that in the community, she had been unhoused for years and was frequently in and out of custody. In addition to her extensive trauma history, she had lived a very unstable life inside and outside of custody which only exacerbated her SMI.

When asked why she asked to be removed from IOP, the patient indicated that she did not want to be in IOP because she could not consume coffee while in the program and she relied on it. It was unclear why her treatment team could not work with her around this issue to

maintain her in the IOP level of care. Behavioral interventions and incentives likely would have assisted in addressing this clinical issue. While caffeine can be quite problematic when its consumption is not controlled in a psychiatric setting, there are different ways to limit the frequency or amount of its use. There may also be other reasons for the patient's refusal and reinforcers of not pursuing treatment which should be properly assessed by the clinical team; that should have occurred before the patient was discharged. This patient reported that at her current level of care, she was not attending mental health group treatment because "no one is calling me out to go to groups." According to the medical record, she had not been seen by her EOP clinician or MDTT. She was not seeing her clinician frequently enough to meet her needs, and she said that she wants to meet with an EOP clinician regularly and more often than what had been the norm.

This patient was struggling with significant symptoms of severe mental illness that she clearly had difficulty managing, even with medications. She did recognize that she was experiencing symptoms of SMI, but had very limited insight. Her inability to manage her symptoms and resulting mood and psychomotor impairment made her vulnerable to victimization. At the same time, she could quickly become irritable and reported a willingness to fight to protect herself or her rights, likely a natural response developed through years of living on the streets, multiple traumas, and a desire to keep herself safe. These competing needs and limited insight made her a very complicated case. She had significant mental health needs that were not being addressed and she had been discharged from a more appropriate level of care, IOP, within two days by her clinician

Based on record review and clinical interview, my assessment of Patient 2 is that she currently has unmet mental health needs and is at the incorrect level of care. Patient 2 should be at the IOP level of care at minimum, not at the OPP level of care. However, a comprehensive evaluation and medication evaluation should occur as quickly as possible. It may be likely that this patient requires inpatient treatment to stabilize so that she can participate and benefit from IOP. Inpatient treatment should include objective, behaviorally-based treatment goals that would improve the patient's functional ability and tolerance for the IOP environment to maximize the probability of success.

Patient 3

Patient 3, a 32-year-old African-American female, had been at the jail for about one month (8/4/24) at the time of our interview. During our interview, she described being unhoused in the community and frequently serving terms of incarceration at the jail over the last ten years. At the time of our interview, she was at the EOP-Intensive level of care (as of 8/11/24). She had been diagnosed with Schizoaffective Disorder, Opioid Use Disorder, and Methamphetamine Abuse Disorder. She was also described in the problem section as having a history of agitation and engaging in high-risk behavior when in the community (e.g., sex work). She had reported a

history of multiple traumas, including physical and sexual abuse, documented in the medical record. She was prescribed Seroquel, Prazosin (likely for PTSD symptoms), and Buspar. Some of her HSRs suggested that she may have been experiencing psychosomatic delusions.

Prior to interviewing this patient, we had been warned of her dangerousness and unpredictable aggression. However, the patient was polite and calm throughout the interview. She reported being deaf in one ear and consequently being loud, which she believed others interpreted as angry or aggressive. She did present with elevated volume of speech but was not agitated. The patient reported an extensive mental health history that included community inpatient psychiatric treatment and prior participation in the Jail-Based Competency Treatment program and was recently being found incompetent to stand trial (PC1370) in the days before our interview. The patient presented as paranoid, and while she denied hallucinations, she went on to describe clear incidents of auditory and visual hallucinations. She expressed delusional beliefs including that she has the ability to "time travel."

Based on record review and interview, because of her undertreated SMI, paranoia, and history of trauma, she perceived threat constantly, believed that people were conspiring against her, and would engage in an aggressive manner to protect herself. According to the medical record, she would become irritable and verbally aggressive. Then custody staff would not allow her to attend treatment groups. This would create a vicious cycle where the patient would become angry and agitated at missing treatment. The patient consistently reported extreme anxiety (a 10 out of 10) to her providers and during this interview. She also reported feelings of depression. She appeared frustrated with the challenges she experienced adjusting to jail operations and accessing needed services. The patient felt misunderstood but had limited insight into her behaviors that sometimes influence decisions regarding access. At times she would be seen cell side due to her refusal to exit her cell. The patient reported that her medications were not helping and believed that she had a poor relationship with her SW.

This patient has struggled with significant symptoms and functional impairment related to her SMI that have been undertreated while at the jail. She has very limited insight and coping skills and views the world around her as unsafe and untrustworthy. This leads to misconceptions of even neutral behaviors and results in intense irritability, verbal aggression, and a willingness to engage in physical aggression to protect herself and her rights. A court has determined that this patient is incompetent to stand trial and recognized her significant mental health symptoms and functional impairment.

Based on record review and clinical interview, my assessment of Patient 3 is that she currently has unmet mental health needs and is at the incorrect level of care. Patient 3 should be at the inpatient level of care, not at the EOP level of care. She would also not be appropriate for the JBCT given the same concerns regarding undertreatment of her SMI.

Patient 4

Patient 4, a 35-year-old African-American male, had been at the jail for around six months (3/12/24) at the time of our interview and was housed on 8 West when we spoke. He has an extensive history of serious mental illness having been hospitalized in the community, prison, and jail. The patient was previously housed in the APU on 2P and in an IOP unit. Per his self-report, when the patient was last in CDCR, he was subject to an involuntary medication order, and after his release from CDCR, he was placed on a W&IC5150 hold. The patient had the following diagnoses: Intermittent Explosive Disorder, Bipolar II Disorder, Bipolar I Disorder, Antisocial Personality Disorder, Borderline Personality Disorder, Other Specified Personality Disorder, mixed personality traits, and Unspecified Personality Disorder. The patient had a rule out diagnosis of Schizoaffective Disorder; he had been repeatedly determined to be a danger to self and a danger to others during his admission. Despite the plethora of contrary diagnoses, one consistent underlying element to those disorders suggested the presence of both psychotic and mood symptoms. The patient was prescribed only Remeron, Buspar, and Benadryl.

During the interview, the patient reported a recent suicide watch in August 2024, for approximately ten days. He said that he was "always on suicide watch" and frequent watch status was supported by the medical record. At the time of our interview, he was at the EOP-Intensive level of care and was on the IOP waitlist. However, his symptoms were clearly not well-managed as evidenced by the frequency of crisis services and placement on watch for danger to self and/or others. The patient reported significant safety concerns and a preference to remain in his cell rather than harm others. Prior to incarceration, he lived a transient lifestyle and endured multiple traumas exacerbating his concerns for personal safety. The patient reported recently assaulting peers within the jail setting and a desire to assault others in his unit; the underlying reason was to protect himself. His SMI appeared to contribute to those behaviors, making adequate treatment even more critical so that he would not continue being a risk to others and possibly extending his incarceration time.

The patient believed that his "mental health was misunderstood" at the jail and that his mental health treatment was not meeting his needs because he had no treatment plan. He reported that he talks to himself in his cell and that he is "freaking out every day and night." The patient appeared to be responding to internal stimuli throughout the interview. For example, he would smile to himself inappropriately. According to medical records, the patient has been placed on a multi-day suicide watch at least twice ***since*** being interviewed. Because of his very limited coping skills, high suicidal intent (per record), and frequent suicide watches, the patient rarely had out of cell time or access to actual therapy since suicide watch included regular assessment but little to no actual therapy. This patient's serious mental health needs were clearly beyond the resources of the county jail system.

Following my medical record review and clinical interview, my assessment of Patient 4 is that he currently has unmet mental health needs and is at the incorrect level of care. Patient 4 should be immediately referred to actual inpatient treatment where he can receive a

comprehensive evaluation with diagnostic clarification and therapy that includes an individual behavior plan. This treatment should be provided in the community since APU does not provide a reasonable alternative. The inpatient treatment should be of sufficient length that he can develop basic skills to assist him in coping with his symptoms and manage them to a degree that would allow him to benefit from the treatment provided within the jail system. This referral and transfer should be a priority of the highest level as this patient continues to suffer daily.

Patient 5

Patient 5, a 28-year-old African American woman, was housed on 7 West and placed at the OPP level of care at the time of our interview. She had been accepted for mental health diversion and was awaiting placement for an inpatient program in the community as determined by the court. Patient 5 had been diagnosed with an Adjustment Disorder with mixed anxious and depressed mood (based on ACMH history) and prescribed trazodone HCL and Lexapro. The patient reported mental health treatment in the community and reportedly had a good support system.

During our interview, she reported that jail staff committed a breach of HIPAA and other privacy statutes and regulations when she was away from the jail due to mental health diversion court. Specifically, her medical test results indicating a positive result for herpes, inside an envelope, were slipped beneath her old cell door. She was not housed in that cell or anywhere at the jail when the envelope was slipped under the cell door. Her prior roommate opened the letter and shared the findings with others in the unit. Upon her return to the jail, Patient 5 was horrified to learn that the other women in the unit knew of her illness and mocked her because of it. Her anxiety and depression began to increase, and she reported that she battled suicidal thoughts as a result of the trauma and isolation due to this privacy violation. Patient 5 reported coping by focusing on her children, being a role model to her children, and trying to get out of jail. However, she also indicated that there were times that she felt overwhelmed by suicidal ideation; during that time, even her coping strategies were not as useful.

Unfortunately, as a result of this clinically significant event, she was increasingly isolated from peers and family. She felt that she could not talk to her family until she had more information about her test results. Over the course of weeks, the patient had sent in one grievance and multiple HSRs to be seen regarding these test results and her acutely high levels of anxiety, yet she was not seen in a timely manner.[8] As a result, this patient was experiencing significant

[8] The patient was eventually seen by a nurse practitioner (NP) regarding her medical test results, after class counsel raised concern about the situation. The NP provided education on the diagnosis of stomatitis and herpes simplex virus 1 (HSV1). The breach of privacy was not addressed during that contact. However, the concerns about the process of notifying patients of their test results had been referred to the supervisory chain of command.

distress and struggled with thoughts of self-harm. While indicating that she would not do anything because she just wanted to get out of jail, her risk of self-harm was significant due to her emotional lability, her feelings of shame, and the intense feelings of betrayal that she felt toward ACH and her prior roommate for misusing her personal health information. The patient was referred to mental health for an emergent referral due to her impulsivity, emotional lability, and a recent significant event that made her feel betrayed, dismissed, and hopeless.

During our interview, the patient similarly reported feeling helpless and having no one to talk to, and she described that she has a personal history of physical, sexual, and emotional abuse. She reported seeing mental health staff about once every 30 to 45 days, often in non-confidential settings. She said that when she requests to be seen in a private location, staff instead document that she refused the mental health encounter. Patient 5 described persistent physical symptoms of anxiety, including a racing heart rate. She reported being unable to get anxiety medications, despite filing multiple sick call slips. The patient reported that a serious lapse in the handling of her confidential medical information by jail staff had exacerbated her despair and sense of helplessness. Despite this patient's multiple risk factors for suicide, the clinician did not conduct an SRA, though it was clinically indicated. While the patient eventually did receive information regarding her test results and clarification that it was not due to a sexually transmitted illness, she should have still been assessed for suicide risk. The patient reported struggling with frequent thoughts of suicide and there was no indication that the medical/health education reduced that risk.

Based on record review and clinical interview, my assessment of Patient 5 is that she currently has unmet mental health needs and is at the incorrect level of care. Further comprehensive assessment is required to identify the patient's immediate mental health status to identify if EOP or IOP would be more appropriate. The patient required a comprehensive assessment and treatment plan. Patient 5 should be at the EOP or IOP level of care, not at the OPP level of care.

Patient 6

Patient 6, a 28-year-old White female, had been at the jail for about four months (5/19/24) at the time of our interview and was housed on 7 West when we spoke. She was at the EOP level of care and on the IOP waitlist. Class counsel spoke to this patient in August 2024 during a restrictive housing tour. According to class counsel, this patient was on discipline status at that time. During that interview, the patient was detached from reality, unable to follow the conversation, and appeared actively psychotic. The patient had been diagnosed with Bipolar I Disorder with psychotic features and had been identified as having a suspected cognitive impairment. She was also diagnosed with alcohol abuse, episodic, stimulant abuse, and an opioid use disorder. It should be noted that there was a diagnostic conflict in the record with clinical notes instead indicating a diagnosis of schizophrenia spectrum or other psychotic disorders. She

was prescribed the following psychotropic medications: Depakene, Haldol, Abilify (monthly injection).

During my interview with the patient, she continued to present as though she was responding to internal stimuli, with her attention and concentration significantly impaired. She demonstrated loose associations, perseverative thoughts, and was unable to engage in even minimal basic conversation. She repeatedly focused on getting "juice." She also appeared to respond better to females over males, something to consider for her treatment providers. The patient was highly paranoid and experienced paranoid delusions. For example, she reported that she had been in a fight with her cellmate because her cellmate threatened to attack her brother, but upon further query, her self-report was quite unreliable given her poor reality testing. When questioned specifically about her cellmate's apparent threat, the patient confirmed that the cellmate had never met the patient's brother and had no reason to know of his existence. The patient had no insight and poor judgment.

The patient further reported placement in IOP on multiple occasions but "hated" it and believed the IOP level of care was "horrible." She had reportedly gotten into a fight with a peer in IOP most recently and was discharged, but she felt "ready." As occurred throughout the interview, she could not explain her comments further if questioned. At the time of our interview, she was at the EOP level of care and had been placed on the IOP waitlist, but she was unaware of her placement on that waitlist. While at the EOP level of care, she reported that mental health staff do not meet with her.

Although some clinical contacts suggest that the patient was able to function, in a referral on August 3, the patient was emergently referred by custody due to having punched a nurse and stated that she was pregnant with "puppies." (The assault actually occurred on August 2, 2024, the day before the referral, but custody did not make a referral at that time due to "staffing.") The patient was not seen until the following day in a non-confidential encounter due to "safety and security" concerns. The clinician determined that the patient was not an assault risk but did not address the delusional belief that the patient was pregnant with puppies in any way. A mental health disciplinary assessment was completed later that date in a confidential setting that revealed that the patient experienced multiple delusions and was tangential and non-sensical while denying hallucinations. The clinician did not appear to recognize the delusional thoughts and somehow found NO nexus between the patient's SMI and the behavior.

This patient has been struggling for several months with severe psychotic symptoms and functional impairment. Because of her mental illness and history, she perceives the world as threatening and responds as if everyone poses an immediate risk to her. She demonstrated somatic delusions during her interview that were consistent with documentation in the medical record.

Based on medical record review and clinical interview, my assessment of Patient 6 is that she currently has significant unmet mental health needs and is at the incorrect level of care. Patient 6 should be at the inpatient level of care, not at the EOP or even IOP level of care; she requires more intensive treatment than those programs can provide. The patient requires a comprehensive evaluation and medication evaluation and would benefit from treatment in a structured therapeutic setting with 24-hour nursing supervision and behavioral treatment. This patient responds well to incentives, which can be used to assist therapy in skill acquisition to allow her to be stabilized sufficiently so that she could safely program in the IOP setting. Treatment at the inpatient level of care will reduce the probability that she may harm others and would be punished for being mentally ill.

Patient 7

Patient 7, a 33-year-old male Pacific Islander, had been at the Jail for around three months (6/10/24) at the time of our interview, and he was housed on 8 East when we spoke. He was at the OPP level of care and on the EOP intensive waitlist as of August 5, 2024. Class counsel spoke with Patient 7 in August 2024 on a restrictive housing tour. According to class counsel, this patient was unable to answer basic questions or form coherent sentences during that interview. He was detached from reality and was unable to attend to his basic needs; he was not showering or grooming, his hair was unkempt, his clothes were filthy, and his fingernails were long and full of dirt. After their tour, class counsel emailed ACMH to express their alarm at the acuity level of several patients' mental health needs, including this patient's needs. Class counsel's email appeared to precipitate this patient's referral to EOP.

In the intervening month between class counsel's interview with this patient and my interview with him, the only apparent change was that this patient had been placed on the EOP waitlist. He was still housed in 8 East, was similarly ungroomed, and was still unable to answer basic questions. The patient had been diagnosed with Schizophrenia and was prescribed psychotropic medications for that disorder. During the interview, he was not oriented to time or place; for example, he could not identify what unit he was housed in; he could not identify when he last took a shower; he could not explain how frequently he was let out of his cell or how many hours of out-of-cell time he was offered in the most recent week. In response to a question about whether people in the unit were stealing his personal property (the patient was assessed to be at high risk of being victimized due to his SMI), he said that he "can't tell" if people are taking his items. The patient did confirm, however, that he is having persistent auditory hallucinations.

On September 5, following referral from this subject matter expert (SME), the patient was moved to the IOP waitlist, but was only a moderate priority for referral. Less than a week later (9/11/24), he was on the APU pre-admit list and on September 18, he was understandably found incompetent to stand trial (PC1370) with a court order that provided for involuntary administration of psychotropic medication.

Based on record review and clinical interview, my assessment of Patient 7 is that he currently has extensive unmet mental health needs and is at the incorrect level of care. Patient 7 should be at the acute inpatient level of care, not at either the OPP, EOP, IOP, or even jail (2P) inpatient level of care. This patient was experiencing extreme mental illness that also made him vulnerable to victimization. He should be at a state hospital for restoration of competency and then evaluated for long-term placement in a community psychiatric facility or structured living setting. He was not appropriate for the jail setting, including the jail-based competency restoration (JBCT) program due to the severity of his illness.

Patient 8

Patient 8, a 33-year-old African-American female, had been at the jail for approximately six weeks at the time of our interview (7/21/24) and was housed on 7 West when we spoke. She was placed at the OPP level of care at the time of our interview and on the waitlist for the EOP. She was diagnosed with depression, unspecified. Patient 11 was prescribed Remeron and Lexapro.

During the interview, the patient reported that she had not received any meaningful treatment during her time in the jail. She had previously been at the jail and was at the EOP level of care during that term of incarceration. Although EOP treatment is limited, she found the treatment that was provided in that program to be helpful. She described that she liked the individual mental health contacts, the structured out-of-cell-time, and the support of the program facilitators. In contrast, at the time of our interview, she was struggling to cope in her general population setting, where no such treatment is provided. Her distress and functional impairment due to SMI have resulted in multiple incidents. For example, after a recent altercation with another incarcerated woman, she was placed in disciplinary detention, where she lost all privileges, had very little out-of-cell time, and went many days without being able to even take a shower. These punitive conditions seemed to only worsen her condition.

The patient had another recent disturbing incident that appears to have stemmed from mental health treatment needs identified during the interview. She described banging her head on the door of her cell, out of frustration about the isolation and lack of out-of-cell time. She recalled, “I wanted mental health to come see me.” Instead, she described custody deputies intervening, putting her in a spit mask and the WRAP device, taking away her clothing, and placing her on suicide watch in the safety smock. The patient felt embarrassed and dehumanized by the way that she was treated by custody, particularly use of the WRAP and spit mask, and custody staff removing her clothing.

Patient 8 reported anxiety, depression, and difficulty sleeping. She had been prescribed a medication to help her sleep, but she found that it was giving her intense nightmares. She had submitted a psychiatric sick call request approximately one month before our interview and was still waiting to see a psychiatrist.

Based on record review and clinical interview, my assessment of Patient 8 is that she currently has unmet mental health needs and is at the incorrect level of care. Patient 8 should be considered for IOP level of care where she can receive intensive mental health services and focus specifically on her symptoms, coping skills to help with distress tolerance, disappointment, and frustration—not in the OPP setting. The patient's unmet mental health needs would be better addressed in the IOP setting.

Patient 9

Patient 9, a 23-year old White male, was booked into the jail about five days before we met (8/30/24), and was housed on 8 West at the time of our interview. His intake date to the jail was somewhat confusing as the medical record indicated that the patient had been screened on August 24 and released from custody on August 27, returning on August 30. The patient was identified as having SMI but carried just an Adjustment Disorder diagnosis (not SMI). The patient had previously been diagnosed with Bipolar Disorder, unspecified, at intake and had a history of opioid abuse. He was on medication-assisted therapy (MAT) for his opioid use but only prescribed the psychotropic Remeron, a medication that should be prescribed with caution for patients diagnosed with Bipolar Disorder due to the possibility of exacerbating those manic symptoms. The patient was prescribed at a low (starting level) dose, hopefully so that he would be closely monitored. The patient was being treated at the OPP level of care, though after our interviews, he was placed on the EOP waitlist for moderate services (effective 9/13/24).

While the patient was initially screened as having no mental health needs, no treatment history, and no current psychotropic medications, he had reported leg pain and was referred for an expedited x-ray and placed on withdrawal monitoring. However, on August 31, the patient was referred to mental health by custody because while in 2M (medical unit). The patient had become incoherent and was scooping up toilet water and tossing it under his cell door. This was an emergent referral, but the patient was not seen for almost 36 hours (0923 hours on 8/31/24; seen 2001 hours on 9/1/24). The contact was documented as confidential but occurred cell side, which is highly inappropriate for such a critical assessment. Cell side contact cannot be considered a true clinical encounter, and any results or findings must be viewed with great skepticism given the lack of confidentiality.

At this cell side contact, the patient was assessed to present with no symptoms but was identified as SMI due to a reported history of bipolar disorder. The patient denied the behaviors observed by custody and documented by nursing. It appeared that the social worker did not review the medical record. Had that occurred, the lack of reliability of the patient's self-report would have been incorporated. The medical record suggested that the patient had no insight into his mental illness and that record review, staff interviews, and an appropriate confidential mental health assessment were required to complete even a minimally adequate review and/or assessment.

This patient was identified by another patient during the September interviews as "having a hard time" and banging and kicking his door through the night. Further evidence of the patient's minimization of his symptoms and behavior and lack of insight was apparent as the patient stated during the interview that he was in a peaceful pod. Patient 9 reported during our interview that he had received mental health care in the community and that had and continued to experience severe anxiety attacks. The nursing receiving screening form indicated that the patient denied current anxiety or bipolar symptoms and denied taking psychotropic medication. However, during my interview, the patient reported experiencing extreme anxiety and tension while housed in the jail and said he was not receiving the anxiety medications in the jail that he took in the community. He reported that he had not received a mental health evaluation at the jail and that he had been charged with a disciplinary infraction without any accompanying mental health evaluation. The only mental health contact prior to the interview was that cell side "assessment."

Three days after our interview, on September 7, another emergent referral was made to mental health by custody for suicidal ideation. A suicide risk assessment was completed in a confidential setting approximately 10 hours later. Several risk factors were not properly documented, and undue weight was given to the patient's denial, particularly given his history of a lack of insight and unreliable self-report. The patient was then cleared from watch.

During our interview, the patient exhibited very flat affect, significant problems with insight, and his thoughts frequently derailed (e.g., frequently jumping from one idea to another that is loosely related or unrelated). He was at times difficult to redirect and clearly struggled to manage his thoughts. The patient's self-report of how he injured his leg was characterized by odd figures of speech and highly unreliable. The patient repeatedly discussed his extreme levels of anxiety and reported that he believed that the staff gang up on him, resulting in reported disrespect toward staff. Patient 9 reported that he had received a disciplinary report for spitting on staff in medical but denied it to be true. No disciplinary mental health assessment was identified in the chart. However, another emergent referral was made on September 10 due to suicidal ideation and the patient was placed on watch. The patient was seen cell side due to refusal. He was found to be at high imminent risk of suicide.

Based on medical record review and clinical interview, my assessment of Patient 9 is that he currently has unmet mental health needs and is at the incorrect level of care. Patient 9 should be at the inpatient level of care, not at the OPP level of care or the EOP waitlist. This patient should also receive a comprehensive evaluation to clarify the diagnosis(es) so that appropriate treatment interventions can be developed.

Patient 10

Patient 10, a 42-year-old female, had been at the jail since March 22, 2024 and was housed on 7 West in the 400 pod when we spoke. The patient was placed at the OPP level of care

at the time of our interview. Following the site visit, she was on the waitlist for IOP level of care (as of 9/10/24) but was later removed and placed on the EOP waitlist. The patient was diagnosed with Unspecified Schizophrenia and other Psychotic Disorder. The medical record indicated that the patient had a rule out diagnosis of personality disorder (nothing further specified). The patient had the following psychotropic prescriptions: Depakote, Lamictal, Risperdal, and trazadone.

Patient 10 reported that she had been on disciplinary status at various times during her detention. She said that when she was initially placed in disciplinary detention, mental health staff had seen her weekly, but that had stopped at some point. She reported previously being in the EOP and IOP programs but was removed after being involved in physical altercations.

During the interview, the patient demonstrated perseverative thoughts, problems with attention and concentration, and appeared at times to be responding to internal stimuli. She reported multiple crisis events resulting in placement on watch and having been admitted to the APU, but that could not be verified through the medical record. When talking about her refusals and lack of programming, she responded by saying, "I don't come out [of my cell] anymore." She talked about experiencing hallucinations and delusions. For example, she stated that, "I see eyeballs a lot." She described having been given flowers that looked like they had eyeballs in the middle of them, and how she was deeply distressed by this image. She became tearful while describing her time in the 400 pod, and at one point said, "I just want to go back into my cell."

Patient 10 appeared quite overwhelmed by her mental health symptoms, had impaired functioning, and was unable to cope with her acute illness. While Patient 10 frequently acted out in an aggressive manner to protect herself whenever she felt threatened, she was also vulnerable to victimization, particularly when in an acute state of decompensation. The patient's presentation was so troubling that this SME requested that she be seen by an ACMH clinician urgently. The patient was willing to engage in further mental health treatment offered to her. She enjoyed the tablet and the educational activities. But she also said that "unless you say you're suicidal, mental health won't come to see you" when you need help.

Based on record review and clinical interview, my assessment of Patient 10 is that she currently has unmet mental health needs and is at the incorrect level of care. The patient would benefit from an inpatient treatment setting with 24-hour nursing monitoring. Inpatient treatment was indicated for Patient 10 at the time of the interview. This would allow for a thorough and comprehensive evaluation that would clarify diagnostic issues, identify the best medication regime, and develop distress tolerance and de-escalation tools so that she could safely program at a lower level of care (IOP).

Patient 11

Patient 11, a 44-year old African-American man, had been at the jail for about four years (12/4/20) at the time of our interview and was housed on 8 West when we spoke. He was at the OPP level of care and had been on the EOP waitlist since December 2023, nearly one year. He had been diagnosed with Depression, unspecified, Alcohol Abuse, unspecified, and Cannabis Use Disorder. The patient had also been identified as non-compliant with his therapeutic plan by medical staff, refusing multiple medical appointments, laboratory (lab) draws, imaging orders, and specialist appointments. He had not yet been evaluated to assess how much his mental health issues impacted his refusals of necessary medical care. The patient was prescribed Wellbutrin XL for depression.

During my interview with the patient, he had pressured speech and was difficult to redirect. He described symptoms of extreme anxiety and paranoia, which occasionally lead to "episodes" during which he experiences auditory hallucinations and detachment from reality. He reported that when he feels an episode might occur, his "body feels different," and he requests to be placed on 8 West so he can limit his contact with other people in an effort to avoid conflict. However, the patient's safety concerns were likely exacerbated by his undertreated mental illness. The patient had reportedly been seen at cell front on August 22 by a mental health prescribing nurse practitioner. However, the note was not completely clear, and my review of the chart note suggested that the Wellbutrin was renewed and increased from 300 to 450 mg without a patient interview. The patient had previously been seen in a non-confidential space (indoor recreation) on August 13 to "monitor progress" when the patient endorsed auditory hallucinations but was described as not having a severe mental illness (SMI). This appointment was a "check in" rather than a true therapeutic contact and the patient was provided with an in-cell activity packet. He remained at the OPP level of care pending EOP placement for nine months. During this time, the patient was seen approximately every six weeks. The patient requested treatment groups to learn ways to cope with his depression and anxiety. His care was clearly insufficient to manage his significant mental health needs.

Following my review of the medical record and clinical interview, my assessment of Patient 11 is that he currently has unmet mental health needs and is at the incorrect level of care. The patient should receive a comprehensive evaluation in a confidential setting and an associated treatment plan. Patient 11 should be at the IOP level of care, not at the OPP level of care or at the EOP waitlist.

Patient 12

Patient 12, a 38-year-old African-American male, had been at the jail for about four months (5/19/24) at the time of our interview and was housed on 8 West when we spoke. He was at the OPP level of care, and he was not on the EOP, IOP, or APU waitlists. The patient was diagnosed with an Adjustment Disorder with anxiety, Amphetamine Use Disorder, and Opioid

Use Disorder. The patient was prescribed psychotropic medications Remeron and buspirone but had a history of diverting medication.

At the time of our interview on September 4, 2024, that patient had not had a confidential clinical encounter in over a month. His previous confidential clinical encounter occurred on August 2, 2024, during an "ad seg placement review" to determine whether his mental health precluded his placement in restrictive housing. During that encounter, the patient reported increased and overwhelming anxiety. Afterwards, the patient began submitting numerous Health Service Requests (HSRs) reporting increased symptoms and decompensation over time. He was not seen by mental health staff again until August 30, in response to a custody referral. During that August 30 interaction, the patient was seen at cell front because he was irritable that he was about to be transferred to a restrictive housing unit at Main Jail after being involved in an altercation at Rio Cosumnes Correctional Center (RCCC). The patient did not want to move to Main Jail. The cell front interview was terminated after a brief time because of the patient's "elevated" mood.

When I interviewed the patient, he had recently transferred from RCCC, and he described the altercation that led to his placement in restrictive housing. Specifically, the patient reported extreme paranoia and anxiety. He described how he was distrustful of people in the jail, and when people left for medical appointments, he tracked how long they were gone to verify whether they were actually at a medical appointment and had not instead been conspiring with custody staff. On the occasion that resulted in an altercation, the patient believed that the other incarcerated person did not actually attend a medical appointment because he was not gone for a long enough period of time. Upon the other incarcerated person's return, the patient attacked him, believing the other incarcerated person was planning to assault him. According to the medical record, mental health staff overheard the patient reporting to custody that he had been "set up" in that incident.

After the fight, the patient was moved to 8 West at Main Jail. At the time of our interview, he had pressured speech, continued to express extreme paranoia, and explained that his mental health needs were not being met. He said that he had requested mental health services at Main Jail because he lacked coping skills, but ACMH had not yet met with him.

Medical records show that after our interview, the patient was eventually seen by mental health staff. That clinical encounter occurred at the patient's cell front because custody staff told the patient's social worker that the floor was too busy for the patient to go to the confidential attorney booth. This contact was for an "ad seg" review and because the patient had requested in an HSR that someone from mental health come speak to him "ASAP." The patient should have been seen confidentially for the critical ad seg review and in light of his request to be seen as soon as possible. During the cell front contact, he reported decreased appetite and sleep. The

contact was brief in addition to being non-confidential, limiting its utility for an ad seg review and crisis response.

Following review of the medical record and notes from my interview, my assessment of Patient 12 is that he currently has unmet mental health needs and is at the incorrect level of care. Patient 12 should be evaluated in a confidential setting to develop an appropriate treatment plan. Based on all available data, the patient requires, at minimum, the EOP level of care, not the OPP level of care.

Patient 13

Patient 13, a 34-year-old Latina woman, was housed on 7 West and placed at the OPP level of care at the time of our interview. She was on the waitlist for the EOP. She had been diagnosed with Post-Traumatic Stress Disorder (PTSD), unspecified drug-induced mental disorder (i.e., a mental disorder induced by an as-yet-unknown substance), and an opioid use disorder. The patient was prescribed prazosin and provided with medication-assisted treatment for her opioid disorder, and vistaril.

Patient 13 reported that she was having a difficult time getting the mental health care she needed. After she arrived at the jail in early 2024, it took nearly a month for her to get on her prior psychotropic medication. She submitted grievances on the issue and finally received the medication. Despite finally receiving medication, she shared that she sometimes missed evening medications because they were not delivered timely. This was of particular concern for her regarding sedating medications. She had to awaken early for breakfast and work but her night medications were often not administered until after midnight. If she took her sleep medications then, she would be tired and sedated the next morning. She was a worker in her unit and took great pride in her position. She also reported that she was the person who would alert staff to concerns about other patients. This job required that she wake up early to begin the workday.

Patient 13 had requested to be seen regularly by mental health staff but says no one comes to see her and no case manager is assigned to her. She was having a difficult time without mental health support.

Based on record review and clinical interview, my assessment of Patient 13 is that she currently has unmet mental health needs and is at the incorrect level of care. Patient 13 should be at the EOP level of care, not at the OPP level of care. The patient is awaiting EOP placement.

Patient 14

Patient 14, a 39-year-old woman, was housed on 7 West and placed at the OPP level of care at the time of our interview. She was on wait lists for both the IOP and the EOP. Patient 14 was diagnosed with PTSD, Major Depressive Disorder, recurrent, moderate to severe, and

Opioid Use Disorder. The patient was prescribed prazosin and Vistaril. This patient had many physical illnesses, including two types of cancer, for which she was reportedly receiving inadequate treatment. She reported that she drank on the street and recently went through detox for alcohol abuse. Historically, she has had acute pancreatitis because of her alcohol consumption. The medical record indicated that she had gastric bypass surgery but it was unclear if that may have been related to gastric cancer (given that the patient reported gastric cancer).

Patient 14 is a complex patient with serious mental health needs and significant medical issues. She arrived at the jail in mid-August 2024, only a few weeks after her release on a prior jail detention. During that prior detention, she required an inpatient level of care and spent time on the 2P acute care unit. After that acute care admission, she was placed in the IOP, where she had multiple groups each day, and received treatment related to socialization, coping skills and more. She informed me, "IOP gave me a reason to live again... I loved the IOP program."

The patient demonstrated difficulty with the clinical interview, sometimes responding with long pauses or tangential comments. Her psychiatric symptoms, as described in the chart, appeared to have worsened in the current setting where she has not received regular treatment from mental health. She became emotional at times and appeared to be in a fragile mental state, trying to hold on tightly to any hope and/or services that would stop the decompensation and help her set appropriate boundaries while learning to cope with her cancer prognoses and adjust to being confined. At one point, the patient was clearly struggling to focus and participate in the interview; when she was asked what was going on in that moment—her eyes had looked glazed over, she was staring at the wall as if she responding to visual hallucinations—she repeatedly mentioned that she had not eaten lunch and was thirsty. Unit security staff helped get the patient a small food item and water so that she would feel better.

Based on medical record review and clinical assessment, my assessment of Patient 14 is that she currently has unmet mental health needs and is at the incorrect level of care. Patient 14 should be at the IOP level of care, not at the OPP level of care.

IV. Findings of Unmet Needs Assessment

Patient	Level of Mental Health Care at the Time of Our Interview	Recommended Level of Mental Health Care
1	OPP	Inpatient
2	OPP Waitlist for EOP	IOP or Inpatient
3	EOP	IOP
4	EOP Waitlist for IOP	Community Inpatient Placement

5	OPP	EOP or IOP
6	EOP Waitlist for IOP	Inpatient
7	OPP Waitlist for EOP	State Hospital then community placement
8	OPP Waitlist for EOP	IOP
9	OPP	Inpatient
10	OPP	Inpatient
11	OPP Waitlist for EOP	IOP
12	OPP	EOP
13	OPP Waitlist for EOP	EOP
14	OPP Waitlist for EOP and IOP	IOP

V. Conclusion

In sum, the mental health care system at the jail is not meeting the needs of the patient population. The various levels of care are not appropriately funded or staffed. Physical plant matters negatively impact access to adequate mental health treatment. Many patients at the jail are at the incorrect level of care, and many are spending months or years on waitlists for levels of care that ACMH has determined is necessary for the patient.

Defendants, particularly Sacramento County, must act urgently to address these serious and systemic deficiencies. Defendants should specifically support ACMH in completion of a comprehensive mental health needs assessment of the jail population. Once the level of need is accurately assessed, Defendants, should conduct a full staffing analysis to assess the staffing needed to provide adequate mental health services to the jail population. This staffing analysis must include custody staffing for appropriate access to treatment and proper supervision (e.g., security observation) as well as ACH medical staff to support particularly medication administration and other nursing functions that support mental health services (e.g., intake screening, APU nursing). Defendants, including ACMH, should use that staffing analysis to generate a comprehensive staffing plan, including as to recruitment and retention needs. Finally, Defendants should review their interim and future possible remodel/build projects with this critical data.

Sincerely,

Mary Perrien, Ph.D.