Eric Balaban (admitted *pro hac vice*)
Gabriel Eber (admitted *pro hac vice*)
ACLU National Prison Project
915 15th Street, N.W., 7th Floor
Washington, D.C. 20005
(202) 548-6605
ebalaban@aclu.org
geber@aclu.org

Daniel J. Pochoda, 021979
James Lyall
ACLU of Arizona
3707 N. 7th Street, Suite 235
Phoenix, Arizona 85014-5059
(602) 650-1854

Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Fred Graves, et al., Plaintiffs,	)	No. CV 77-479-PHX-NVW
v.	)	
Joseph Arpaio, et al., Defendants.	)	

I, PABLO STEWART, do hereby declare:

1. In 1973, I earned a Bachelor of Science Degree at the United States Naval Academy in Annapolis, Maryland. In 1982, I received my Doctor of Medicine from the University of California San Francisco (UCSF), School of Medicine. In 1985, I received the Mead-Johnson American Psychiatric Association Fellowship for demonstrated commitment to public sector psychiatry and was selected as the

Outstanding Psychiatric Resident by the graduating class of the UCSF, School of Medicine. In 1985-1986, I served as the Chief Resident of the UCSF Department of Psychiatry at San Francisco General Hospital and was responsible for direct clinical supervision of seven psychiatric residents and three to six medical students.

2. Throughout my professional career, I have had extensive clinical, research, and academic experience in the diagnosis, treatment, and prevention of mental illnesses in correctional and other institutional contexts. In my work, I have specialized in community and correctional treatment programs for individuals with chronic and severe mental illnesses, as well as substance abuse and related disorders.

3. I have also specialized in the needs of severely mentally ill individuals in sheltered treatment programs in institutional contexts, such as the Mental Health Unit (MHU) currently operating in the Maricopa County Jail (MCJ). As discussed in the body of my report below, during my recent tour of MCJ and my review of medical records and relevant reports and documents, I encountered many serious problems with the quality of the mental health care currently being delivered in the MHU.

4. I also have extensive experience managing, monitoring, and reforming correctional mental health systems. Between 1986 and 1990, I was the Senior Attending Psychiatrist for the Forensic Unit of the University of California, San Francisco, which was located at San Francisco General Hospital. In that capacity, I had administrative and clinical responsibility for a 12-bed maximum-security psychiatric ward and worked as the liaison with the Jail Psychiatric Services of the City and County of San Francisco. My duties in that position included advising the San Francisco City Attorney on issues pertaining to forensic psychiatry.

5. Between August 1988 and December 1989, I served as the Director of Forensic Psychiatric Services for the City and County of San Francisco. In that capacity, I had administrative and clinical oversight responsibility for the psychiatric care provided to the inmate population in San Francisco at both the county jails and in

the 12-bed locked inpatient treatment unit at the San Francisco General Hospital.

6. I have also served as a psychiatric expert or consultant to various federal courts or other organizations implementing remedial decrees covering the provision of mental health care in correctional institutions. For ten years, between April 1990 and February of 2000, I served as a court-appointed medical and psychiatric expert for the Court in the consent decree case *Gates v. Deukmejian*, E.D. Cal. Case No. CIV S-87-1636. Among other things, that case involved the provision of adequate psychiatric care to mentally ill inmates at the California Medical Facility (CMF) in Vacaville, California.

7. My experiences working on the *Gates* case also informed me about the difficulty of providing mental health services in locked, high security units. As part of the *Gates* case, CMF was forbidden from housing mentally ill inmates in its Willis Unit, a three-tier administrative segregation unit, because of the severity of conditions and the acknowledged difficulty of providing adequate mental health services in this type of setting. Housing mentally ill individuals in the Willis Unit was also forbidden because of the difficulty of doing emergency response in the unit. As discussed in greater detail below, one of the major areas where MCJ's treatment programs are currently falling short of the Court's Fourth Amended Judgment and minimal standard of care is in its segregation/closed custody units, including the Special Management Unit (SMU) located at the 4th Avenue Jail facility, and the segregation units at the Estrella facility, which houses all female prisoners.

8. Between October 1996 and July 1997, I served as a psychiatric expert for the United States District Court for the Northern District of California in the case of *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Ca. 1995), an omnibus case involving psychiatric care and other issues at Pelican Bay State Prison in Crescent City, California. In my work on the *Madrid* case, I gained first-hand knowledge concerning the severe impact of prolonged isolation in segregation units on mentally ill inmates, as

well as additional concrete understanding of the need for constant monitoring of both non-mentally ill and mentally ill inmates in lock-up units in order to prevent any further decompensating, since housing in these units by itself sometimes causes, contributes to and/or intensifies psychiatric instability.

9. Between July of 1998 and February of 2004, I served as a psychiatric consultant to the National Council on Crime and Delinquency (NCCD) and subsequently for the Institute on Crime, Justice and Corrections at Washington University (when it took over monitoring responsibilities from NCCD) in their efforts to monitor juvenile detention and treatment facilities operated by the State of Georgia. In that case, I monitored an Agreement between the United States Department of Justice (USDOJ) and the State of Georgia designed to improve the quality of care in its juvenile detention facilities. The Agreement encompassed mental health care, medical care, educational services, and treatment programs.

10. Also as part of the monitoring in that case, Georgia created significant new mental health treatment programs with dedicated staffing and capacity limitations, including most significantly a new inpatient treatment facility for boys and a second new inpatient treatment facility for girls.

11. Between June of 2003 and December of 2004, I was hired by the State of New Mexico as a defense expert for the implementation phase of the psychiatric sections of the "Ayer's Agreement" covering the New Mexico Corrections Department (NMCD). The Agreement was a settlement between a class of New Mexico prisoners and the NMCD concerning the provision of adequate psychiatric care for inmates in New Mexico's highest security facility. The Ayers Agreement concerned a mental health treatment program in a disciplinary detention unit similar to the SMU and MCJ. The treatment program implemented in the unit was based in part on the treatment standards for the Psychiatric Security Unit (PSU) mental health care programs in California. New Mexico implemented the new treatment program with an

acknowledgement that they needed to maintain minimum clinical staff-to-inmate ratios given the severe nature of the housing conditions in the locked-down unit, and the potential for mental decompensating.

12. Between March of 2003 and the summer of 2006, I worked as an expert for the USDOJ in connection with inspections to identify and remedy various problems at the Maxey Training School, a youth facility with large medical and mental health treatment programs in Whitmore Lake, Michigan. The case involved the adequacy of medical and mental health care provided at the facility. The case included an investigation of excessive lock downs of suicidal youths.

13. In 2007 and 2008, I prepared expert statements and testified before the court and the three-judge panel in the *Coleman/Plata* overcrowding litigation. My expert report in that case was cited twice in the United States Supreme Court decision upholding the three-judge court's imposition of an order requiring California to reduce overcrowding.

14. In 2008 and 2014, I testified before this Court in this case in support of Plaintiffs' opposition to the Defendants' motions to terminate the relief related to mental health care at MCJ. I concluded both times that Defendants failed to provide adequate mental health care to seriously mentally ill prisoners at MCJ, and those in need of mental health treatment. As a result, mentally ill prisoners at MCJ unnecessarily suffered, and were put at risk of harm through the deficiencies in MCJ's mental health care system. In some cases, the risk of harm mentally ill prisoners endured was exacerbated by their harsh living conditions, particularly for those housed in the SMU, and the segregation units throughout the Jail. My conclusions were based upon a multiple-day site visit to MCJ facilities, interviews, discussions with staff, and a review of medical records and other documents relevant to mental health care then being offered at MCJ.

15. Since 1986, I have held academic appointments as Clinical Instructor, Assistant Clinical Professor, Associate Clinical Professor, and Clinical Professor in the Department of Psychiatry, University of California, San Francisco, School of Medicine. I received the Henry J. Kaiser Award for Excellence in Teaching in 1987 and was selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic years 1988-1989, 1990-1991, and 1994-1995. I also coordinated a course on Prisoner Health at University of California San Francisco School of Medicine between January 2002 and January 2004.

16. I currently work as a private psychiatric consultant and as a Clinical Professor in the Department of Psychiatry at the University of California San Francisco, School of Medicine. At UCSF, I currently facilitate a weekly psychotherapy-training group for residents in the Department of Psychiatry as well as performing other teaching responsibilities.

17. My resume is attached hereto as **Exhibit A.**

18. I have been retained by plaintiffs' attorneys in the *Graves* case as an expert on correctional mental health care and the treatment of mentally ill pre-trial detainees [hereinafter referred to variously as "prisoners," "detainees," and "patients"] and those in need of mental health care at MCJ. I have been retained to offer my expert opinion on whether Defendants have demonstrated compliance with the Revised Fourth Amended Judgment (Dkt. 2299).

19. My opinions set forth below are based upon the documents and other evidence that I have reviewed to date concerning current conditions within MCJ on my tours of the Jail, which included visits to the 4th Avenue Jail SMU, and the lockdown units (Towers A-D) at the Estrella facility, and on my professional knowledge and my experiences working in correctional settings. Before each tour, I also requested documents and information of various sorts relevant to the operations of the mental

health programs at that institution, and throughout MCJ. The documents I reviewed included a variety of reports, court filings, prisoner medical records and other materials relevant to the current conditions in MCJ from February 27-August 31, 2015. The materials I have reviewed are identified in this declaration.

20. The opinions I offer here relate to the mental health care system at each institution I visited, as well as those MCJ facilities that I did not visit. All MCJ facilities operate under a unified set of policies and procedures, mental health care at all facilities is provided by Correctional Health Services (CHS), a county-based health care provider, and providers and staff move among and between facilities providing care, just as prisoners are transferred among and between facilities. The health care records and other data I reviewed also covered care at all facilities.

OPINIONS

A. <u>Opinion One</u>: Defendants Have Failed Demonstrate Their Compliance with the Mental Health-Related Implementing Provisions of the Revised Fourth Amended Judgment and Prisoners at Maricopa County Jail are Still Subjected to Needless Risk of Harm.

1. It is my opinion that Defendants have not demonstrated compliance with the mental health-related implementing provisions of the Revised Fourth Amended Judgment, as set out in detail below.

2. On September 30, 2014, the Court entered Findings of Fact and Conclusions of Law. Dkt. 2283. It found deficiencies in the identification, assessment, and treatment of pretrial detainees with respect to mental health care.

3. On September 30, 2014, the Court also entered the Fourth Amended Judgment, in which it ordered additional remedies to correct certain ongoing inadequacies in the provision of medical and mental health care to pretrial detainees at MCJ. Dkt. 2284. The Fourth Amended Judgment imposed three general orders on

Defendants. *Id.* at 1-2. First, the Court ordered Defendants to "provide a receiving screening of each pretrial detainee, prior to placement of any pretrial detainee in the general population. The screening will be sufficient to identify and begin necessary segregation, and treatment of those with mental or physical illness and injury [and] to provide necessary medication without interruption." *Id.* at 1-2. Second, the Court ordered that pretrial detainees "shall have ready access to care to meet their serious medical and mental health needs." *Id.* at 2. Finally, the Court ordered that Defendants must "ensure that the pretrial detainees' prescription medications are provided without interruption where medically prescribed by correctional medical staff." *Id.* at 2.

4. The Court further issued thirty-one implementing remedies with which Defendants must comply. *Id.* at 2-6. The Court stated that these remedies were "to show compliance with" the general remedies retained in the Fourth Amended Judgment. *Id.* at 2. The Court ordered Defendants to "adopt policies and procedures or amend existing policies and procedures" to implement the thirty-one provisions. *Id.* at 2. Several of the thirty-one requirements pertain to the mental health care of prisoners at MCJ. *See id.* at 2-6.

5. The Court entered a Revised Fourth Amended Judgment on December 10, 2014. Dkt. 2299.

6. As required by the Fourth Amended Judgment, Defendants filed a Notice of Compliance ("Notice") on December 16, 2014. Dkt. 2304. The Notice set out the Correctional Health Services (CHS) and Maricopa County Sheriff's Office (MCSO) policies and procedures adopted or revised to comply with the Judgment.

7. As required by the Fourth Amended Judgment, on September 15, 2015, Defendants filed their Report of Data Collected and Summarized ["Compliance Report"]. Dkt. 2333. On September 25, 2015, Defendants filed their Supplemental Report of Data Collected and Summarized ["Supplemental Report"]. Dkt. 2336.

8. Defendants have not implemented policies and procedures sufficient to meet the requirements of all of the implementing remedies addressing mental health services. Additionally, Defendants' own reported compliance numbers with respect to some of the provisions demonstrate noncompliance on their face. In other instances Defendants have provided no data or other compliance information demonstrating compliance. Defendants' methodologies for calculating compliance rates for many provisions are inadequate or flawed, and have led Defendants to report exaggerated compliance rates that distort the reality of their compliance. Furthermore, Defendants have relied on faulty, inaccurate, and incomplete data in calculating compliance with some of the provisions.

9. Based on my experience assessing this and other correctional health care systems, and in serving as a correctional health care administrator, I believe that a 90% threshold over the six-month reporting period should be the standard Defendants must meet to demonstrate compliance with the Court's implementing remedies.

10. Below, I have set out my findings with respect to each mental health-related implementing provision contained in the Revised Fourth Amended Judgment.

Subparagraph 5(a)(5)

11. Defendants have failed to demonstrate full compliance with Subparagraph 5(a)(5) of the Revised Fourth Amended Judgment, pertaining to mental health intake.

12. In its September 30, 2014, Findings of Fact, this Court identified deficiencies in the processes for the intake screening of prisoners in Defendants' facilities. With respect to mental health screening, the Court concluded that Defendants failed to show that "pretrial detainees who presented with serious mental health needs at intake consistently were timely assessed by a mental health provider to initiate or continue necessary mental health treatment, including continuation of psychotropic medications prescribed before arrest." Dkt. 2283 at 32 ¶ 59. The Court

noted the importance of "timely mental health assessment" in order to determine prisoners' needs and to "begin appropriate treatment." *Id.* at 30 ¶ 50. For the most seriously mentally ill, appropriate treatment begins with an assessment "face-to-face by a mental health provider." *Id.* The Court found that prisoners with positive intake screenings for mental health were not receiving timely access to mental health providers. *Id.* at 30-32. As a result, prisoners were in some instances improperly moved from intake without proper clearance from a mental health provider. *Id.* at 31 ¶ 53. Additionally, some pretrial detainees who were on prescription psychotropic medications before entering the Jail faced interruptions in receiving their medications. *Id.* at 32 ¶ 58.

13. Animated by these findings, Subparagraph 5(a)(5) of the Court's Fourth Amended Judgment ordered that, at intake, prisoners must be timely assessed by mental health staff and timely referred to mental health providers where appropriate. Dkt. 2284 at 3. The provision reads: "If a pretrial detainee has a positive mental health screening or does not respond to all of the mental health screening questions, the detainee will be assessed by mental health staff while . . . in the intake center. The mental health staff will identify the urgency with which the pretrial detainee must be seen by a mental health provider." *Id.*

14. In their Notice of Defendants' Compliance with Revised Fourth Amended Judgment, Defendants set out their updated Standard Operating Procedures, purporting to comply with the requirements of the Revised Fourth Amended Judgment. Dkt. 2304 at 1-2. Defendants' updated procedures set out mental health screening indicators and provide that "[a]ll patients who are nonresponsive or who endorse mental health questions on the receiving screen are seen by mental health staff before leaving the intake center." SOP J-E-05 (Dkt. 2304-1 at 36-37). Intake mental health staff "determines level of acuity and urgency of provider appointment to be scheduled . . . . All patients who endorsed the [mental health] questions, or are

unresponsive are scheduled for a psychiatric provider appointment." *Id.* (Dkt. 2304-1 at 37). Those prisoners triaged as "urgent" must be seen by a provider within 24 hours; those triaged as "priority" must be seen within 72 hours; and those triaged as "routine" do not carry a specified time frame within which they must be seen by a provider. *Id.* The selection of the code is "based on triage and clinical need." *Id.*

15. As required by the Court, Defendants supplied data in their Compliance Report asserting compliance with the mandates of this provision. Dkt. 2333 at 9-10. Following particularly poor compliance rates in March and April, Defendants reported compliance rates of 82% in May; 85% in June; 93% in July; and 98% in August. *Id.* at 10. Two months of compliance rates above 90% in a six month period does not amount to compliance with this provision.

16. Furthermore, Defendants' methodology is flawed. Defendants' TechCare reports list a triage code assigned by mental health staff after positive intake screens, as the policy requires. These listed triage codes do not appear in the medical records I reviewed. I was told by Dr. Noggle, the Jail's mental health director, that there are no triage codes documented as part of the intake process, and that for the TechCare reports CHS determined the triage category by reading the intake records and then deciding post-hoc what urgency had been assigned to the provider appointment. I was informed by CHS staff that there is no designated space on the intake form to note the triage code. Defendants' own admission indicates they are violating Subparagraph 5(a)(5) and their own policies and procedures, which requires mental health staff to assign one of three triage codes for a provider appointment based on clinical need.

17. The Revised Fourth Amended Judgment was entered after finding that this same exact gap existed in Defendants' prior evidence. *See* Dkt. 2283 at 28 ¶ 40 ("Defendants have not shown that as of August 9, 2013, pretrial detainees who presented with serious medical health needs at intake consistently were timely seen

face-to-face by a medical provider."). This problem has not been resolved. Defendants' monthly TechCare reports are incomplete and cannot provide evidence of full compliance with Subparagraph 5(a)(5) of the Revised Fourth Amended Judgment.

18. As the Court found, mental health screenings and initial staff assessments are important precisely because they are a means to ensure that prisoners with serious mental health needs are promptly assessed by a provider to establish a care routine and provide access to psychotropic medications where necessary. In the absence of actual triage codes, the only way to determine if mental health staff has correctly determined per revised policy the urgency with which a patient must be seen by a provider based on clinical need is to determine when that patient was actually seen by a provider.

19. The records I reviewed indicate that, in fact, the TechCare reports list prisoners as being triaged as "urgent" or "emergent," but they are not timely evaluated by a provider under the timeframes established per policy. For example, according to Defendants' TechCare report, Patient FA [redacted] was assessed at intake on May 27, 2015, where her mental health screen was positive, noting prior mental health treatment, medications, and a history of auditory hallucinations. According to Defendants' data, Ms. FA was triaged as "emergent." However, my own record review indicated that a provider did not see her until May 31—after she was found tying a towel around her neck and was transferred to the MHU. While the patient's medical record shows that a psychiatric evaluation for May 28 for mental health medications was scheduled, it was not scheduled as "priority," and the provider appointment never took place. A mental health assessment—not a provider appointment—was scheduled for May 30.

20. Patient CS [redacted] was booked on July 25, 2015 and assessed that day by mental health staff. Defendants' TechCare data shows that she was triaged as "urgent." At intake, she reported taking Paxil and Vistaril for anxiety and depression.

She later told an RN at intake that she was taking Paxil and Vistaril and had a recent psychiatric hospitalization via Mountain Vista. Two days later, she repeated her mental health history to MHP Savage, reported a history of benzodiazepine and heroin use, and she was suffering withdrawal. Despite her "urgent" triage, my own record review revealed that it took five days before she was seen by a provider for her medications to be restarted. By this time, the patient had not been sleeping and was, according to the provider's note, "crying non-stop." There is no reason why this depressed, drug-dependent woman had to wait five days to restart her community medications.

21. Patient CB [redacted] was booked on June 29, 2015 and, according to Defendants' TechCare reports, was triaged "urgent." During intake, the patient reported auditory and visual hallucinations and a history of previous psychotropic medications. This patient had been jailed at MCJ until June 4, 2015, when he was released to Desert Vista for a court-ordered evaluation after he was found incompetent and unrestorable. Given his positive history, recent psychiatric hospitalization, and being actively symptomatic, he should have been assessed by a provider within 24 hours under CHS policy. My record review shows that his first psychiatric provider appointment took place on July 1, beyond the 24-hour time period specified in Defendants' policies.

22. Patient JP [redacted] was booked on July 31, 2015. His suicide risk assessment was performed by MHA Merrell, who noted that the patient was currently community enrolled as a seriously mentally ill (SMI) patient, had been recently hospitalized at Desert Vista, and reported Risperdal as his current medication. The MHA scheduled a psychiatric evaluation for three days later, on August 3. Defendants' TechCare data indicates that the patient was triaged "urgent," which under CHS policy would have required a 24-hour provider appointment. However, the only triage code listed in his record is "priority," under the sick call tab in the patient's

suicide risk assessment form. Given the patient's presentation at intake, Patient JP should have been triaged as "urgent" and a provider exam scheduled within 24 hours.

23. Patient NG [redacted] was booked on July 16, 2015. Her screening noted that she was actively being treated with Lithium ER through Partners in Recovery. Her Partners in Recovery record listed a diagnosis of bipolar disorder. According to Defendants' TechCare data, she was triaged "emergent." MHA Merrell saw Ms. NG at intake after the patient became upset when asked to put on her jail uniform. MHA Merrell reported that the patient was SMI and had already been scheduled for a provider assessment. but, there was no documented provider appointment in her record. During the patient's H&P the following day, she reported a one-week hospitalization at Desert Vista for suicidal thoughts. The patient was seen by a provider on July 20. It should not have taken four days for this patient, who had a documented mental health history in the community, to be seen by a provider and continued on her medications.

24. Several patients are absent from Defendants' data. For example, Patient RO [redacted] was booked on July 3, 2015. During booking, he made bizarre statements, such as claiming he had been bitten by a rattlesnake. He was noted as having rapid, unpredictable movements. Mental health staff saw the patient during intake, during which he mentioned People of Color Network—a community-based county mental health provider. His record does not note a provider referral or provide an urgency code for a referral. Under CHS policy, he should have been triaged urgent and seen by a provider within 24 hours. The patient was moved to the MHU the following day. Despite this, he does not appear in Defendants' report for July 2015.

25. Patient TS [redacted] was booked on May 14, 2015. During a suicide risk assessment by a MHA that day, he reportedly stared straight ahead and was only minimally participatory in the interview. He made bizarre statements and reported previous mental health treatment. The MHA noted that Mr. TS would be placed in

isolation and re-assessed after court. The MHA did not provide an urgency code for a provider assessment. The patient's record also includes scanned records from his community provider (Southwest Network) noting current medication of Risperdal Consta 50 mg IM and a diagnosis of reactive psychosis. This medication was not renewed at the Jail. He was moved to the MHU the following day. Under CHS policy, this patient should have been triaged as urgent and seen by a provider within 24 hours. He was not seen by a provider within 24 hours. The patient is not included in Defendants' data.

26. Patient AW [redacted] was booked on May 9, 2015, and was assessed by mental health staff. Her intake screen was positive for mental health, noting a diagnosis of schizophrenia. Defendants' TechCare data indicates that she was triaged "emergent." Her record, however, shows no urgency code noted for a provider appointment following her suicide risk assessment by MHP Ochoa Smith. The MHP noted that the patient was inappropriate, rambling and delusional. The MHP entered an order for an appointment by mental health staff, but no provider appointment. The following day, RN Viadoy saw Ms. AW, who reported a February 2015 suicide attempt and was bizarre and delusional on exam. She was moved to the MHU that day. Her first provider assessment was in the MHU on May 11. Based on her presentation at intake, she should have been triaged urgent and seen by a provider within 24 hours under CHS policy. This did not happen.

27. In all, I reviewed 47 health care records. Of those, 28 patients had bookings and intake assessments during the six-month reporting window, and 22 of those patients indicated positive mental health screenings according to the criteria listed in the remedial provision and CHS policy. None of the 22 records is compliant with Provision 5(a)(5), as none of them noted an urgency code for a provider appointment following a positive intake screen. I found additional areas of non-compliance with the remedy in 9 (41%) of the records I reviewed, as described above.

Subparagraph 5(a)(6)

28. Subparagraph 5(a)(6) requires the following: "If the receiving screening indicates a pretrial detainee is at risk for suicide, a psychiatrist, psychiatric nurse practitioner, or physician assistant will conduct a face-to-face assessment of the pretrial detainee within 24 hours after the receiving screening." Dkt. 2299 at 3.

29. The Court entered this remedial provision after finding that Defendants were not adequately identifying and treating individuals at risk for suicide. In its Findings of Fact and Conclusions of Law, the Court stated, "[N]o quality improvement study or other evidence shows that as of August 9, 2013, pretrial detainees who required psychiatric stabilization or were identified as being at risk for suicide during the intake process consistently were timely transferred to the MHU." Dkt. 2283 at 31 ¶ 54. Compliance with Subparagraph 5(a)(6) is essential to prevent subjecting pretrial detainees to conditions that pose a substantial risk of exacerbation of mental illness, decompensation, or suicide. *See id.* at 51 ¶ 199, 52 ¶ 206 (noting multiple suicides at the Jail since 2009 and pointing out that most suicides occur within the first 48 hours of incarceration).

30. In response to the Court's findings and the mandate of Subparagraph 5(a)(6), Defendants updated their Standard Operating Procedures to require that all patients at risk for suicide be placed on suicide watch and receive a face-to-face provider assessment within 24 hours. *See* SOP J-G-05 (Dkt. 2304-1 at 47-48); SOP J-E-05 (Dkt. 2304-1 at 55). Individuals will be scheduled for an "'urgent 24 hour provider appointment'" and will be "seen at intake center or at next housing facility." SOP J-G-05 (Dkt. 2304-1 at 48).

31. As they described in their Compliance Report, Defendants calculated compliance with this provision by determining whether each prisoner identified at intake as a suicide risk and placed on suicide watch was assessed by a provider within 24 hours. Dkt. 2333 at 11-12. Entries were marked compliant where either the

prisoner was seen by a provider within the 24-hour window or the prisoner was released from custody within the first 24 hours. *Id.* at 12.

32. Defendants' methodology is flawed. Patients released within 24 hours should not have been included in the percentage calculation. Subparagraph 5(a)(6) is concerned with provider contact occurring within twenty-four hours and is not concerned with patients who were released early and therefore were not required to see a provider. Adding to the calculation patients who were released early has no methodological substance and functions only to mask the true rate of compliance. These prisoners should have been removed from the data.

33. In their Supplemental Report, Defendants reported improved rates of compliance. *See* Dkt. 2336 at 3. They reported compliance rates of 98.7% in June, 99.5% in July, and 98.9% in August. *Id.* However, they arrived at these new rates by reviewing the records for only the noncompliant entries. *See id.* Defendants corrected the "inaccurately" marked noncompliant entries, but they failed to audit the compliant entries for inaccuracies or other errors. This unbalanced review process could distort Defendants' compliance data.

34. Finally, a comparison against my own record review showed inaccuracies in Defendants' data. My record reviews found that some patients were placed on suicide watch at intake, but were missing from Defendants' data. For example, according to my own record review, Patient HB [redacted] was booked on April 11, 2015 and, following a positive mental health screening and suicide assessment by mental health staff, she was placed on suicide watch. She was taken off suicide watch the following day. This patient is absent from Defendants' underlying data. Patient DC [redacted] was booked on March 27, 2015. According to my record review, he was placed in an isolation cell from intake. The suicide watch flow sheets indicate that he was placed on suicide watch beginning March 27 at 1930 hrs. This patient is not included in Defendants' TechCare report for March 2015. From my

review of an April 23, 2015 suicide risk assessment, it appears that Patient KD [redacted] was placed on suicide watch after she refused to dress out at intake and expressed delusional beliefs. She was seen the following day by a provider and suicide watch was discontinued. Even these instances of compliance with the requirements of Subparagraph 5(a)(6) was not reported in Defendants' TechCare data. Finally, Defendants' data indicates that Patient JA [redacted] had an August 26, 2015 intake, during which he was placed on suicide watch; in my own review of the patient's records, I found no indication that he was placed on suicide watch or otherwise identified as a suicide risk on or around that date. His record contained no speed letters, suicide watch flow sheets, or orders indicating such.

35. I also found one instance in which a patient should have been identified as a suicide risk but was not, in violation of Defendants' own policies and procedures. Patient DO [redacted]'s records showed his history of suicide attempts in custody, including prior suicide attempts by cutting, choking, and overdose. He was minimally responsive and mumbling during his suicide risk assessment, and a previous diagnosis of schizophrenia was noted. Despite his extensive history and presentation during the assessment, the patient was deemed stable for closed custody status. There is no indication in the patient's record that a provider referral was made, and no triage code was noted. Though the assessment form notes an appointment date for a psychiatric evaluation on March 3, he was not seen by a provider until March 6.

36. I reviewed 47 patient records altogether; 28 of the patients were booked and had receiving screenings during the six-month assessment period. I found 2 patients who were noncompliant with this provision. As described above, I also identified several discrepancies with Defendants' TechCare data.

Subparagraph 5(a)(14)

37. Subparagraph 5(a)(14) pertains to the Health Needs Request (HNR) process.

38. The Court's September 2014 Findings of Fact identified deficiencies in Defendants' provision of mental health care with respect to HNRs. *See* Dkt. 2283 at 48 ¶ 175. It found that Defendants "have not shown that pretrial detainees who submit mental health Health Needs Requests stating clinical symptoms are assessed face-to-face by mental health staff within 48 hours." *Id.*

39. The Revised Fourth Amended Judgment required Defendants to update their policies and procedures with respect to HNRs. Subparagraph 5(a)(14) requires that "[a]ll mental health Health Needs Requests stating or indicating a clinical symptom will be triaged face-to-face within 48 hours of their submission." Dkt. 2299 at 4.

40. Following the mandates of the Fourth Amended Judgment, Defendants revised their HNR policies and procedures to track the required language. Defendants' revised HNR procedure requires that mental health staff provide face-to-face triage for mental health HNRs stating a clinical symptom "within 48 hours of receipt" or, for HNRs indicating an acute, critical need, "as soon as possible." SOP J-E-07 (Dkt. 2304-1 at 97). For patients triaged as having an "urgent psychiatric need," a "24 hour face-to-face psychiatric provider sick call appointment" must be scheduled. *Id.* For non-urgent needs, appointments may be scheduled with mental health staff or psychiatric providers. *Id.*

41. Defendants' underlying data for each month indicated the total number of prisoners who submitted HNRs stating a mental health symptom. Dkt. 2333 at 22-23. Defendants derived rates of compliance for each month based on whether prisoners who submitted HNRs stating a clinical symptom were seen face-to-face by mental health staff within 48 hours. *Id.* Defendants reported compliance rates of 82% in March, 94% in April, 96% in May, 94% in June, 95% in July, and 94% in August.

42. Although pretrial detainees who submit HNRs stating clinical symptoms may be seen face-to-face by mental health staff within 48 hours, it is unclear from the

data provided that an actual assessment took place. Relatedly, Defendants' data does not capture whether those prisoners triaged as "having urgent psychiatric need," thus requiring under CHS policy an assessment by a provider within 24 hours, actually received such assessment. Instead, the data indicates only whether some face-to-face contact with mental health staff occurred. Triage of prisoners stating clinical symptoms in their HNRs is a means to meaningful provider access; it is not the end. In her February 2014 Report, Dr. Kathryn Burns noted the importance of such data: "Timeliness of triage response time is routinely audited/monitored at all jail sites and discussed at clinic quality improvement meetings. . . . However, other key aspects such as assignment of the appropriate triage code, assignment to appropriate staff for follow-up, whether follow-up is consistent with the assigned urgency code and whether the follow-up is clinically appropriate must also be included in the QI study process in order to begin to address quality of care . . . ." Dkt. 2215-1, Eleventh Report of Kathryn Burns, MD, MPH, on Correctional Health Services Compliance With Third Amended Judgment ["Eleventh Report"] at 7. A report detailing the summary and collection of data on the disposition of the HNR, including the type and triage category of follow-up referral , triage category for referral (emergent, urgent, routine), and date referral completed would more accurately reflect Defendants' compliance rates for Subparagraph 5(a)(14) and with their revised policies and procedures.

43. Additionally, because Defendants did not submit underlying data specific to individuals stating clinical symptoms in their HNRs, it is not possible to evaluate Defendants' data for accuracy as compared with my own record reviews.

44. My own review of patient records identified several violations of Subparagraph 5(a)(14). Several patients were not timely assessed face-to-face by mental health staff, as required by the provision. Patient VW [redacted] filed an HNR on June 11, 2015, requesting to speak to a doctor about going to a psychiatrist. In his

HNR, he wrote, "I find myself feeling worked up and struggling a bit to keep aggression down. There is something about this place that pulls me to the tail rather than the head." It appears that he was never assessed face-to-face following this submission. He received a written response to his HNR from MHP Martinez, stating, "This is not what psych is for. You can ask for PC if you are afraid for your safety . . . ." A corresponding note from MHP Martinez indicated that the response was the extent of follow-up from the patient's HNR. Patient GL [redacted] filed an HNR on July 10, 2015, from Estrella B Tower, stating that she wanted her medication dosage increased in order to get rest and relief from the anxiety and distress she had been experiencing. She was not seen by mental health staff for three days. Patient MG [redacted] filed an HNR on June 30, 2015, in which he made multiple delusional statements and claimed his life was at risk. He was seen on July 3 by RN Kiss at his cell. He was not seen by or referred to mental health staff. Patient SB [redacted] filed an HNR on July 13, in which she reported worsening hair loss and tremors as a result of the medication she had been prescribed. According to her record, as of July 28, there had been no response to her HNR and no appointment made to address her complaint.

45. I also identified one patient who submitted HNRs stating a mental health symptom and was timely seen face-to-face by mental health staff, but received inadequate assessments from mental health staff. Poor management and prioritization of follow-up appointments and referrals results from this practice, and symptomatic patients are further delayed in receiving adequate care or provider assessments.

46. Patient SB [redacted] was booked on February 26, 2015. She had a positive mental health screening, during which her history of anxiety and current prescription for anxiety medications were noted. Ms. SB filed an HNR on March 15, 2015, asking for medication for her anxiety. She was seen briefly by MHP Otero-Smith but was not referred to a provider. She filed another HNR on March 17, stating

the same request. She was seen by MHP Bly and reported worsening symptoms. She was told that she needed to wait until her next scheduled appointment to get her medication. She was not seen by a provider until March 23.

47. Among the 47 patient records I reviewed, there were 12 relevant mental health HNRs. Of those, 6, or 50%, were noncompliant with the requirements of Subparagraph 5(a)(14).

Subparagraph 5(a)(15)

48. The Court identified deficiencies with respect to Defendants' mental health referral process in its 2014 Findings of Fact and Conclusions of Law. It found that Defendants "have not shown that a mental health provider timely assesses face-to-face each pretrial detainee with a mental health condition identified as urgent by detention, intake, medical, or mental health staff." Dkt. 2283 at 48 ¶ 174.

49. Subparagraph 5(a)(15) of the Revised Fourth Amended Judgment requires Defendants to implement the following: "Upon referral by detention, intake, medical, or mental health staff, pretrial detainees who display active symptoms of mental illness or otherwise demonstrate an emergent mental health need will be seen face-to-face by a mental health provider within 24 hours of the referral." Dkt. 2299 at 4.

50. Defendants' revised procedures provide that, following a referral from detention, intake, medical, or mental health, mental health staff will evaluate the patient to determine whether an appointment with a provider or other mental health follow-up is needed. SOP J-E-07 (Dkt. 2304-1 at 106-07); *see also* SOP J-E-05 (Dkt. 2304-1 at 101-02). If staff determine that "the mental health condition is emergent," then they will "schedule a face-to-face psychiatric provider appointment within 24 hours." *Id.*

51. Defendants calculated compliance by evaluating whether those prisoners referred to CHS "as displaying active symptoms of mental illness or demonstrating an

emergent mental health need" were seen by a provider within 24 hours of the referral. Dkt. 2333 at 24. Defendants reported poor compliance rates in their initial Compliance Report, at just 69% in March, 45% in April, 50% in May, 72% in June, 74% in July, and 75% in August. Dkt. 2333 at 25. After auditing their noncompliant entries, Defendants reported improved compliance rates of 94% for June, 95% for July, and 96% for August. Dkt. 2336 at 7. However, as discussed *supra* with respect to Subparagraph 5(a)(6), Defendants' audit process consisted of reviewing only the "noncompliant" TechCare entries. *See id.* at 6. By reviewing only the noncompliant entries for errors—including "data entry errors"—Defendants may have produced skewed results. *Id.* at 7.

52. I reviewed the electronic medical charts for a selection of the patients whose referrals were originally listed as noncompliant in the TechCare reports and then changed to compliant or removed from the data in Defendants' audit process, according to Defendants' Supplemental Report. *See* Doc. 2336 at 5-7. Defendants provided a list of 19 entries that they removed from the TechCare data in calculating their revised compliance rates because the patient did not demonstrate a mental health need under Subparagraph 5(a)(15). *Id.* at 6. In my review of 13 of these entries, I found that 4 of the 13 patients did, in fact, display symptoms that required a provider assessment. In all 4 cases, the patient was either not referred to a provider or was not seen within 24 hours, as the provision requires. These entries were noncompliant and should not have been removed from the data in Defendants' revised compliance calculations. Defendants also provided a list of 6 entries erroneously marked noncompliant because of data entry errors. In my review of the patient charts corresponding to each entry, I found one case in which, despite a data entry error, the patient still was not seen by a provider within 24 hours and was properly marked noncompliant. Defendants' audit process was flawed.

53. Furthermore, Defendants counted as compliant entries in their revised compliance rates those prisoners who were released within 24 hours. *Id.* at 5. Those entries should have been removed from the data population altogether, rather than added to the "compliant" entries; prisoners who were released prior to the referral are not pertinent to an assessment of whether the referrals are actually taking place within the time frame delimited.

54. A comparison against information gathered during my own record reviews revealed discrepancies with Defendants' data and numerous instances of noncompliance with the requirements of the provision. According to Defendants' Supplemental Report, the underlying data provided by Defendants should include every referral from detention to mental health staff, whether or not the prisoner was triaged for a provider assessment. Dkt. 2336 at 6 ("The TechCare reports generated included every referral in the data population, including those that were deemed to not qualify under subparagraph 5(a)(15) upon assessment by mental health staff."). However, in my own review of patient records, I identified a number of patients whose multiple referrals from detention officers to mental health staff do not appear in Defendants' data. These include multiple instances where the prisoner displayed active symptoms of mental illness that should have triggered a timely provider assessment, as well as instances in which the prisoner was triaged for a provider assessment. In compiling the mental health referrals, Defendants looked only to documented correspondence between MCSO and CHS; thus, referrals documented by notes from mental health staff alone were not included in their data. This methodological flaw helps explain why many relevant referrals were not captured in Defendants' data.

55. I identified a number of cases in which referrals were simply left off Defendants' data.

56. Patient FA [redacted] was referred by detention officers on June 24 and 25, 2015 for racing thoughts, hearing voices, and increased anxiety. A review of her medical record shows she had been refusing her Zyprexa in the week before these referrals. The patient saw MHA Goodroad, and told her that the voices were telling her she is useless and that she had stopped taking her medications for Ramadan. Though the MHA noted that she would talk to a provider about changing the patient's medication distribution, there was no documented consult, and the patient was not referred to a provider.

57. Patient AW [redacted] does not appear in Defendants' data, despite her multiple referrals from detention officers to mental health staff—referrals that took place on May 15, June 7, June 16, July 11, and July 20, 2015. On June 7, a referral was made by Detention after the patient was observed exhibiting odd behavior in Estrella D Tower. MHP Griemsmann saw her cell-side and reported that her cell was malodorous and she appeared to have toothpaste in her hair. The patient reported being nude in the cell the previous night. She was not referred to a provider. On June 16, the patient was again referred from Detention for making statements that she was a danger to others. She reported having auditory hallucinations and had cut off her hair because the voices were speaking through it. She requested an increase in her medications. MHP Lewis did not refer the patient to a psychiatric provider. The other referrals came after the patient expressed concern that she would have a bad reaction and hurt someone in her unit or herself or otherwise presented a danger to herself or others. She was only timely seen by a provider after the July 20 referral. Given her presentation, she should have been referred to a provider following the other detention referrals.

58. Patient LL [redacted] was referred from detention officers on April 23, 2015 after she reportedly told Sgt. Means that she was "psycho"; she was not seen by any mental health staff until May 3. The patient is not included in Defendants' data.

59. Patient FO [redacted] was referred from MCSO on May 21, 2015, following his bizarre behavior, and May 31, after he was observed trying to leave his unit, appeared fearful, and refused to speak with any officers; neither referral is included in the TechCare data. Following the May 31 referral, he was seen by MHA Herrera, who noted that he seemed internally preoccupied. Despite being symptomatic, he was not referred to a provider.

60. Patient PW [redacted] was referred from MCSO on June 24, 2015 for problems with his cellmate and chronic masturbation; he was seen by MHA Frey, who wrote that the patient was disorganized, and reported suffering from auditory hallucinations. Despite being symptomatic, he was not referred to a provider. This patient does not appear in the TechCare data.

61. Patient CB [redacted] was seen by mental health staff on March 27, 2015, following a referral from Medical after she was reportedly screaming and had stated she was hearing voices. On exam by mental health staff, she was manic and reported auditory hallucinations. She was again seen on April 14 following a referral from Detention for auditory hallucinations. On exam by mental health staff, she was crying and agitated, and asked for a change in her medications. She was referred by detention again on May 19 for making bizarre statements. On exam by mental health staff she was "psychotic and her auditory hallucinations are causing her to worry." Despite being symptomatic, she was not referred to a provider after any of these detention referrals. None of these referrals is included in Defendants' data.

62. Patient BI [redacted] was referred from detention staff on June 17, 2015, after he was observed acting strangely and talking to himself; he was not seen. He was referred again the following day by another officer for "making statements that do not make sense and that other inmates have told [the officer] that the patient scares them." The patient was seen by a provider on June 19, more than 24 hours after the initial

referral from detention. Despite this, the referral is marked as "compliant" in Defendants' data, which reports the referral date as June 18.

63. Provision 5(a)(15) requires Defendants to ensure that mental health staff (MHAs and MHPs) refer to a provider within 24 hours patients "who display[s] active symptoms of mental illness or otherwise demonstrate[s] an emergent mental health need." As with Subparagraph 5(a)(14), the driving force behind this provision is the importance of timely assessments of symptomatic prisoners by psychiatric providers. As the Court recognized, "[e]valuating a pretrial detainee's mental health condition, developing or modifying the pretrial detainee's treatment plan, and deciding when a pretrial detainee should be placed in or discharged from a specific facility to obtain appropriate mental health care must be performed by a mental health provider after the provider has assessed the pretrial detainee face-to-face in space that at least provides sound privacy." Doc. 2283 at 47.

64. My record reviews have revealed case after case of seriously mentally ill detainees who displayed active symptoms of mental illness or otherwise displayed an emergent mental health need to mental health staff and were not referred to providers, in violation of both CHS policy and the Court's remedy.

65. Patient FA [redacted] had a positive intake screen and was transferred to the MHU within days of her booking. While in the MHU, she was seen by Dr. Worthen and was noted as possibly delusional, with a diagnosis of unspecified psychosis. Following her discharge from the MHU on June 5, 2015, the patient was referred to mental health staff by detention officers on multiple occasions. On June 5, she was seen by MHP Otero as a follow-up to her MHU discharge. On exam, she was pacing her cell and asking to see a provider because the voices were bothering her. She also reported that at times her hallucinations were command hallucinations, but not that day. Despite being symptomatic, she was not seen by a provider. Two days later, she was referred after she made danger-to-self (DTS) statements. Despite the

patient's reports that she was hearing voices, that the voices were telling her to harm herself, and that her isolation in Estrella lockdown was making her symptoms worse, the MHP who saw the patient did not refer her to a provider. She was transferred back to the MHU six days later after detention staff observed cuts on her neck and arms and referred her to mental health. On exam, she complained that the voices were telling her to harm herself and complained that she needed more medication. During her June 5-13 stay in Estrella segregation, the patient was not seen by a psychiatric provider. This pattern repeated itself following the patient's second release from the MHU. Between June 15 and June 29, while the patient was in Estrella segregation, detention officers made multiple referrals following reports that the patient was hearing voices. Until her return to the MHU on June 29, after she was found in her cell with cuts on her neck and arms from razor blades, the patient was not once referred to a psychiatric provider. Her encounters with mental health staff during that time were not meaningful, and though she was symptomatic and in need of a provider assessment, she was not referred to a provider per CHS policy and the Court's remedy.

66. Over the course of two months, Patient MG [redacted] was seen several times by MHAs and MHPs, during which he displayed serious symptoms. At no point was a psychiatric referral ordered. On June 10, 2015, when he was seen by MHA Uribe, the patient reportedly stated, "'I hear SRT under the floor, they cut off my phone and shine a red dot laser at me. They are using gas to try to poison me.'" On June 26, when he was seen by MHP Dykstra, the patient stated he had electronic devices implanted on him when he was young, and stated that once they are taken out, he will be "'ripped.'" MHP Dykstra characterized the patient as hyper-verbal and difficult to redirect. He spoke non-stop under his breath at times. MHP Dykstra wrote, "r/o malingering vs internal preoccupation and delusional thought content." On July 27, MHA Uribe saw patient MG, who was malodorous and complained about equipment and a baby monitor being installed in his head. He was not referred to a

provider. From May 11 to August 4, 2015, Mr. MG was not referred to or seen by a provider, despite being symptomatic, and clearly in need of more intensive treatment.

67. Patient DG [redacted] was seen by a MHA on May 19, 2015, following a request from a detention officer. She had been observed talking to herself and claimed she was being illegally held. Though the MHA's report noted that she was already scheduled for a health assessment, the patient did not receive one until twelve days later. This referral does not appear in the TechCare data. She was again referred by Detention on May 28 for talking to herself and acting bizarre. The MHP wrote in a note that the patient would be seen "in the coming week" for a mental health assessment. There is no mention of a provider referral. Subsequently, on May 31, she was seen by an MHP following another referral from a detention officer who reported that she was talking to herself. Although the patient denied having any auditory or visual hallucinations and denied having any mental health history, the MHP assessed that "patient does not appear to be fully in touch with reality. Pt appears to be experiencing symptoms of psychosis. Paranoid persecutory appears to respond to internal stimuli." Although the patient was referred to a psychiatric provider, it was five days before she was seen, and this exam only occurred after detention again referred the patient for yelling in her unit. This referral is also not in the TechCare data. On July 21, MHP Griemsmann was unable to fully assess Ms. DG because she told the MHP to get away from her cell door. MHP Griemsmann noted that she was responding to internal stimuli; she was still speaking to herself in her cell. She was uncooperative and easily agitated, and she continued to refuse mental health services. The patient was not referred to a provider.

68. Finally, the care of Patient FO [redacted] is emblematic of the deficiencies in the referral process from mental health staff to a provider. The patient remained very psychotic and disabled, deteriorating in the SMU when he should have been admitted for inpatient treatment. From the time that the patient was admitted on

May 19, 2015, he was intermittently seen by MHAs and MHPs following referrals for his bizarre behavior. During exams, he was often non-verbal; he refused to cooperate; appeared guarded, mistrustful, and internally preoccupied; and did not engage. Despite his repeated presentation as mentally ill and in need of treatment, the patient was not referred to a provider until August 20. In one subsequent instance, in October 2015, the patient became verbal and made delusional statements, including: "'you pay for this food right? I know it is from your school.' 'I'm not supposed to be on this side of the complex, this is the women's side.' 'Is the man across the hall an FBI agent?'" The patient was not referred to a provider. The patient was found incompetent and unrestorable on October 13, 2015. Ultimately, during his assessments by several different MHAs on May 21, May 27, May 31, and July 10, 2015, the patient was never appropriately referred to a provider for further assessment. All of these MHAs noted that the patient was psychotic, yet none of them referred him to a provider. Provision 5(a)(15) seeks to ensure a timely provider assessment whenever patients like Mr. FO "display active symptoms of mental illness or otherwise demonstrate an emergent mental health need." Doc. 2299 at 4.

69. I identified noncompliance among the following additional patient records: CB [redacted]; DC [redacted]; RG [redacted]; SH [redacted]; DO [redacted]; JP [redacted]; NF [redacted], HB [redacted]; AG [redacted]; PW [redacted]; TW [redacted]; and DY [redacted].

70. In all, 32 of the 47 records I reviewed were relevant to this provision. Of those, 21, or 66%, were noncompliant for the reasons discussed above. Many of the records show a pattern of repeated failures by mental health staff to abide by the remedy or CHS policy to timely refer symptomatic patients to a provider. Additionally, as discussed, many of these records were not included in Defendants' TechCare reports.

Subparagraph 5(a)(16)

71. Subparagraph 5(a)(16) requires that "[m]ental health providers will assess pretrial detainees in an area outside of their cells that affords sound privacy except when there are legitimate safety, security, and treatment reasons for not doing so." Dkt. 2299 at 4.

72. Defendants revised their policies and procedures to require that MHU psychiatric providers, on evaluation of patients following MHU admission or for transfer or discharge, "see patients 'in a confidential setting outside of their cell . . . unless there is a safety, security or treatment reason for not doing so, which is documented.'" Dkt. 2333 at 25; *see also* SOP J-G-04 (Dkt. 2304-1 at 124-25). Defendants further revised their procedures on psychotropic medication management to require that psychiatric evaluations be conducted as specified in Subparagraph 5(a)(16). Dkt. 2333 at 25; *see also* SOP J-G-01-01 (Dkt. 2304-1 at 133). Defendants asserted compliance rates of 89% in March, 100% in April, 99% in May, 89% in June, 99.5% in July, and 96% in August. Dkt. 2333 at 26.

73. The clear language of Subparagraph 5(a)(16) and the Court's 2014 findings require all mental health provider assessments to be conducted in a setting that affords confidentiality, regardless of the reason for the encounter. *See* Dkt. 2299 at 4 ("Mental health providers will assess pretrial detainees in an area outside of their cells that affords sound privacy except when there are legitimate safety, security, and treatment reasons for not doing so."); Dkt. 2283 at 47 ¶ 168 ("Evaluating a pretrial detainee's mental health condition, developing or modifying the pretrial detainee's treatment plan, and deciding when a pretrial detainee should be placed in or discharged from a specific facility to obtain appropriate mental health care must be performed by a mental health provider after the provider has assessed the pretrial detainee face-to-face in space that at least provides sound privacy.").

74. The two updated operating procedures cited by Defendants in their Compliance Report (SOP J-G-04 and SOP J-G-01-01) are limited to a narrow category

of assessments: those conducted by psychiatric providers in the MHU the next day after admission and before a transfer or discharge determination, and those conducted for the purposes of psychotropic medication management. *See* Dkt. 2333 at 25; SOP J-G-04 (describing the private assessment requirement for MHU psychiatric providers evaluating patients in the MHU, on admission, transfer, or discharge); SOP J-G-01-01 (describing the private assessment requirement for psychiatric evaluations in the context of psychotropic medication administration and management). Defendants, however, calculate their compliance rate based on all mental health provider assessments, and not solely the limited categories specified in their revised procedures.

75. Defendants' asserted compliance rates do not accurately capture their true level of compliance. For June through August 2015, Defendants generated TechCare reports for all prisoners who were seen by a mental health provider, showing whether they were assessed privately or cell-side in each assessment. Dkt. 2333 at 25. For those not seen privately, the data indicates whether there was a reason for the cell-side assessment—"Safety Concerns," "Security Concerns," "Treatment Reasons," "Patient Refusal," or "Patient Unavailable"—based on Defendants' chart audits. *Id.* at 25-26. Defendants counted an assessment as "noncompliant" only where the assessment was conducted in a non-private space and none of the five reasons was entered. *Id.* at 26.

76. Despite Defendants' asserted compliance, then, many patients are still being seen in conditions that do not afford sound privacy. From its collected data, Defendants could have reported the total percentage of non-confidential assessments for the Court's evaluation; instead, they filtered out those non-confidential assessments still deemed "compliant" because a "legitimate reason" was documented. The non-confidential assessments constituted a significant portion of all compliant entries; for example, by my own assessment, in August 2015, almost 30% of all provider assessments were conducted in a non-private area. Thus, Defendants' asserted

compliance rate—close to 100% for some months—depends to a substantial degree on the assessments performed in a non-confidential area due to a claimed "legitimate reason." It is not possible to assess Defendants' true compliance without investigating the validity of those reasons provided. Actual compliance with Subparagraph 5(a)(16) depends on how Defendants' defined a "safety," "security," or "treatment" concern, and whether their definitions constitute a "legitimate reason" for denying a private assessment.

77. Patient records routinely indicate cell-side, non-private provider assessments. The corresponding notes for the assessment should indicate a reason why there was no confidential assessment. However, in many cases, in my review, the record included only the term "safety reasons," "security reasons," or "treatment reasons," which evidently had been chosen by the provider from a drop-down menu that is part of the electronic medical record. In these instances, the provider's note should indicate the nature of the reason for the cell-side assessment. For example, a provider may indicate that a patient was too agitated to be removed, necessitating a cell-side assessment. Routinely in the patient records I reviewed, however, the accompanying provider notes give no explanation of the actual safety, security, or treatment issue that necessitated the non-private cell-side visit. Or, in some instances, the notes provided undercut the reason selected. Where they appear in Defendants' TechCare data, such entries are still deemed "compliant," even though the patients' records suggest there was no legitimate reason backing the reason selected.

78. For example, Patient FA [redacted] was seen by Dr. Drapeau on August 3, 2015, face-to-face in an area that was not private. Although the drop-down box noted "treatment reasons" for the lack of a private visit, there is no explanation in the provider note as to what those treatment reasons were. There is no indication from the note that the patient could not be managed in a private space; in fact, on exam, the patient was noted as neat, calm, and oriented. No behavioral problems were noted.

Similarly, Patient JB [redacted] was seen cell-side on June 29, 2015, due to "treatment reasons," as selected from the drop-down box. However, there are no treatment reasons described in the provider's note. In fact, the note describes that the patient presented with no apparent distress and was indifferent.

79. Patient RB [redacted] was seen cell-side on May 15, 2015 "due to being on security over-ride;" however, no explanation of the override is given in his record. Patient GL [redacted] was seen cell-side on August 3, 2015 due to an unexplained "security override"; the entry is marked "compliant" in Defendants' data. The patient was again seen cell-side on August 10; "safety concerns" was selected from the drop-down menu. However, there are no documented safety concerns in the provider's note, which, to the contrary, reported that the patient was "pleasant and cooperative," less paranoid and delusional, and was no longer yelling out all day. The entry is marked "compliant" in Defendants' data. Patient LL [redacted] was seen on August 22, 2015 cell-side for "security reasons"; however, no reasons were explained in the provider's note. The note stated, "no threatening behavior now." The entry is marked "compliant" in Defendants' data.

80. Patient JF [redacted] was seen cell-side on June 29, 2015 due to "treatment reasons." According to the provider's note, the patient was sleeping and the provider "did not want to disturb him" while he was resting. The patient was seen cell-side on July 4, again for "treatment reasons"; however, the provider's note indicated no clinical reason as to why no private assessment was offered. The note stated that the patient did not appear distressed, was "more appropriate," and was "much more respectful" than he had been. Again, both entries were deemed compliant.

81. Patient RO [redacted] was seen cell-side on August 10, 2015; "safety concerns" was selected as the reason for the lack of a confidential space. The provider's note did not document any safety concerns. There was no indication that

the patient was offered a private area. The provider's note further reported that the patient was interrupting the provider, who was trying to talk to another patient. Patient MM [redacted] was seen cell-side by a provider on August 21, 2015; though noted as "treatment reasons," there is no explanation as to what the treatment reasons were.

82. Patient AW [redacted] was seen cell-side by a provider on July 12. Though Defendants' TechCare data reports this assessment as "compliant" based on "safety concerns," the patient's underlying record and provider note from that day shows that no reason was selected from the drop-down menu. The provider's entire note reads, "[R]esting quietly. Seen at cell side. Chart reviewed." There is nothing in the note indicating a safety concern.

83. Patient DC [redacted] was seen cell-front by a provider on July 12, July 13, July 17, and August 2, 2015; there is no indication in the patient's record or the provider's notes from the assessments as to why the patient was not seen privately. The entries are deemed "compliant" in Defendants' TechCare data, citing "security," "safety," or "treatment" reasons, with the exception of the August 2 assessment, which is missing from the data. Additionally, this patient was assessed cell-side on July 25 and August 1; the provider notes for these visits indicate "provider's time constraints" as the reason for not assessing the patient privately. These entries are deemed "compliant" in Defendants' data, with "treatment reasons" listed as the explanation.

84. Patient JW [redacted] was frequently seen cell-side. On June 22, 2015 the patient was seen at his cell; he was never offered a confidential room, and—despite the TechCare entry indicating "security concerns"—there is no indication in his record or in the corresponding provider note of a security override. On July 6, the patient was seen cell-side. The entry is marked "compliant" in Defendants' data, due to "security concerns." However, again, the patient was not offered a confidential room, and there is no indication in the patient's record that MCSO had a security override in place. The failure of the provider to offer a confidential room is particularly notable because,

the following week, the patient accepted a confidential room for assessment when it was offered to him. The patient's August 15 provider assessment was also cell-side, with no indication in his record as to whether a confidential room was offered.

85. Patient JA [redacted] was also frequently seen cell-side. Assessments on April 3 and July 31, 2015 were conducted cell-side due to "provider's time constraints," according to the provider notes for those dates. On Defendants' TechCare report, the July 31 assessment is deemed "compliant" for "treatment reasons." An August 3 cell-side assessment indicated "treatment reasons" from the drop-down menu; however, the provider's note contained no explanation as to the treatment reasons that necessitated the lack of a confidential visit. Another provider assessment, on May 15, occurred cell-side because it took place during a detention shift change. Cell-side assessments on March 27 and May 2 did not include any explanation for the lack of a confidential space.

86. Patient DO [redacted] was seen cell-side on multiple occasions from March through May 2015 due to detention shift change or, alternately, because of "provider's time constraints b/c of this provider's pt volume." The patient was also seen cell-side on June 20 due to "security concerns"; however, nothing in the provider's note indicates any actual security concerns or indicates that the patient was offered a confidential visit. Similarly, on July 13, the patient was seen cell-side for "treatment reasons," as indicated from the drop-down menu and reported in Defendants' TechCare data. However, there is nothing in the corresponding provider note to indicate any actual treatment reason for the lack of a confidential setting. Both entries are marked "compliant" in Defendants' data.

87. Patient CB [redacted] was seen cell-side on multiple occasions, including March 26 and May 5, 2015, due to "security concerns." In neither instance did the provider's note specify or spell out the security concern that prevented the patient from being assessed in a private area.

88. Additionally, I encountered numerous instances in which patients were seen cell-side with no documented reason in the patient's record for the lack of a private assessment.

89. Patient AW [redacted] was routinely seen cell-side. On March 19, 2015, the patient was seen cell-side, with no reason documented. On April 28, and again on May 26, the patient was seen by a provider; his record includes no indication of where the assessments took place or whether they occurred in private. Similarly, Patient RB [redacted] was seen cell-side on July 28, 2015. Defendants' TechCare data lists "patient refusal" for the lack of private assessment; however, the patient's record shows no explanation as to why he was not offered a private room to be assessed. Patient TH [redacted] was seen cell-side on March 15 and March 29, 2015 with no explanation given in his record for the lack of confidential assessment. Patient MG [redacted] was seen on two occasions by a provider during the reporting period, May 11 and August 4, 2015. Although the provider's notes indicate that the patient was seen with privacy, it is not clear whether this indicates a cell-side encounter. Notes from a MHP in the patient's record, for example, indicate that the patient was seen "in privacy *at cell*."

90. Finally, my record reviews further revealed that Defendants simply failed to include various assessments in their data. Patient RG [redacted], for example, is absent from Defendants' data; the patient was seen by a provider on July 17, 2015. Patient AG [redacted] was, according to his record, seen by providers on June 2, June 28, June 30, and July 5, 2015; none of these entries is included in Defendants' data.

91. I reviewed 33 records for compliance with this provision. Among those. 16, or 48% were noncompliant. Most of the noncompliant records included multiple instances of noncompliance with the provision. Further, as described above, many of the noncompliant assessments were included as compliant entries in Defendants' TechCare data.

Subparagraph 5(a)(17)

92. Subparagraph 5(a)(17) requires Defendants to "adopt and implement written criteria for placing pretrial detainees in each level of mental health care, including subunits within the Mental Health Unit." Dkt. 2299 at 5.

93. In its Findings of Fact and Conclusions of Law, the Court found serious deficiencies: "Although there are criteria for placement in each level of mental health care, including subunits within the Mental Health Unit, Defendants have not shown that the placement criteria are clearly articulated in writing and consistently and timely applied." Dkt. 2283 at 47-48. The Court also noted problems in Defendants' process for timely transferring prisoners in MHU to less restrictive units. *Id.* at 49. Relatedly, it identified problems in Defendants' MHU discharge practices. Defendants failed to provide prisoners in acute units of the MHU with "sufficient opportunity to become clinically stable in stepdown treatments" before transfer from the MHU. *Id.* at 48. The Court's findings are similar to concerns that I described in my 2013 Declaration, and ones described by the Court's mental health expert, Kathryn Burns, MD. *See, e.g.*, Burns Seventh Report at 8; Burns Eleventh Report at 2-3; Stewart 2013 Dec. at 28 ¶ 80, 31-33 ¶¶ 85-91.

94. Defendants updated their policies and procedures to provide written criteria for admission to the MHU for those "'presenting with acute or chronic [mental health] needs who cannot be managed in [general population]." Dkt. 2333 at 26; SOP J-G-04 (Dkt. 2304-1 at 137). Defendants updated their policies to include six admission criteria: recent suicide attempt; current danger to self or others; recent history of self-injury; hallucinations directing harm to self or others; "seriously disordered behavior that interferes with the ability to function in general population;" "major disability in social and interpersonal functioning;" and severe side effects from psychotropic medications. Dkt. 2304-1 at 138.

95. Defendants further specified the criteria for placement in each subunit or step-down unit within the MHU. Dkt. 2304-1 at 142. Units P-3 and P-5 are appropriate for those who are a danger to themselves or others or are "unable to provide for basic self-care that would result in impending, serious self-harm." *Id.* Unit P-1 is appropriate for those still at "elevated risk for decompensation after an acute psychiatric episode" but who are able to participate in therapeutic activities. *Id.* Unit P-2 is appropriate for those whose functionality "is acutely and severely impaired due to a treatable mental health condition" but who are able to participate in therapeutic activities. *Id.* Finally, Units P-4 and P-6 are appropriate for those who "continue to demonstrate severe functional impairment due to a treatable mental health condition," but who are able to interact and socialize on the unit beyond therapeutic activities. *Id.*

96. Finally, Defendants updated their procedures to articulate three levels of outpatient care: "Basic," for those who are symptomatic but present minimal risk; "Supportive," for those with symptoms who present medium risk; and "Intensive," for those at high risk "due to more serious, often enduring" symptoms and other factors. *Id*. at 144-45.

97. Defendants have asserted compliance with Subparagraph 5(a)(17) based exclusively on the fact of having amended its policies and procedures. *See* Dkt. 2333 at 26-27. They have not provided any data assessing their implementation of these revised policies and procedures, despite the clear language of the provision requiring that Defendants not only adopt but also "implement" the policies and procedures. My own review has revealed that Defendants have failed to comply with this provision and their own revised policies.

98. Defendants' problems with respect to placing patients in appropriate levels of care are longstanding.

99. In her Remedial Plan, Dr. Burns recommended that the Jail develop and implement appropriate MHU admission and discharge criteria to ensure that clinically unstable and seriously ill prisoners are timely transferred to and remain in the MHU. *See* Remedial Plan at 4-5. In my 2013 Declaration, I wrote that without the implementation of such criteria, the Jail would be running an unreasonable risk of delayed admissions of seriously mentally ill prisoners who need to be treated in the MHU, premature discharges from the MHU of unstable patients, and under-utilization of the step-down units to ensure adequate treatment for MHU prisoners once they are stabilized. Stewart 2013 Dec. at 28-29 ¶ 81.

100. As I reported in my 2013 Declaration, prisoners continued to grow increasingly symptomatic without being transferred to the MHU and were prematurely discharged from the MHU or cycled in and out of it. *See* Stewart 2013 Dec. at 27-28 ¶¶ 78-79, 29 ¶ 82. In her Eleventh Report, Dr. Burns noted the ongoing deficiencies in admission and discharge criteria and practices, citing in particular the practice of "premature discharges of mentally ill and failure to transition patients through the levels of care in the interest of maintaining bed availability for intoxication/withdrawal monitoring." Burns Eleventh Report at 2. Dr. Burns also noted the continued lack of access to out-of-cell therapeutic activity for prisoners in the MHU. *Id.*

101. Despite Defendants' updated policies and procedures, in practice the admission criteria for the MHU remain too high and the discharge criteria too low. Defendants are not adhering to their own criteria. As a result, seriously mentally ill prisoners languish in the outpatient facilities, while clinically unstable patients are discharged back to these facilities.

102. Additionally, despite Defendants' written criteria for different units within the MHU, many prisoners spend their entire stay in the acute units and are not moved to the step-down units when clinically appropriate. The step-down units offer greater out-of-cell time and more psychosocial rehabilitation services. These services

are structured programs that are a critical aspect of adequate care for seriously ill prisoners in the MHU. Though P-3 and P-5 are intake units, many prisoners spend weeks or months housed in these units, which operate as lockdown units, with little or no psychosocial rehabilitation programming. Psychosocial programming is an essential element of treatment for these patients. Without it, they are at risk of growing more ill, or not responding fully to the limited treatment they do receive. This deterioration can take many damaging forms, including an increase in hallucinations, delusions, incidents of self-harm, and non-adherence to treatment and medications.

103. I further found that the step-down units, though used more than they had been in the past, are still woefully underutilized. In the records I reviewed, it was still common for prisoners to be admitted to the acute units, spend their entire MHU stays in those units, and be discharged from them, all without ever being stepped down to the other MHU units.

104. It is my opinion that the Jail's failure to more fully utilize the step down units has two notable consequences: (1) It results in clinically unstable patients being prematurely discharged from the MHU, and (2) it contributes to these patients' failing to thrive in the outpatient facilities, resulting often in their being transferred back to the MHU after they grow acutely ill and behaviorally impaired.

105. Finally, and relatedly, the care of mentally ill prisoners housed in the outpatient facilities (LBJ outpatient, 4th Avenue, Estrella, Durango, and Towers) continues to be dangerously inadequate, despite Defendants' adoption of criteria for outpatient levels of care. A crucial aspect of providing mental health services in the outpatient facilities is having adequately administered levels of care. It is my opinion, however, that outpatients in need of mental health services at the Jail are often denied critical treatment as a result of badly managed levels of care.

106. It is my opinion that Defendants are not in compliance with Subparagraph 5(a)(17) of the Revised Fourth Amended Judgment. Even to the extent Defendants have adopted appropriate written criteria for the placement of patients in each level of mental health care, Defendants do not adhere to the criteria in making placement determinations. My record reviews demonstrate a clear pattern of patients suffering because they have been placed in inappropriate, inadequate levels of mental health care. Over the six-month period that was the focus of my review, I found many prisoners who were kept in the outpatient facilities though they met the criteria for MHU admission. I also found case after case of clinically unstable patients being prematurely discharged from the MHU—most typically directly from the MHU's acute units (P-3 and P-5)—to outpatient facilities without being stabilized and stepped down through the MHU sub-units. These are the same problems the Court identified in its September 2014 decision.

107. Among the 47 patients whose records I reviewed, 29 of the patient records, or 62%, exemplified the problems of delayed MHU admissions, premature MHU discharges, inadequate step-downs, and insufficient care of seriously mentally ill patients in the outpatient setting. A sampling are described below.

108. Patient CB [redacted] deteriorated at the 4th Avenue facility, where he did not have adequate access to care given his condition. On February 26, 2015, he was noted as agitated, uncooperative, and yelling obscenities. He was diagnosed as suffering from an "Unspecified Psychosis." Despite his severely deteriorated condition, a follow-up visit four weeks out was scheduled by Dr. Fangohr. A March 14 note from mental health staff reported that he did not appear capable of understanding or expressing an understanding of the alternatives to the particular treatment offered. He was again noted as agitated, angry, and verbally abusive. Dr. Fangohr's next follow-up, on March 26, found that the patient's cell was littered with debris. He refused his psych medication and continued to be uncooperative. Still, his

next follow-up appointment was scheduled for six weeks out. This pattern repeated itself at the patient's next provider appointment, on May 5. On May 17, MHA Herrera noted that the patient was disheveled, agitated, and guarded, and his cell was filled with trash. He reportedly had been yelling at detention staff earlier. He was not referred to a provider. The patient was found incompetent and unrestorable and was ordered civilly committed on May 28, 2015.

109. This patient presented with severe psychotic and mood symptoms for four months yet did not receive any meaningful treatment. The patient was basically left to suffer from significant psychotic and mood symptoms until he was deemed incompetent and civilly committed after his charges were dismissed.

110. The patient was noted as an "S" or "Supportive" level of care—for individuals with symptoms and "medium" mental health risk. The patient was only seen every six weeks, which is too long an interval given his presentation. Given his ongoing symptoms and deteriorating condition, this patient required a higher level of care, and was miscategorized under the revised levels of care policy.

111. Patient NF [redacted] is an extremely difficult patient who presents a great risk of assault. The patient was moved to the MHU shortly after his March 14, 2015 intake, after he assaulted a fellow prisoner in general population. A month later, on April 14, the patient was discharged from the MHU. When Dr. Picardo tried to assess him that day, he had to be seen cell-side because he was too violent to remove from his cell. Dr. Picardo wrote, "he displays unprovoked physical attacks causing bone crushing harm," though noted no psychosis and no mania. The patient presented a "high DTO risk" and would "charge at other unprovoked." His record includes multiple use of force incidents, which took place on March 30 and April 8. In mental health staff assessments from April through July, it was reported that he did not engage in response to questions and his cell was frequently littered with food debris, with food or spit smeared over his cell window. Only a diagnosis of "Unspecified

Psychosis" was noted. On July 30, the patient was deemed incompetent and unrestorable and was discharged from the restoration to competency (RTC) program.

112. The patient's assaultive behavior and clinical presentation were sufficient to have him placed in the MHU under the revised policy. Instead, he was discharged from the MHU despite being clinically unstable and a danger to others, and he remained in an outpatient level of care, where he posed a risk to others and his condition did not improve.

113. Patient AG [redacted] was transferred between GP and the MHU, often without the utilization of the MHU's step-down units. On February 4, 2015 the patient was discharged from the MHU to GP after a short stay there due to suicidal ideation. The patient was discharged even though, at his discharge assessment, he reportedly stated "everybody knows about spirits. The spirits talk to me." He further stated he did not need medications. A month later, after another stay in the MHU, the patient was again transferred back to GP, despite presenting as guarded and "somewhat paranoid." During assessments by mental health staff in subsequent months, the patient was symptomatic. He displayed paranoia and thought blocking, and was described as possibly delusional. The patient was moved to suicide watch on May 22, after he reportedly stated that others were trying to take his identity and stated that different voices come out of his mouth. On June 2, the patient was discharged back to GP directly from potential suicide watch. On June 23, the patient again was moved back to the MHU as potentially suicidal. He had been in a fight with another prisoner in GP and, while in medical, he defecated on himself and changed clothing only with much prompting. The patient was discharged from potential suicide watch and sent back to GP on July 7, despite being non-compliant with medication and treatment. He was deemed incompetent and was civilly committed by court on July 23, 2015.

114. This patient was transferred in and out of the MHU, often being sent to GP straight from a suicide watch. Defendants' own policies plainly provide MHU

step-down units for patients who "can be managed in a less intensive level of care," as where they are capable of participating in therapeutic activities but still "demonstrate elevated risk for decompensation after an acute psychiatric episode." This level of care would have been more appropriate for the patient after being stabilized on P-3. Rather than utilizing the step-down treatment options, however, Defendants bounced the patient from MHU suicide watch straight to GP, despite lingering concerns over his capacity to function there. This only prompted the patient's multiple returns to the MHU.

115. Patient DG [redacted] is another example of Defendants' failure to properly assess and assign the patient to the level of mental health care most appropriate to her clinical presentation and diagnosis. This patient was allowed to completely decompensate in an outpatient facility, and remained there, even as her psychosis worsened. During a March 5, 2015 assessment, the patient made bizarre statements, including, "Technology is being used on me. They can listen to the mind. The thing they did to Christ . . . They made him black." She reported being afraid to eat the food and believed that someone was trying to poison her. During an April 8 assessment, it was noted that the patient had been off medications for two weeks due to possible side effects. She presented as very delusional, speaking about shape shifting and stating, "My name is Satan diamond eternity." Still, the patient was found marginally stable for GP. At another follow-up appointment, on April 22, Dr. Drapeau wrote that the patient had grossly decompensated. She was rambling, disorganized, and tangential. She had poor hygiene. Still, the patient was found stable for GP. The patient was finally moved to the MHU several days later, for hair pulling and psychosis. During her assessment on May 3 in P-5, the patient was rambling, nonsensical, delusional, and suffering from hallucinations. She was noted as psychotic and was engaging in self-harming behaviors. Despite the patient's presentation, Dr. Patel saw her on May 4 and wrote that the patient "was basically playing games to

remain here for a week . . . . She is not suicidal and she is using the system to get a break . . .” Dr. Patel discharged her back to Estrella segregation that day. On exam following her discharge, and continuing over the next couple of weeks, she was delusional, had loose thoughts, and was pulling out her hair.

116. Among Defendants’ MHU admission criteria is “[s]eriously disordered behavior that interferes with the ability to function” in GP. This patient required a higher level of care than that which she received while remaining in an outpatient level of care. Defendants violated their own policies establishing levels of care by allowing the patient to so steadily decompensate without admitting her to the MHU. Furthermore, the patient was permitted to remain in the MHU for just a day before being discharged.

117. Patient DO [redacted] was booked on March 3, 2015. His mental health history includes SMI with POC Capital Center, a diagnosis of schizophrenia, and a history of suicide attempts while in custody. From his booking, he remained at the 4th Avenue Jail until March 27. Through March, the patient refused treatment—he engaged only minimally during assessments and refused medical tests. During an assessment on March 13, the patient was seen standing naked in his cell, pacing, and making odd movements. His responses to the provider were either too low to be heard or, often, were unintelligible. His cell was dirty. A note from March 24 reported that the patient was refusing his morning doses of his medications. His EMAR showed multiple medication refusals throughout the duration of his incarceration. By his March 27 assessment, the patient was reported as disorganized and psychotic. He was agitated, made fast movements, and looked frightened and disturbed, mumbling nonsensical statements. The patient was finally admitted to the MHU, due to possibly having akathisia.

118. This patient spent a month in an outpatient level of care before being transferred to the MHU, a level of care more suitable to his presentation and condition.

Given the patient's history of multiple suicide attempts while in custody, his consistent refusals of treatment and medication, and his consistently bizarre behavior during assessments, he was not appropriate for an outpatient level of care.

119. Patient JP [redacted] is another example of a patient who remained in an outpatient level of care when he required a higher level of care. The patient was booked on February 21, 2015. During his intake, he reported auditory hallucinations, a prior diagnosis of bipolar disorder, and a prior suicide attempt. He was bizarre in presentation and appeared to be under the influence of drugs or alcohol. He was cleared for outpatient housing. On February 26, the patient was brought to medical after being observed standing in the shower with his clothes on for two hours. He had lost 8 pounds since his booking. He was referred from detention on February 27 after he was observed spitting and urinating on the floor of his cell. He was referred again on March 2 for tearful, bizarre behavior and for refusing his last two meals. The following day, he reported that voices were trying to speak through him, and that he was drooling or burping in an attempt to keep the voices from speaking through him. He further reported feeling like there were devices in him. He declined to start an antipsychotic drug. Despite his presentation and history of suicide attempt, a follow-up was scheduled for four weeks out. A March 9 note from Dr. Stalcup reported that the patient has command auditory hallucinations, though he does not listen to them. It had been a week since the patient last ate.

120. The patient was finally admitted to the MHU on March 11. By that time, he was tangential, unaware of his situation, and reported auditory and visual hallucinations. He continued to refuse medical and mental health medications and had continued to refuse to eat, resulting in a loss of 20 pounds since his booking. Despite his condition, the patient remained in the MHU for just one day before being discharged back to a segregation placement. There was nothing done to address his refusal to eat, his weight loss, or his refusal of medications and treatment.

121. Despite his discharge back to an outpatient level of care, the patient was not functional. A March 13 note from Dr. Stalcup reported that he was delusional, experiencing auditory hallucinations, and not eating. MCSO were unable to find him a cellmate due to his poor hygiene and psychotic behavior. The note further reported that the patient was unable or unwilling to meet his basic needs: he was not showering, eating, or taking medications that had been prescribed. In spite of this, he was found stable for outpatient care in segregation. His condition persisted through April and May. On April 1, PA Fleming wrote that Patient JP continued to refuse his anti-hypertension medication, endangering his life. On exam, he was psychotic, delusional, disheveled and malodorous. On April 28, Dr. Fangohr saw the patient cell-side due to concerns about his behavior. He refused medication, and had refused labs. Dr. Fangohr wrote that the patient had been grandiose and psychotic. His blood pressure that day was 172/104. Despite his acute presentation, a follow-up was scheduled for four weeks out. By May 7, his weight had dropped to 173.6 pounds, a loss of 25 pounds from his February admission. On June 5, 2015, he was deemed incompetent and unrestorable and was discharged from the RTC program.

122. This patient remained in an outpatient level of care in lockdown for far too long, given his condition; when he was finally admitted to the MHU, he remained there for just one day. Defendants' MHU admission criteria include, among other criteria, "[s]eriously disordered behavior that interferes with the ability to function in general population." On these criteria, Defendant should have been admitted to the MHU at a much earlier date, and he should have remained there. He had a history of suicide attempt, experienced hallucinations throughout the duration of his incarceration, and, by a provider's own report, could not function on his own. His case is another instance in which Defendants' plainly eschew their own written criteria for placing seriously mentally ill prisoners in the appropriate levels of care.

123. Patient DY [redacted] displayed psychiatric symptoms along with behavior that made him a danger to others. Still, this patient remained in outpatient care and did not receive appropriate treatment. He was booked on January 29, 2015. During intake, he reported a history of mental hospitalization and previous psychotropic medications, confirmed via records from previous jail stays. At intake, he reportedly appeared internally preoccupied but was deemed stable for GP. The first of multiple assaultive behaviors took place on January 31, when the patient kicked his cellmate. Though the patient was moved to the MHU, he remained there for just one day. On March 8, the patient was referred from detention after again assaulting his cellmate. On examination following the incident, he displayed inappropriate laughter.

124. From his MHU discharge in early February, the patient was not seen by a provider until March 17. On assessment that day, Dr. Sorokin reported that the patient was internally preoccupied, using nonsensical speech, and appeared not to be fully processing information. He laughed aloud for no reason and talked to himself during the meeting. Dr. Sorokin noted that it was unclear whether the patient would be safe around others and declined to initiate emergency involuntary medication after the patient's repeated refusals.

125. The patient was involved in another inmate-on-inmate fight on May 11, after which he was seen by nursing staff. After this incident, he was not seen by a provider until June 1. During this "limited eval," NP Burgett noted the patient's history of assaulting others and his psychosis, but declined to find him a danger to others. From his booking, the patient was not prescribed any medications.

126. This patient was responsible for three assaults on other inmates during the four months of his incarceration period. He presented a clear danger to others and was not able to function in the general population setting. Despite this, Defendants failed to move him to the MHU or alter his level of care.

127. Patient FA [redacted] was booked on May 27, 2015; she had a positive mental health intake screen and reported treatment for auditory hallucinations. She was transferred to the MHU on May 31 after she was found in her cell tying a towel around her neck. Following her transfer, she was seen by Dr. Worthen, who noted delusional thoughts and a diagnosis of unspecified psychosis. The patient reported auditory hallucinations and expressed delusional thoughts. She requested Zyprexa and it was prescribed to her on June 2. The patient was discharged to a lockdown unit that same day, without any time to stabilize on medications, though the discharge note from Dr. Worthen states, "discharge to GP." When she was seen by MHP Otero for her discharge from the MHU, the patient reported that she was hearing voices. Nevertheless, she was discharged. The patient continued to experience symptoms following her first discharge from the MHU. She made danger-to-self statements and reported that she continued to hear voices, and she asked for more medications. After being referred to mental health by detention on June 7 for threatening to hurt herself, she told MHP Thompson her voices would not go away, and that her ongoing isolation in Estrella lockdown was making everything else worse.

128. The patient returned to the MHU on June 13, after she was observed with cuts on her neck and arms. She reported hearing voices commanding her to hurt herself. She asked for more medication. During a provider evaluation the next day, the patient reportedly stated, "'I said I was suicidal but I wasn't. I would never kill myself. I think you put a microchip in me that makes me think people are out to get me. I'm just telling the truth.'" She began banging her head against her cell door and had to be restrained. On June 15, she was seen by Dr. Patel. The patient reportedly stated that she was not suicidal and had cut herself because she was having a hard time in Estrella. She further reported that she was continuing to hear voices. Dr. Patel ordered an increase in her dosage of Zyprexa, discontinued suicide watch, and

discharged her to Estrella that same day, without allowing any time to assess her response to the medication change..

129. While in Estrella segregation, the patient continued to deteriorate. She intermittently refused her Zyprexa. Multiple mental health referrals were made by detention officers. During her time in Estrella segregation, from June 16 to June 29, she was seen by mental health staff on rounds. However, the rounds were not meaningful encounters; though she was noted as symptomatic and was still periodically refusing her medications, the rounds never resulted in a provider referral or a meaningful assessment. On June 29, she was found in her cell in Estrella segregation, after razor blades were distributed, with long cuts to her neck and arms. She was taken back to the MHU. She had not been seen by a provider during the entire period she was in Estrella lockdown.

130. This patient, on multiple occasions, was prematurely discharged from the MHU and placed at serious risk for self-harm. She did not receive sufficient care or adequate follow-up while in Estrella segregation between her stints in the MHU. The patient engaged in behaviors that indicated she was at risk of self-injury and was not able to function in an outpatient setting. Defendants failed to follow their own written policy, which includes history of self-injury among the MHU admission criteria. Defendants' further failed to utilize the MHU step-down units, which would have allowed the patient to stabilize before being discharged back to an outpatient level of care.

131. Patient RB [redacted] was booked on June 1, 2014. From September 3, 2014, through the end of the monitoring period, the patient was in the SMU, where he did not receive a level of care appropriate for his condition. At intake, the patient reported experiencing auditory hallucinations nearly every day. He further reported a history of prescriptions for psychotropic medications. He also made bizarre statements during intake, including stating that he was the President and controlled Obama's

decisions; that he was not harmed when people tried to shoot him; and that he saw demons, a bigfoot-like figure, and horns and extra eyes on people. His record includes Magellan records noting him as SMI inactive and listing a diagnosis of schizophrenia, paranoid type.

132. By March 2015, the patient was refusing to take his medication. A cell-side visit by Dr. Fangohr on March 24 consisted only of the patient nodding his head that he was okay without medication. The patient's Zyprexa prescription was allowed to expire on May 11. At a May 15 cell-side assessment, the patient reported hearing voices, though he denied DTO/DTS. He was seen cell-side by mental health staff on July 17; he showed no interest in maintaining a conversation and his responses were brief. He was unresponsive to Dr. Fangohr's attempts to assess him on July 28; his cell was littered with newspapers, and the patient was lying in his bunk. Dr. Fangohr noted a plan to follow up with the patient in two months.

133. The patient was thereafter seen monthly by a MHA and every sixty days by a provider. When I spoke with the patient in October 2015, he was extremely psychotic. He did not engage with me when I attempted to converse with him and appeared to be in a great deal of distress. He had not received psychotropic medications for almost six months at that point. Despite his medication non-compliance, I found no evidence from the patient's record that the prescribing physician was cognizant of the problem.

134. This patient was very sick and required a higher level of psychiatric care than the infrequent, cursory, cell-side assessments that he received at his outpatient level of care.

135. Patient SB [redacted] suffered under inadequate outpatient care for almost three months before she was admitted to the MHU, where she was held for just one day. This patient suffered needlessly and was placed at risk for self-harm and harm to others. The patient was booked on February 26, 2015 and had a positive intake

screening, during which she showed anxiety and reported a current Valium prescription. Her record showed her SMI history and treatment through Partners in Recovery for bipolar disorder and anxiety, with current medications of Valium 5 mg BID and Abilify 10 mg q HS.

136. The patient was referred for a provider assessment on February 27 following an altercation with another prisoner. The patient was threatening to kill herself while in Estrella segregation. She was reportedly upset, screaming, and had a blanket tied around her neck. In response, Dr. Drapeau "advised her that she needed to quit acting like a bitch (as a way to GET her attention). . ." The patient was found stable for GP, and was not offered her community-prescribed medications. A March 4 note from NP Bankson advised that the patient was not on medications and was "[d]oing real bad," with lots of anxiety. The patient demanded her community-prescribed medication and began cursing at the provider when her request was denied; she had to be escorted from the room by security staff. Over the course of March 2015, the patient reported to mental health staff and via an HNR that her anxiety was worsening and that she was in need of her community-prescribed medication to treat it. She was finally prescribed anti-anxiety medication on March 23. By May 5, however, she refused her medication. On May 17, the patient was admitted to the MHU after she made DTS statements. She was discharged by Dr. Patel the following day, after she denied being DTS/DTO and said she wished to return to Estrella. In an HNR filed on July 13, the patient stated that she was losing hair and had developed worsening tremors since starting on Tegretol. The patient's complaint was not addressed for at least two weeks after it was submitted.

137. From the time of her booking, the patient made DTS statements and displayed self-injurious behavior when she wrapped a towel around her neck. She was denied her confirmed community-prescribed medications. By Defendants' own written policies, the patient should have been admitted to a higher level of care at the

MHU. Instead, she remained at an outpatient level of care, where she was denied the medications she badly needed and was allowed to decompensate.

138. Patient DG [redacted] was booked on May 18, 2015, and her mental health screening was negative. She was seen on May 19 following a detention referral after she was observed talking to herself. While in Estrella segregation, the patient was seen by mental health staff on multiple occasions following referrals, beginning on May 28. Over the next ten days, mental health staff reported that she did "not appear to be fully in touch with reality;" that she was experiencing symptoms of psychosis and was responding to internal stimuli; that she was loud and difficult to redirect; that she had irrational, disorganized, and loose thoughts; and that she was refusing her medication, claiming she was allergic to all medication. For the most part, her assessments by mental health staff were not meaningful and did not result in provider assessments.

139. By the time she was admitted to the MHU on June 9, the patient reportedly was yelling and screaming in her cell and appeared "psychotic and possibly manic." She refused to take her medication. Just two days later, on June 11, Dr. Patel wrote that she was "psychiatrically stable not suicidal and intent to harm others." That same day, MHA Hardemann found the patient difficult to assess because the patient refused to talk or answer questions. She reportedly stated that she thought the ceiling in her cell was a monster. She needed redirection and prompting to enter her cell. Nevertheless, Dr. Patel discharged the patient from the MHU the following day, on June 12.

140. The patient remained in Estrella segregation from June 12 until her July 30 discharge. On June 22, the patient was seen by Dr. Drapeau. She was reportedly disheveled and had loud and rapid speech with loosely organized thoughts. She refused any psychiatric medications. In spite of this presentation and the patient's refusal to take any medications, her next provider follow-up was scheduled for one

month out. Though a progress note in the patient's file showed that the treatment team recommended that another MHP assess the patient for a possible persistently and acutely disabled (PAD) petition, it was never carried out.

141. The patient continued to deteriorate through July. A July 21 assessment noted that the patient was responding to internal stimuli and continued to speak to herself in her cell. She was agitated, uncooperative, and refused mental health services. On July 29, the patient was seen after apparently refusing to go to court. According to Dr. Drapeau's note from that day, the patient remained delusional about others' control over her and was yelling at staff. She again refused medication. In spite of the patient's condition, Dr. Drapeau noted that she was "stable for GP."

142. This patient suffered needlessly because she did not have adequate access to mental health care. Despite her psychotic presentation at booking, she never received the care she needed. The patient was not timely admitted to the MHU despite her symptoms, and she was discharged from the MHU before she had a chance to stabilize.

143. Patient BI [redacted] is emblematic of Defendants' practice of inappropriately discharging patients from the MHU before they have stabilized. The patient was brought from intake to the MHU on June 3, 2015. During a June 9 assessment by MHA Redhouse, the patient reportedly made such bizarre statements as "I know who you are. . . . You Indian liar. I am going to request injunctions for tampering with my checks. . . ." He was discharged to GP three days later by Dr. Worthen who saw him cell-side and noted no DTS/DTO and no psychosis. No medications were offered to Patient BI during his brief MHU stay.

144. On June 18, the patient was referred from detention after he was observed wandering around, talking to himself, acting strangely, and possibly stealing from others. The following day, another officer reported that he was making nonsensical statements, and that other patients stated that he scared them. During a

suicide risk assessment that day, the patient reportedly stated that he "knows all the members of Star Trek and that he has been offered a job with the federation when he gets out of jail." He was characterized as hypomanic, irritable, hostile, and paranoid. He showed delusional thinking; rapid, pressured, and loud speech; and a labile mood. He was seen the following day by Dr. Jaffe. The patient had so decompensated that Dr. Jaffe was unable to follow him; he displayed persecutory and delusional thought processes. The patient was re-admitted to the MHU and placed on suicide watch from June 19 through June 22.

145. He remained unstable in the MHU. A July 28 assessment from Dr. Worthen noted that he had disorganized thoughts and a hypomanic, elevated mood. He refused medications and was easily agitated. An August 3 assessment reiterated the same. The patient was "too unstable" to be brought into a confidential room, so he was seen cell-side. He was deemed incompetent and unrestorable and was discharged from the RTC program on September 2, 2015. Until his discharge on October 1, 2015, the patient continued to refuse treatment.

146. As a result of the patient's initial premature discharge from the MHU, he was unstable and had to be rapidly returned to the MHU and placed on suicide watch.

147. Patient GL [redacted] was improperly discharged from the MHU before she had stabilized, resulting in the patient's bouncing back and forth between the MHU and GP. Defendants failed to adhere to their own written policies for utilizing the step-down units in the MHU before discharging patients. Consequently, this patient was not placed at the appropriate level of care and suffered unnecessarily for it.

148. The patient was booked on June 7, 2015. She was first transferred to the MHU on June 28 following detention referrals reporting that she was acting "bizarre" and "disturbed" while housed in Estrella segregation. While in the MHU, on July 6, the patient was given a forced injection after being deemed DTS. Dr. Patel noted that she was hyper, agitated, and paranoid. She had disorganized, loose, and rapid thought

processes. She was also reportedly smearing her cell walls and window with peanut butter and/or feces. She refused her medications. Just three days later, on July 9, she was discharged from the MHU to Estrella lockdown, after being noted as much less symptomatic on Haldol. She was not stepped down in the MHU.

149. While back in lockdown, the patient's condition deteriorated. She filed an HNR on July 10, asking for an increase in her medication dosage to relieve the anxiety and distress she was experiencing; she was not seen by mental health staff for three days. On July 10, she reportedly stated that she wanted to pull her hair out and felt that she might go crazy. She reported to NP Bankson on July 15 that she felt like she was going to kill herself and stated that she "can't be in that little room anymore." She reported that she had been striking her neck with a comb to try to kill herself. She further reported hearing voices instructing her to just do it and not to trust the provider. She was sent back to the MHU that day.

150. The patient remained in the MHU lockdown unit (P-5) for four days. On July 20, Dr. Patel discharged her back to Estrella lockdown at her request, after she complained that her current unit was depressing and lonely, and that she could not use here privileges while in P-5.. She was not stepped down in the MHU.

151. Just two days later, on July 22, the patient was re-admitted to the MHU with a note indicating active SMI and reporting that she was potentially suicidal. On evaluation, Dr. Patel noted that the patient was hearing voices and feeling paranoid and delusional. He wrote, "she is having anxiety, depression and psychotic symptoms of hallucinations and paranoia." Despite these observations, Dr. Patel wrote that the patient was okay to return to Estrella after just one more day of observation. She was discharged on July 25 and again was not stepped down before her discharge.

152. Back in Estrella, the patient reportedly threatened to harm herself in order to obtain the correct medications. She was confrontational, angry, hostile, and demanding. She was noted as stable for her current housing. However, by July 27, the

patient was back in the MHU after threatening to harm herself or others if she did not obtain the correct medications. Dr. Patel wrote that she was paranoid and delusional, with loose and disorganized thoughts and speech. She was "very psychotic." An assessment by Dr. Patel on August 3 noted that she was paranoid, delusional, and illogical. On August 5, she was reportedly threatening officers and staff, was psychotic, and reported auditory hallucinations.

153. This patient was seriously mentally ill and should not have been repeatedly discharged from the MHU before being stabilized. She was not stepped down from the most restrictive MHU unit (P-5), which operates like a lockdown unit. The patient showed a pattern of DTS and self-injurious statements and behavior as well as other psychotic symptoms. Returning the patient to Estrella lockdown on multiple occasions directly contravenes Defendants' own policies with respect to MHU admission criteria. This patient could not and did not receive the appropriate level of care in the outpatient setting.

154. Patient LL [redacted] provides another example of a patient who languished in an outpatient level of care for a month before being transferred into the MHU. Again, despite Defendants' updated policies and procedures, in practice the admission criteria for the MHU are too stringent and discharge criteria too loose.

155. The patient was booked on April 4, 2015. At booking, despite a negative mental health screening, she was reportedly disoriented and appeared to be under the influence of something. Following a referral from detention, she was seen by mental health staff on April 14. She was reportedly arguing with other prisoners, unable to follow directions, and unstable. She was talking to herself and was not making sense. During an assessment by NP Burgett on April 17, she appeared disoriented and loose and provided nonresponsive answers to questions. She was not transferred to the MHU for stabilization She was again referred to mental health from detention on

April 23 for acting "schizo." She was not seen by mental health staff following this referral.

156. On May 3, she was seen by MHP Griemsmann following another referral from detention. There was blood on the floor of her cell and on her clothing and she had put her uniform in the toilet, stating that the clothes were dirty. Her cell was messy and littered with trash. The patient was refusing her medications, and a possible PAD petition was noted. Still, the patient remained in segregation. The following day, she was seen by NP Burgett, who noted she was having menses and letting blood drip on the floor. She was disoriented, confused, and agitated. The patient was finally transferred to the MHU that day.

157. The patient was transferred from the MHU back to Estrella segregation on June 5. Just two days prior to her discharge, Dr. Patel wrote that the patient was "confused and disoriented" and was "possibly responding to perceptual disturbances." Dr. Patel wrote that the patient "[m]ay be psychotic but it is difficult to evaluate as she does not report any symptoms." The patient was not stepped down.

158. Throughout the month of June, the patient remained symptomatic in the outpatient setting. During an assessment on June 5, she stated, "There are people out there jumping on my mom I can hear her crying for me." On another occasion, she was reportedly pulling her hair out and eating it. She was reported as laughing inappropriately, having random crying fits, and rambling incoherently. Still, the patient was found stable for outpatient care and was not referred to a provider. Her assessments by mental health staff were not meaningful. She was not seen by a provider from the time of her MHU discharge until July 1, 2015, despite her acuity.

159. The patient was moved back to the MHU on July 1. That day, an officer reported that she was menstruating but was not using hygienic products. Her bunk had been changed out four times that morning, and the bunk of the inmate below her had

been changed once. NP Bankson noted that the patient was smearing blood on her hands, face, and hair.

160. By the time the patient was first transferred to a more appropriate level of care, she had severely decompensated and displayed highly psychotic behaviors. The mental health contacts she received while in segregation were not meaningful and did not aid in her treatment or care. The pattern only repeated itself as the patient was discharged from the MHU, decompensated in segregation, and was re-admitted. The inappropriate discharges from the MHU placed the patient at risk to herself and others.

161. Patient RO [redacted] similarly cycled in and out of the MHU, never stabilizing or receiving appropriate treatment. He was initially moved from booking to the MHU on July 4, 2015. During an assessment the following day, he reportedly said that he was in the MHU because he wanted administrative segregation. He said he had a broken foot and ankle and stated he had been bitten by a rattlesnake. He also stated that during his previous jail stay he had been sexually assaulted by other prisoners who had removed the window to his cell and then replaced it with toothpaste. Dr. Picardo wrote, "[patient] does not display any distress he is attention seeking and wants medical attention." Dr. Picardo noted a plan to discontinue his suicide watch and discharge the patient to general population.

162. Several days later, the patient made DTS statements and was admitted back into the MHU. During an assessment by Dr. Balaji, the patient reportedly stated, "they are drilling along my jaw line and sending electricity through me." He was seen by Dr. Worthen the following day, who wrote that the patient had made a series of somatic complaints. He further wrote, "suspect symptom exacerbation for housing." An assessment report on July 17 noted that the patient continued to express bizarre and paranoid thoughts, and had smeared fecal matter on his cell window. Just two days later, Dr. Picardo noted a plan to send the patient back to GP. Dr. Picardo prescribed Risperidone, which was immediately refused by the patient. Despite his continued

refusal to take his medication, delusional thoughts, and other symptoms, the patient was discharged from the MHU. Within a day, he was re-admitted to the MHU after making delusional and suicidal statements.

163. Despite remaining seriously symptomatic, this patient was dismissed by providers and never received any meaningful assessment, intervention, or sustained offers of medication. His premature discharges from the MHU should not have been based upon his degree of cooperation with treatment staff; the medical record clearly documents Dr. Picardo's frustration with this patient. Frustration should not be the basis of clinical decision-making. Again, Defendants in this case eschewed their own written guidelines for MHU criteria.

164. Patient AW [redacted] is emblematic of those prisoners who have cycled in and out of the MHU to Estrella lockdown without being appropriately treated. The patient was moved to MHU P-5 from booking on May 8, 2015, after a positive mental health intake screening that noted schizophrenia but no current medications, a prior suicide attempt in February 2015, and bizarre statements and behavior during booking. She refused to cooperate with treatments or assessments for the first three days she was in the MHU. In an assessment by Dr. Patel on May 13, the patient was cooperative but reported hallucinations. Dr. Patel noted the patient was "psychiatrically stable" and wrote that he planned to discharge her to GP that day. A follow-up assessment the next day noted that she appeared disheveled and had latent responses to questions or refused to answer. She nevertheless was discharged without being offered medications or being stepped down.

165. In her post-discharge follow-up at Estrella, the patient appeared disheveled and had either latent responses to the MHP's questions or refused to answer altogether. On May 15, the patient was referred from detention, as she had been asking to go into protective custody out of fear that she would react and hurt someone in her unit. An assessment on June 5 noted that the patient was hearing and seeing

things and was talking out loud to voices and commenting on her visual hallucinations. She also reported a history of treatment for schizophrenia and bipolar disorder with Depakote and Risperdal. NP Bankson noted a diagnosis of schizoaffective disorder and a plan to prescribe Risperdal and Depakote. This prescription came nearly a month after the patient had been admitted. The patient continued to experience symptoms while in Estrella lockdown. On June 7, detention referred her to mental health after she exhibited odd behavior in lockdown. On exam, she was malodorous, but it was noted that she had recently been prescribed medication. On June 16 during an assessment following a referral from Detention, she reported that she cut off her hair because voices were speaking through it. She was deemed stable for lockdown housing and no provider referral was made.

166. Following DTS statements on July 1, the patient was re-admitted to the MHU. When assessed by Dr. Patel that day, she again stated that she felt suicidal. Dr. Patel wrote, "she appeared manipulative to stay here in P-5 as oppose to segregation in Estrella." The following day, she reported that she was no longer suicidal, but that she still sometimes experienced auditory hallucinations. At the patient's request, Dr. Patel increased her Risperidone prescription. The patient was then discharged back to general population the day after her admission, just after her medications were altered. The patient was not stepped down.

167. On July 11, the patient was again re-admitted to the MHU after making DTS statements. She reportedly told Dr. Jaffe the following day that she said she was suicidal in order to avoid her lockdown unit. Dr. Jaffe noted that she displayed no manic or clinically depressive signs and discharged her from the MHU back to lockdown.

168. While in Estrella segregation, on July 20, the patient was referred from detention for making statements that suggested she was a danger to herself. She also reported having conflicts with the other prisoners. On July 25, the patient was re-

admitted to the MHU after making DTS statements. She was ordered discharged two days later, even though on examination that day Dr. Patel wrote that she "reports hearing voices telling her she is no good and hopeless." On a subsequent assessment, she reported that she was suicidal and did not want to go back to Estrella; she was not transferred out.

169. Despite this patient's ongoing complaints of wanting to harm herself, suffering hallucinations, and exhibiting bizarre behavior, Dr. Patel returned her to Estrella lockdown multiple times, where she remained actively psychotic and episodically suicidal. This case demonstrates flagrant violations of Defendants' own criteria for MHU admission—namely, where the prisoner is a current danger to herself or others. The patient was repeatedly discharged from the MHU to Estrella segregation, only to be bounced back. The patient's repeated lockdown placements further exacerbated her mental illness.

170. During my October 2015 visit to MCSO, I personally evaluated patient DB [redacted]. I am very familiar with this patient, having evaluated him multiple times over a period of years. This patient is best cared for in a structured psychiatric setting like the MHU, where a consistent behavioral and medication plan can be instituted and followed. However, this has not been the case during his incarceration at Defendants' facilities. This patient was placed in the MHU for a period of days before being transferred out to his regular housing. He was subsequently housed in the MHU for a few days in May 2015 for being a danger to himself. In September, he was sent back to the MHU after seriously slashing his own arm. After just one day in the MHU, he was discharged back to the SMU, where he promptly swallowed a metal object (by his own report) and returned to the MHU. Throughout this time, the patient was on and off a host of different medications, prescribed by different providers. This type of inconsistent treatment only serves to further destabilize an already fragile and labile patient.

171. It remains my firm recommendation that this patient be housed in the MHU and have a consistent treatment plan implemented. This will very likely decrease the frequency of his serious, and potentially lethal, acting-out behavior. I personally evaluated him on October 26, 2015, on the SMU, and found him to be at risk for self-harm due to his labile and unpredictable behavior, which is secondary to his suffering from a serious and debilitating Personality Disorder. His placement in the SMU, the most restrictive and punitive housing unit at the Jail, exacerbates his mental illness.

172. Patient AD [redacted] was booked on March 4, 2015; her intake screen was positive for mental health, as she refused to answer any questions. At intake, she was observed speaking in a baby-type voice and was seen biting her wrists. Her record showed a history of P-5 admissions for self-harm behaviors. She was admitted to the MHU on March 5.

173. On March 14, the patient was discharged to Estrella segregation, despite the fact that her EMAR shows multiple refusals of CIWA checks, medications, and tuberculosis testing through March 12. While in segregation, the patient filed multiple HNRs in which she stated she was not getting the appropriate medications. During an MHP assessment on March 18, the patient was reportedly not oriented to time, and, though she denied DTS/DTO, the patient kept talking softly as she looked off to the side. On March 24, she told Dr. Drapeau that she was seeing things and hearing voices of "friends." She believed that she was being fed people in her food. A plan was noted to see her again in one month. On March 30, the patient was transported to the ER from Estrella after strangling herself; she was found with sheets tied around her neck and extremities. She was moved from the ER to the MHU on March 31. She stayed in the MHU for the next several months, where she remained acutely psychotic and disorganized. During a June 4 assessment by Dr. Patel, she stated she is "Lucifer

and not Amber. Amber needs a vacation." Despite her degree of acuity, she was discharged from the MHU on June 5 to Estrella lockdown.

174. Back in Estrella lockdown, she refused initial mental health assessments on June 7 and June 9. During a June 19 assessment, she reported doing fine but also stated she was hearing and seeing things. On August 14, she was seen by Dr. Drapeau. She made a number of nonsensical statements, including "'people are eating other people outside the jail?'; 'you can hear gunshots every day from in here'; 'are people trying to get inside the jail?'; 'I am tortured by the Devil in Phoenix'; 'I see a lot of ghosts. You can pick up the phone and demons come out.'" Despite being very psychotic, Dr. Drapeau felt that she was stable for general population/closed custody housing and planned to follow up with her in one month. Through August, the patient periodically refused her meds, and all her medications were discontinued on September 8. Off her medications, she became increasingly psychotic. When I evaluated her on October 27, I observed her to be very psychotic in that she was hearing voices and reported speaking to God and other supernatural entities.

175. This patient displayed serious symptoms indicating the potential for self-harm or harm to others. Still, she was kept in an outpatient level of care. She was discharged from the MHU inappropriately, and was then kept in lockdown units, which exacerbated her mental illness.

176. Patient RG [redacted] was booked on October 7, 2012, and he has been housed in the SMU since December 9, 2014. He has not received adequate care in the outpatient setting and requires treatment at a higher level of care. On February 26, 2015, he was reported to be making nonsensical statements and yelling profanities. He appeared psychotic. He had been refusing his medications from the time he was booked. When he was seen almost a month later, he stated, "Bitch I am being watched" and reportedly became agitated and hit the window. His next follow-up was scheduled for six weeks out. More than a month later, on April 28, he was seen by Dr.

Fangohr, who wrote that he again began yelling profanities and kicking the door. The next follow-up was scheduled for three months out. On August 7, the patient was seen by MHA Uribe and reportedly stated, "I don't work or play with others I don't care nigger. The light in my room is my clock and my knee is the year. I've been here for over 90 days and that is kidnapping no control over 90 days. I need a psych eval. Don't turn nothing off nigger."

177. This patient is seriously mentally ill; he has been extremely psychotic and agitated, living in unsanitary conditions in his cell, not eating adequately, and suffering needlessly. He presents with a tremendously unstable mood and is at serious risk of harming others. He has been seen sporadically by providers. Despite his presentation, he has been kept in the SMU under conditions that exacerbate his illness.

178. Patient MM [redacted] provides another example of a patient being moved in and out of the MHU without a proper treatment plan. The patient was moved to the MHU from intake on July 10, 2015 following her positive mental health screening and her presentation as unkempt and delusional at intake. Records received shortly thereafter from her community provider (People of Color Network) included a court-ordered treatment (COT) plan and list of medications. The patient refused to speak with Dr. Patel when he sought to examine her on July 14. She was discharged from the MHU two days later, after she began taking her medications. She remained in Estrella segregation until her initial discharge on July 30, 2015.

179. On August 21, 2015, the patient was booked again and was admitted to the MHU that day. The following day, she was noted as potentially unsafe and she refused to be assessed. She refused her medications and was described as agitated, disoriented, and uncooperative. She was noted as possibly delusional and paranoid during an exam by Dr. Patel on August 24. She was nevertheless discharged from the MHU to Estrella lockdown the following day. On exam following her discharge, she was described as speaking loudly and urgently. She apparently stated at one point, "'I

don't want to work for the person who made billions of dollars off of me . . .my book and songs,'" in addition to making other statements. In assessments during September and October 2015, the patient was described as rambling and unable to answer questions. She was tangential and talking about her delusions.

180. I am very familiar with the patient, as I have personally evaluated her during my previous tours of the jail. She is a good example of a patient that falls between the cracks. Due to the chronic nature of her mental illness, it is my firm recommendation that a system-wide treatment plan be created which specifies where she should be housed based on her clinical presentation at the time. Until this is accomplished, it is my further recommendation that she be housed in the MHU as a common sense measure.

181. Patient TW [redacted] was booked on May 9, 2014. He remained symptomatic and uncooperative with staff as he remained in segregation through to his September 2015 release. On March 19, Dr. Fangohr noted that the patient's Abilify prescription was discontinued following his consistent refusals. Assessments from May through August noted that the patient's room was full of trash and food containers. The patient was also observed talking to himself. He consistently refused to engage, declining to go to confidential treatment space, not responding to staff and providers, refusing his medications, and refusing his labs. On August 19, 2015, he was deemed incompetent and unrestorable and was discharged from RTC. This is a case of a seriously mentally ill individual who was allowed to languish in segregation. I have personally observed cases like this one, where an extremely disturbed patient is kept in segregation without any meaningful treatment while the trash and filth pile up in his cell. The course of his "treatment" in the Jail did not meet any standards for adequate psychiatric care and is further proof of the staff's deliberate indifference to the needs of the mentally ill inmates. This patient needed to be transferred to a higher level of care.

182. Patient CB [redacted] was booked on January 22, 2015. The patient was moved to the MHU from Estrella segregation on March 17 after she made suicidal statements to mental health staff. While in the MHU, the patient reportedly improved but was still hearing voices. She was discharged to outpatient care on March 24. She remained in outpatient care—in Estrella segregation—until her release. On March 25, a day after her discharge, she told MHP Rivera she was still hearing voices, but stated it was not worth it to stay in the acute female MHU unit (P-5). She expressed interest in being transferred to the female MHU step-down unit (P-6), but this evidently was never offered to her. On March 27, the patient was referred by detention staff for yelling, screaming, and stating that she was hearing voices. On March 30, the patient reported mood outbursts and said she was still hearing voices daily. She was also experiencing paranoia that someone was out to get her and her twins to murder them. She continued to report auditory hallucinations into April, stating, "He's hurting my heart. He is turning my heart into garbage. The voice is Frank Guzman." The patient was reportedly visibly upset by her hallucinations; she was tearful, crying, and agitated. The patient continued to complain of her hallucinations through April and into May. Despite her presentation, she was seen infrequently by a provider. On May 19, following a referral from MCSO, the patient told a MHP that her voices were telling her that her son was being cooked in the jail kitchen. A June 29 assessment noted that the patient continued to have auditory hallucinations, visual hallucinations, and delusions, in addition to her depression and anxiety. During the exam that day, the patient was slurring her words and stuttering. She described the voices she was hearing as those of her ex-boyfriend and "Wolfie." She further reported that one week ago, she thought her babies were kidnapped from the foster home by Frankie, their father; she saw her baby sitting on a bed, and Frankie was slapping him so hard his head almost came off.

183. On July 23, the patient was found incompetent, her charges were dismissed, and she was ordered civilly committed by court. This patient required transfer to a higher level of care; she remained symptomatic and suffered unnecessarily in outpatient segregation.

184. Patient PW [redacted] was admitted on February 19, 2015. At intake, his mental health history, treatment in the community, and previous medications were reported. Outside records confirmed his SMI status via his community provider. At intake, he was frequently speaking out loud to himself in a foreign language, as if he were speaking with another person. During assessments in April and May, Mr. PW declined medication, declined an interpreter, and refused confidential visits. He was noted as tangential and delusional, but was still deemed stable for his current housing. The patient also reported auditory hallucinations. On June 24, he was referred from MCSO for problems with his cell mate and for chronically masturbating. On assessment the following day, Mr. PW again reported auditory hallucinations. On June 25, he was deemed incompetent and unrestorable, and was civilly committed via his criminal court.

185. This is a challenging case due to the presence of psychosis and the language issues with this patient. It does not appear from the record, however, that they put forth any real effort to engage him in treatment. There was an assumption on the part of staff that he was not suicidal. This is particularly bothersome given the fact that the staff documented that they could not adequately understand what he was saying. In a case like this, the staff is obligated to assume that he is suicidal and place him on suicide precautions. Instead, he remained in outpatient care.

186. Patient HB [redacted] was booked on April 11, 2015. She had a well-documented mental health history, both while incarcerated and in the community, and was confirmed SMI on COT. The patient was moved briefly to the MHU at intake after making nonsensical statements, including stating that she had an animal living

inside her stomach. Over the next several days, the patient frequently asked to be prescribed the medications she had been on before her arrest. She was discharged to Estrella segregation on April 14 by Dr. Patel, who deemed her to be drug seeking. None of her confirmed community-prescribed medications were ever offered to this patient while she was in the MHU.

187. Patient HB was moved from the MHU to Estrella segregation. The day after her discharge, Dr. Drapeau saw the patient, who was "begging" for her community-prescribed medications. On exam, she was talkative, had rapid speech, and had loose and tangential thoughts. Patient HB asked to be taken out of Estrella segregation, but was told "she will need to wait for 30 days."

188. Patient HB began to refuse her medications, and did so for two weeks, during which she was not seen by a provider. Ms. HB was reportedly difficult for MCSO to manage. She had run out of her cell naked and had screamed and yelled delusional statements from her cell. She was not seen by mental health staff from May 1 to May 11. On May 11, she was found flooding her cell. She was reportedly odorous, loud, and unresponsive to attempts to redirect her; she was admitted to the MHU. She remained symptomatic back in the MHU, where she was reported as paranoid and delusional and periodically refused her medications. On May 26, Dr. Patel reported that she "hears people upstairs through vent—hallucinations. She is also paranoid that she does not want to take medication at night because [if] someone comes in her room at night and sexually assaulted her, she would not know. She was laughing and laughing for no reason." Nevertheless, she was discharged back to outpatient care in Estrella segregation.

189. The patient continued to deteriorate in segregation. On June 7, she reportedly appeared actively psychotic and talked about hearing voices telling her things. She expressed delusions about cameras and people watching her. A note from a MHP that day wrote that, given her behavioral problems stemming from her

psychosis, she should not be in isolation. "[I]t seems the most effective treatment for this patient would be to reside in stepdown MHU, as she is in Rule 11 and continues to be actively psychotic." The patient continued to periodically refuse to take her medications and remained symptomatic. On June 26, she was described as agitated and responding to internal stimuli. She stated she "did not want to be a male transformer." On July 23, the patient was found incompetent and unrestorable in RTC. This patient received poor care as she was moved between Estrella segregation and the MHU. She was prematurely discharged from the MHU, which resulted in her continued decompensation in outpatient care and eventual return to the MHU and placement on suicide watch.

190. Patient HM [redacted] did not receive adequate treatment while in outpatient care. He was booked on March 28, 2015. He was on COT via the Osborne Clinic before his arrest, being treated with Risperdal Consta 37.5 mg IM q 2 weeks. The patient has a history of assaultive and aggressive behavior. During a May 21 cell-side assessment, the patient refused to engage. The provider noted that there appeared to be a bowel movement on the floor next to the patient's toilet. He was further noted as difficult to assess on June 11, as he remained on his bunk and was minimally responsive. This patient is developmentally disabled. Due to this fact, staff should have sought specialty consultation for this condition. Essentially, Mr. HM is receiving no treatment for his condition other than medication. The psychiatric staff should invite in a specialist in the treatment of the developmentally disabled to develop a viable treatment plan for this very impaired patient.

191. Patient MG [redacted] has remained in the SMU since his February 26, 2015 discharge from the MHU. While there, he was denied timely access to a provider and suffered unnecessarily. He was seen several times by MHAs and MHPs over the course of several months, during which he displayed serious symptoms. At no point was a psychiatric referral ordered. On June 10, 2015, when he was seen by

MHA Uribe, the patient reportedly stated, "'I hear SRT under the floor, they cut off my phone and shine a red dot laser at me. They are using gas to try to poison me.'" On June 26, when he was seen by MHP Dykstra, the patient stated he had electronic devices implanted on him when he was young, and stated that once they are taken out, he will be "'ripped.'" MHP Dykstra characterized the patient as hyper-verbal and difficult to redirect. He spoke non-stop under his breath at times. MHP Dykstra wrote, "r/o malingering vs internal preoccupation and delusional thought content." Given the uncertainty over a diagnosis, the patient should have again been referred to a provider but was not. On July 27, the patient again made a series of delusional statement to MHA Uribe during a cell-side encounter. On exam, he was rambling and malodorous. Again, the MHA failed to refer the patient to a provider, noting that he had steady eye contact. Despite his acuity, he remained housed in the SMU, was denied psychosocial rehabilitation treatment, and was only seen by a provider twice from May through August 2015. This is a case where a patient with a confirmed psychiatric history was not referred to a provider in a timely manner. At various times during his incarceration, this patient presented with serious incidents of self-harm as well as psychotic symptoms. At no time during these episodes was he referred to a mental health provider in a timely manner. He suffered needlessly due to these omissions. He requires a higher level of care, and his extended stay in the SMU has exacerbated his mental illness.

192. Patient AU [redacted] was booked on June 9, 2015. His mental health history, community treatment, and psychotropic medications were noted during his H&P assessment on intake. These included current medications of Haldol, Trazadone, and Depakote, and community diagnoses (via COPE) of bipolar disorder. Despite his reported community-based treatment, he was not referred to a mental health provider He was referred to mental health on June 11 after making DTS statements. By the time a medication order was entered, on or around June 17, Mr. AU declined his

medications. He was then seen by mental health staff on July 25, after he was referred by detention for reporting that he was feeling suicidal. He was then admitted to the MHU the next day. On admission, the patient was uncooperative and irritable, and he declined to provide any details about his suicidal statement. He was unable to recall the charges that led to his incarceration. This patient was discharged prematurely from the MHU and allowed to decompensate in GP, which necessitated his being re-admitted to the MHU.

193. Patient PW [redacted] was booked on January 29, 2015. During his positive mental health screening, a diagnosis of schizophrenia was noted. The patient began to decline his medications and decline treatment shortly after booking. He was noted as psychotic and responding to internal stimuli during assessments in March and May. Despite this, he was found stable for his current housing. During a May 31 assessment, he reportedly stated he was ready for his "green door card" to help him get out of jail. He claimed that an officer ate his green door card with the sandwich and had been playing games with him. He was described as verbose with loose associations, disorganized thoughts, internal preoccupations and paranoia, and impaired cognitive function. The patient was deemed incompetent and unrestorable and released on June 17, 2015. This case is troubling, as it is another example of the staff not providing adequate psychiatric services to an overtly psychotic patient. He needlessly suffered from being improperly treated for over six months.

194. Patient FO [redacted] has remained in the SMU since May 31, 2015, where he has received inadequate care and where his mental illness was exacerbated due to his restrictive housing. Patient FO was booked on May 19, 2015. On May 21, 2015, MHP Scarpati saw Mr. FO after he was referred to mental health for bizarre behavior (standing still and not talking). He remained in general population During a May 27 assessment by a MHP, the patient refused to cooperate, and sat with a fixed smile on his face. He was transferred to the SMU after he tried to leave his unit,

appeared fearful, and refused to speak with officers. On exam, he was internally preoccupied. Despite his presentation, he was moved to the most isolated and punitive unit in the entire Jail, the SMU. He was not referred to a provider. During a July 10 assessment, the patient was non-verbal, with intermittent eye contact and jerky movements. He was reportedly guarded, mistrustful, and seemed internally preoccupied. Again, he was not referred to a provider. This patient was first seen by a provider on August 20, during which he was reported as being paranoid, hypervigilant, and responding to internal stimuli. His condition did not improve. His Risperdal prescription was discontinued after a cell-side contact with Dr. Fangohr, after he had refuse medications and did not respond to the provider. When I evaluated the patient, on October 26, 2015, his presentation had not changed. He is very psychotic and disabled, but he presents as quiet and withdrawn. There is no evidence from the chart that any mental health staff attempted to engage Mr. FO in treatment. The patient continues to suffer needlessly due to this lack of treatment. His placement in the SMU is contraindicated.

Subparagraph 5(a)(18)

195. The Court's Findings of Fact and Conclusions of Law identified longstanding problems with the placement of seriously mentally ill prisoners, particularly in the MHU. Beyond the findings discussed with respect to Subparagraph 5(a)(17), *supra*, the Court noted that Defendants failed to show that providers make admission and discharge determinations based on face-to-face assessments. Dkt. 2283 at 48 ¶ 171.

196. Subparagraph 5(a)(18) requires that "[a] mental health provider will determine the placement of each seriously mentally ill pretrial detainee after performing a face-to-face assessment, including upon admission into, transfer within, and discharge from the Mental Health Unit." Dkt. 2299 at 5.

197. Defendants updated their procedures to require that an MHU psychiatric provider see the patient "for face to face evaluation by the next day after admission" into the MHU. Dkt. 2333 at 27; SOP J-G-04 (Dkt. 2304-1 at 152). Defendants' updated policies further require that the provider must also see patients face to face to "conduct[] clinical assessments to determine if [the] patient is appropriate for transfer to other MHU units for further treatment or to GP." *Id.* (Dkt. 2304-1 at 152-53).

198. Defendants measured compliance with this remedial provision by comparing the date and time of each placement to that of the provider assessment and "whether the assessment was completed prior to the MHU placement." Dkt. 2333 at 27-28. The overall compliance rate combined the percentage of those prisoners who were assessed prior to their admission into, transfer within, or discharge from the MHU with that of those prisoners who were released within twenty-four hours. Dkt. 2333 at 28. Defendants did not assess the placement of seriously mentally ill detainees in any of the outpatient levels of care, though Provision 5(a)(18) by its plain terms applies to all levels of care, including both the MHU and outpatient levels.

199. Defendants' initial report demonstrated poor compliance with Subparagraph 5(a)(18)—83% in June, 82% in July, and 85% in August. Dkt. 2333 at 28.

200. Following these poor initial compliance rates, Defendants conducted "chart review audits of the circumstances deemed noncompliant" in their data. Dkt. 2336 at 8. As discussed *supra*, Defendants' audit process in preparing their revised compliance rates consisted of reviewing only the "noncompliant" entries. *See id.* By reviewing only the noncompliant entries for errors, Defendants' auditing may have produced skewed results. Even the updated compliance rates Defendants reported in their Supplemental Report still indicated insufficient compliance in July (87%), with higher rates of compliance reported for June (92%) and August (96%).

201. Defendants reported that they measured compliance based on whether the face-to-face assessment was completed prior to the MHU placement. *See* Dkt. 2333 at 28. However, the underlying data on which Defendants have relied indicates that Defendants did not, in fact, measure compliance based on whether provider assessments were conducted before placement. Instead, a placement is indicated as compliant within the data as long as a provider assessment was listed in the data at all—whether it was conducted before or after the placement itself. A placement is indicated as noncompliant only where no assessment date and time is listed at all. The underlying data is replete with "compliant" admissions, transfers, and discharges in which the accompanying assessment that is listed was apparently performed after the placement.[1]

202. Furthermore, Defendants include in their compliance data entries for patients who were released prior to assessment. *See* Dkt. 2333 at 28. These entries are irrelevant to the true measure of whether a provider made face-to-face determinations of the placement of seriously mentally ill detainees. Subparagraph 5(a)(18) aims to ensure that qualified mental health providers make patient placement determinations, and that they do so following an in-person assessment. Patients who were released before being placed are irrelevant and serve only to cloud the compliance figures.

203. My record reviews also uncovered discrepancies between Defendants' TechCare data and the underlying patient records. Several patient transfers are simply absent from Defendants' data: Patient NF [redacted] (MHU stay from March 14-April 14, 2015); Patient DB [redacted] (MHU stay in May 2015); Patient AG [redacted] (MHU stay from June 23-July 7, 2015); Patient JA [redacted] (MHU transfers on March 23, 2015 and July 20, 2015); Patient VW [redacted] (MHU transfer from P-3 status on

[1] Defendants appear to have measured whether an assessment was performed within 24 hours of the admission, transfer, or discharge.

March 10, 2015, for which there was no corresponding provider assessment, and MHU discharge on May 30, 2015).

204. In other instances, underlying patient records showed instances of noncompliance that were noted as compliant in Defendants' data. Patient WI [redacted] was booked on July 8, 2015, and was moved to the MHU the following day. Defendants' TechCare data shows that he was assessed by a provider on July 9 at intake prior to his admission to the MHU. However, his underlying record shows no associated mental health provider assessment leading to his MHU transfer. Defendants' data shows that Patient DC [redacted] was transferred within the MHU on July 12, 2015, with a corresponding provider assessment that same day. The patient's record does indicate a transfer to P-1, then to P-2, on that day. Although the patient's record shows that he was seen that day by a provider for a routine follow-up assessment, it contains no corresponding note from a provider ordering either of those moves. On July 13, Dr. Jaffe wrote that he saw the patient on P-1-B because A Side had been closed for repairs, so it is not altogether clear that this patient was moved for clinical reasons.

205. More fundamentally, Defendants' TechCare data does not show their compliance with Subparagraph 5(a)(18) and CHS policy. This provision was entered because the Court found that patients were not being placed in the appropriate level of care based on their clinical presentation. *See* Dkt. 2283 at 47. This remains a serious problem at the Jail, notwithstanding Defendants' asserted rates of compliance. Even where providers do conduct timely face-to-face assessments, in practice, patients are not timely admitted to the MHU, they are not appropriately stepped down, and they are prematurely discharged, all in violation of CHS policy. As a result, they decompensate and suffer needlessly. Defendants have not measured whether the MHU admissions, transfers, and discharges ordered were appropriate based on the patient's presentation. As the numerous patient narratives listed under Subparagraph

5(a)(17), *supra*, suggest, Defendants have not shown compliance with the underlying purpose of this provision.

Subparagraph 5(a)(19)

206. Subparagraph 5(a)(19) requires the following: "Pretrial detainees discharged from the Mental Health Unit will be assessed by mental health staff within 48 hours after discharge." Dkt. 2299 at 5. By this remedy, the Court sough to address the following problem: "Some pretrial detainees are transferred directly from an acute unit to general population housing without transition placement within the Mental Health Unit, they are not stable enough to remain in general population housing, and they are transferred back to the Mental Health Unit." Dkt. 2283 at 49 ¶ 164. Ensuring a timely assessment of discharged MHU patients would help identify those who remain unstable and need to be readmitted to the MHU.

207. In 2014, I testified that clinically unstable patients were being prematurely discharged from the MHU to outpatient facilities. Mar. 6, 2014 TT at 13:18-23, 36:16-20, 42:10-17 (Stewart). I explained in my November 2013 Declaration that, for this reason, it was crucial that all detainees discharged from the MHU be timely assessed to ensure that those prematurely discharged were readmitted. Stewart 2013 Dec. at 40 ¶ 110. Otherwise, prematurely discharged patients remain at risk of languishing in outpatient facilities unequipped to provide adequate care. *Id.* These patients are at risk of serious harm from exacerbation of their mental illnesses and from victimization by their fellow detainees. *Id.* The Court noted in its Findings of Fact that Defendants failed to show that patients discharged from the MHU were assessed by a mental health professional or provider within 24-48 hours after discharge. Dkt. 2283 at 48 ¶ 173.

208. The Revised Fourth Amended Judgment requires that Defendants adopt policies and procedures to ensure timely assessment of patients discharged from the MHU, and Defendants submitted a procedure intended to comply. *See* SOP J-G-

04(E)(12) ("Patients discharged from MHU are assessed by mental health staff within 48 hours after discharge from MHU.").

209. Defendants calculated their compliance with this provision by determining the percentage of prisoners discharged each month from the MHU who were seen by mental health staff within 48 hours of their discharge. On their face, Defendants' reported rates do not indicate consistent compliance, at 85% in May, 88% in June, 96% in July, and 92% in August. *See* Dkt. 2333 at 29. Again, only two months of compliance exceeding 90% do not demonstrate compliance with this provision.

210. The problem the Court sought to remedy by this provision—the premature discharge of clinically unstable patients from the MHU, and the failure to transfer them back to the MHU timely, remains. In my record reviews, I identified numerous examples in which patients were still clinically unstable when discharged from the MHU and remained clinically unstable when they were first seen by mental health staff at their post-MHU discharge assessment.

211. Patient FA [redacted] was discharged from the MHU on June 2, 2015, despite reporting auditory hallucinations and being newly prescribed Zyprexa. She was seen for the first time three days later, on June 5, after officers reported that she had become angry. MHP Otero assessed her; Ms. FA was reportedly walking around the room and reported hearing voices. Not only did the assessment occur beyond the 48-hour timeframe, but also this patient remained unstable and should not have been discharged.

212. On multiple occasions, Patient GL [redacted] was prematurely discharged from the MHU, remained clinically unstable in outpatient care, and returned to the MHU. She was discharged from the MHU on July 25, 2015a. She was not stepped down before her discharge. When she was seen the following day, July 26, by MHP Scarpati, Ms. GL reportedly threatened to harm herself so that she could obtain the

correct medications. She was noted as confrontational, angry, and hostile; MHP Scarpati deemed her stable for her current housing. A nursing note from the following day stated that the patient stated she would kill herself if she did not get a shot. She was reportedly pacing in her cell and refusing to contract for safety. Ms. GL was moved back to the MHU.

213. Patient LL [redacted] was discharged from the MHU on June 5, 2015, despite remaining unstable. Just two days before her discharge, she was noted as confused, disoriented, and responding to perceptual disturbances. She was non-compliant and symptomatic, though she denied having any symptoms. Ms. LL was not stepped down before her discharge. During her post-MHU discharge assessment by MHA Lewis, on June 5, Ms. LL reportedly stated, "'I don't believe in this place I don't know why I am here.'" She further stated, "'There are people out there jumping on my mom I can hear her crying for me.'" Despite her presentation, she was found marginally stable for outpatient housing. She was seen again, two days later, after detention referred her for her bizarre behavior. She was pulling her hair out and eating it, and she was laughing inappropriately. She remained in outpatient care.

214. Patient AW [redacted] was discharged from the MHU on May 13, 2015. She was seen by MHP Bly the following day for her post-MHU discharge assessment. On exam, Ms. AW appeared disheveled, with a piece of paper in her hair. She made fixed eye contact and either refused to answer questions or had latent responses. She was found marginally stable for outpatient care. The following day, May 15, the patient was referred from detention after she apparently asked to go into protective custody because she feared she would react and hurt someone in her dorm. This patient had two subsequent MHU admissions and discharges. In each case, she was discharged prematurely before stabilizing.

215. I identified similar problems with respect to the following additional records: HB [redacted]; AD [redacted]; SH [redacted]; DG [redacted]; RO [redacted]; MT [redacted]; MM [redacted]; DG [redacted]; CB [redacted]; and JP [redacted].

216. There are also discrepancies between Defendants' TechCare reports and the underlying patient records. Defendants' data indicates that Patient RO [redacted] was discharged from the MHU on July 22 and assessed the following day in compliance with the provision. In fact, his record shows that he was never actually discharged. On July 23, the patient was ordered discharged; while in the holding tank at the 4th Avenue facility, though, he stated he was suicidal and he was moved back to the MHU. Patient DB [redacted] was in the MHU for a few days in May 2015, according to his record, before returning to his regular housing; he does not appear in Defendants' data. Patient AG [redacted]'s July 7 discharge back to GP is not reflected in Defendants' data.

217. I reviewed 18 records for compliance with this provision. Of those, 14, or 78%, were noncompliant. Of the noncompliant records, 3 included violations of the requirement that a patient be seen by mental health staff within 48 hours following a MHU discharge. The other noncompliant records, as described above, include patients who remained clinically unstable at the time of their post-MHU assessment after a premature MHU discharge but who were not referred to a provider for a determination of appropriate placement and care.

Subparagraph 5(a)(20)

218. Subparagraph 5(a)(20) requires that Defendants "consult with CHS mental health staff before placing a seriously mentally ill pretrial detainee in any type of segregated confinement." Dkt. 2299 at 5.

219. Defendants amended their policies and procedures to ostensibly comply with this requirement. Their policy mandates that "CHS will consult with [MCSO] before a patient is placed in segregation." SOP J-E-09 (Dkt. 2304-1 at 170). "A

licensed nurse reviews the patient's health record" to evaluate any needs that contraindicate the placement, including but not limited to SMI status and history of suicide attempts while incarcerated. *Id.* Mental health staff "review and document considerations regarding impact of segregation in the patient's health record and provide written considerations to MCSO." *Id.* Where isolation is being used as a sanction against an SMI individual, mental health staff must document in writing "any considerations and recommendations . . . specific to the use of isolation as a sanction." *Id.*

220. In their compliance report, Defendants stated that they generated "data for each seriously mentally ill pretrial detainee for which MCSO requested an evaluation during the reporting month." Dkt. 2333 at 29-30. Defendants calculated the rate of compliance with Subparagraph 5(a)(20) by comparing the time of the consultation against the placement into segregation. Dkt. 2333 at 30. Where the consultation occurred prior to the placement, it was deemed compliant. *Id.* The data collected measures compliance based on whether, among those prisoners for whom MCSO requested a consultation, that consultation took place before or after the prisoner was placed into segregation.

221. The compliance rates Defendants initially reported showed poor compliance, at just 61% in June, 57% in July, and 80% in August. Dkt. 2333 at 30. In auditing their data to arrive at amended compliance rates in the Supplemental Report, Defendants again re-evaluated only the data entries deemed noncompliant, possibly skewing their resulting amended compliance rates. *See* Dkt. 2336 at 9. Even Defendants' updated rates, notwithstanding their methodological flaws, demonstrate poor compliance: 61% in June, 80% in July, and 92% in August. The August rate alone is insufficient to show full compliance during the six month reporting period.

222. What's more, Defendants' measure of compliance does not accurately capture the true rate of compliance. Defendants have included in their data only those

incidents in which CHS consultation was requested. *See* Dkt. 2333 at 29-30. The data apparently do not account for any prisoners placed into segregation where no consultation was requested. Defendants' compliance data assumes that every segregation placement of a seriously mentally ill prisoner was accompanied by a consultation request. Instead, CHS should have used a baseline measure of all admissions into segregated confinement of seriously mentally ill prisoners. That would provide a truer picture of Defendants' rate of compliance.

223. By structuring their compliance data based on consultation requests, rather than actual segregation placements, Defendants may have created other methodological problems. In numerous instances, Defendants' data captures multiple consultations pertaining to a single placement. For example, prisoner AE [redacted], according to Defendants' data, was placed in segregation on August 17, 2015. However, for this single placement, there are two consultation entries listed in Defendants' August 2015 TechCare report: August 6 and August 13, both marked "compliant." The data includes multiple compliant entries for Prisoner TZ [redacted] based his August 21 placement into segregation; consultations are listed for August 5 and August 20. Defendants' reports contain many of these duplications.

224. Ultimately, this methodology has produced warped results. Defendants seemed to recognize this in their Supplemental Report, where they noted the number of duplicates in the July and August TechCare reports. *See* Dkt. 2336 at 9-10. However, as discussed *supra*, Defendants' audits looked only at the noncompliant entries. *Id.* To arrive at their updated compliance rates, then, Defendants corrected only the duplications marked "noncompliant." They failed to remove the duplicative "compliant" entries. I identified 15 duplications of "compliant" entries from Defendants' June, July, and August 2015 data. Defendants' failure to exclude these entries further skewed the amended rates of compliance they reported.

225. Further, other entries in Defendants' TechCare data are marked compliant, despite the fact that no data is listed for the date and time of placement into segregation or the time delay from consult to admit. Using the TechCare reports alone, as Defendants calculated compliance, it is not possible to deem such incomplete entries "compliant" or "noncompliant."

226. My own review of patient records also showed a pattern of serious discrepancies between the information reported in Defendants' TechCare reports and the underlying patient records.

227. First, my record review revealed numerous instances in which patients were placed in segregation with no documented mental health consultation. Many of these entries are absent from Defendants' TechCare data.

228. Defendants' data includes one entry for Patient FA [redacted], indicating a May 31 placement in segregation. According to her housing history, however, the patient was transferred from the MHU into Estrella segregation (B Tower) on June 2; where she remained until June 13. Her record contains no documented consultation with CHS staff before she was placed in segregation for this stay. The housing log showed that the patient was again placed in segregation on June 15, with no documented CHS consult before the placement; this placement is not included in Defendants' data.

229. According to her record, Patient HB [redacted] was moved from the MHU into Estrella segregation on March 17, 2015; there is no documented CHS consultation on her segregation placement in her record. The TechCare data shows a March 12 placement into segregation; the patient was in the MHU at this time. The patient was released and subsequently re-booked on April 11, 2015; she was moved from the MHU to Estrella segregation on April 14. According to her record, there is no documented CHS consultation with MCSO before the patient was moved to segregation. This placement is not included in Defendants' TechCare report. The

patient was moved from the MHU into Estrella segregation again on May 26; she was not cleared by CHS staff for segregation housing before being placed in segregation. In ordering her discharge from the MHU, Dr. Patel wrote only "DC to GP today"; Dr. Patel did not clear the patient to be housed in segregation. This placement does not appear in Defendants' data.

230. Patient GL [redacted] was moved in and out of Estrella segregation from the time she was booked in June 2015; despite this, the patient is not listed in Defendants' TechCare data. She was placed in segregation following her booking, on or around June 7, 2015, and on the following dates: July 9, July 20, July 25, and August 22. Her record does not include any documented CHS consultation with MCSO over these segregation placements. Again, none of the placements is included in Defendants' data.

231. Patient LL [redacted] is listed in Defendants' data as being placed in segregation on April 15 following a consultation the previous day. My review of the patient's record showed that she was first placed in segregation on April 14; that, following a brief period in GP, she was moved back to Estrella segregation on April 23; and that, after she was in the MHU, she was placed back in Estrella segregation on June 5. Of these three separate placements in segregation, Defendants' data captured just one—and, for the one placement that was listed, the date of the actual placement was incorrect. Additionally, the patient's record showed no consultation between MCSO and CHS for her April 23 or June 5 placements. These placements violated the requirements of Subparagraph 5(a)(20).

232. Patient AW [redacted] was placed into segregation on multiple occasions from her May 9, 2015, booking. According to the patient's housing history, she was placed in segregation on the following dates: May 20, May 24, May 29, June 16, July 2, July 12, August 2, August 6, and August 22. Her record documents correspondence between MCSO and CHS for less than half of these placements. Meanwhile,

Defendants' TechCare reports show placements on May 24, July 10, and August 22. Defendants correctly captured just two of this patient's numerous placements into segregation. Furthermore, Defendants deemed the July 10 placement "compliant" based on a June 16 consultation, where the patient's record shows the consultation took place the following day, June 17. The TechCare data for this patient presents a wholly unreliable picture of her segregation history and Defendants' compliance with the requirements of Subparagraph 5(a)(20).

233. Patient AD [redacted] was booked on March 4, 2015. She was moved from the MHU to Estrella segregation on March 14, where she remained until March 30. She was again moved from the MHU to Estrella segregation on June 5. The only documented correspondence between MCSO and CHS regarding her placement occurred on March 17, three days after her first placement in segregation, in violation of Subparagraph 5(a)(20). There is no documentation of any consultation regarding her subsequent June 5 placement. Neither instance was included in Defendants' TechCare reports.

234. Patient MM [redacted] was placed in Estrella segregation on July 16, where she remained through her initial July 30 discharge; her record contains no documented correspondence between MCSO and CHS clearing the patient for placement into segregation. This noncompliant placement is not included in Defendants' TechCare report.

235. Patient SB [redacted] was sent from E dorm to Estrella segregation at D Pod on May 15; there is no documented consultation with CHS about this move to segregation. It is not included in Defendants' TechCare data.

236. Patient CB [redacted] was re-booked on June 29, 2015. His record shows that, by July 13, the patient was in segregation. There was no related correspondence clearing him for segregation placement, though he had a current PAD Order for

involuntary treatment, and had been hospitalized at Desert Vista just two weeks before his booking. He is not included in Defendants' data.

237. I identified numerous other examples of segregation placements missing from the TechCare reports. Patient DB [redacted] has spent most of his incarceration in the SMU; however, his stays were punctured by stays in the MHU, including in May 2015. On his return to the SMU from the MHU, MCSO was required to consult with CHS before the placement back into segregation. This incident is not included in Defendants' TechCare data. Patient DG [redacted] was in segregation at Estrella as of March 2015. After being moved to the MHU, the patient was placed back in segregation on May 4. This placement is not included in Defendants' TechCare data, which lists just one placement on March 20. According to her housing logs, Patient CB [redacted] was placed in Estrella segregation on March 24. She does not appear in Defendants' data. Patient LW [redacted] was admitted on July 19, 2014, and has spent most of his incarceration in the SMU. Defendants' TechCare data indicates that he was placed in the SMU on July 21, 2014. However, my record review showed that the patient was sent to the MHU, from which he was discharged back into segregation on April 17, 2015. This placement is not included in Defendants' data. Patient NF [redacted] was booked on March 14, 2015. His record includes mental health segregation rounds during March and April 2015, indicating that he was placed in segregation. He is not included in Defendants' data.

238. Patient DY [redacted] is listed in Defendants' data as a compliant entry for an August 13 placement. However, according to the patient's record, he was not actually newly placed in segregation; rather, he was moved from the 4th Floor closed custody pod to the 2nd Floor closed custody pod. This move should not have been reported under this provision. In short, Defendants' methodological flaws call into question the clarity and accuracy of Defendants' asserted rates of compliance.

239. Even where a mental health consultation took place, the TechCare data does not provide any insight into the nature of the consultation preceding the placement into segregation or whether the consultation is consistent with the CHS SOP. For example, the SOP requires a licensed nurse to determine "whether mental health needs . . . contraindicate the placement or require accommodation," considering a list of non-exclusive factors including a history of suicide attempts. SOP J-E-09B (Dkt. 2304-1 at 170-71). Further, mental health staff also conducts a review regarding the impact of segregation on the patient. *Id.* Finally, a provider is contacted "if there is any concern or question about the patient's suitability for placement in segregation." *Id.* My own review of the records show non-compliance with CHS' revised policy. The consultation, when it does occur, is usually nothing more than a rote exercise by mental health staff using boilerplate language approving the placement, and that staff does not adhere to the more complete assessment required by CHS policy.

240. For example, a June 3 note by MHP Page indicated that Patient FA [redacted] was placed in segregation. It provided the standard language of so many such notes: "no contraindications to segregation noted at this point in time[.] [H]owever due to patient's mental illness, isolation over time may contribute to increased psychiatric distress. Patient must be monitored to determine if segregation is negatively impacting the patient. CHS will communicate concerns to MCSO should the patient appear to be decompensating due to segregation."

241. This same exact language is consistently employed for CHS consultations with MCSO preceding segregation placement. This language appeared in records for the following patients whose records I reviewed: LL [redacted]; DG [redacted]; AW [redacted]; AD [redacted]; JP [redacted]; and DY [redacted].

242. CHS relied on this boilerplate and approved segregation placements for these patients despite evidence of the patients' decompensation while in lockdown, or other indications that lockdown placement was contraindicated. For example, as

stated above, no contraindications were identified with respect to Patient FA [redacted] for her June 2, 2015 placement into segregation. Just a few days prior, however, Ms. FA had to be removed from segregation after an emergency call reported that she was found tying a towel around her neck. Similarly, mental health assessments of Patient AW [redacted] relied on the boilerplate language on multiple occasions, despite notes in Ms. AW's chart showing her serious decompensation while in segregation. No contraindications were found in a June 17, 2015 chart review, despite the fact that in the prior two weeks, the patient reported auditory and visual hallucinations and stated voices were speaking through her hair. The same language was used on an August 22, 2015 note, despite the patient's continuing hallucinations and multiple suicidal and self-harm statements during her segregation placements in July and August.

243. Patient HB [redacted] had multiple chaotic stays in Estrella segregation in April-May 2015, but was nonetheless cleared to return to Estrella segregation via the same boilerplate language in June 2015. A June 7 assessment reported that she was seen screaming, spoke about voices telling her things, and expressed delusions about cameras and people watching her. The MHP wrote that, given her psychotic behavior and behavioral problems, the patient would be better suited to a step-down unit of the MHU. The very next day, MHP Fischer conducted a chart review and wrote, "[N]o contraindications for segregation noted at this point in time."

244. In some instances, CHS evaluated patients and determined that, "due to the severity of the patient's mental illness and past response to being in a more isolated environment," the patient may be adversely impacted by segregation, such that "[i]solation and lack of contact with others is likely contraindicated." Under CHS SOP J-E-09B, if there is "any concern or question regarding the patient's suitability for segregation," a provider must be contacted to determine the appropriate placement of the patient. The records of such patients should thus include a documented consultation with a provider. However, providers are not consulted even in the few

records where mental health staff does indicate a concern/question about segregation placement.

245. For example, Patient AD [redacted] was moved into Estrella segregation on March 14; documented CHS-MCSO consultation occurred on March 17, three days later, during which CHS indicated that segregation was likely contraindicated. There is no indication in the patient's record that a provider was consulted after CHS noted the contraindication. This patient was actively psychotic and complained about not receiving appropriate medications when she was moved to segregation. She was moved back to the MHU after she attempted to strangle herself in her lockdown cell. She should not have been cleared for lockdown placement, given her acuity.

246. Patient DG [redacted] was moved from intake to Estrella segregation on May 19, 2015, where she remained through June 9, 2015. Defendants' TechCare data indicates that MCSO consulted with CHS on May 19 before the patient was placed in segregation the following day, May 20. The patient's housing history shows the May 19 placement in Estrella segregation (C Tower). Additionally, per my review of the patient's record, however, the only note from MCSO for this time period is a referral from detention noting that the patient is (already) in segregation. There is no request for CHS to assess the patient's placement in segregation, and there is no record that CHS performed any such assessment. The patient's records further confirm this patient's placement in Estrella segregation (C Tower) on June 12, following a brief stay in the MHU. There was no documented consultation between MCSO and CHS before the patient was moved. This placement is not included in Defendants' TechCare data. The patient's record includes a note from MHP Otero—entered three days after the patient was placed in segregation—with boilerplate language stating no contraindications to segregation at the time.

247. My record review shows that this patient had significant problems during previous segregation stays that raise serious questions as to whether segregation

placement was contraindicated. The patient had multiple detention referrals for erratic behavior during her May 19-June 9 segregation stay that indicate segregation placement was contraindicated. On June 9, the patient was moved from segregation (C Tower) to the MHU after a crisis call from detention prompted by the patient yelling and screaming in her cell. Dr. Drapeau, who ordered the MHU transfer, reported that the patient was very irritable, malodorous, psychotic, and likely manic. MHP Otero's boilerplate note clearing this patient to return to segregation in June is just another example of how empty an exercise these segregation reviews are at MCJ.

248. Despite her chaotic May 19-June 9 stay in Estrella lockdown, patient DG was returned there on June 12 after a three day MHU stay. She remained in lockdown until her July 30 discharge. There is no documented consultation between MCSO and CHS before this unstable patient was moved back to lockdown. Three days after the move, MHP Otero entered a note with the same boilerplate language on segregation found in other charts: "no contraindications to segregation noted at this point in time however due to patient's mental illness, isolation over time may contribute to increased psychiatric distress. Patient must be monitored to determine if segregation is negatively impacting the patient. CHS will communicate concerns to MCSO should the patient appear to be decompensating due to segregation." Given this patient's presentation and decompensation during her previous lockdown stay, renewed placement in lockdown was contraindicated.

249. The records of Patients LL [redacted], SH [redacted], and JP [redacted] include the same CHS language indicating that segregation is likely contraindicated; in none of them, though, is there a documented consult with a provider. In each of these cases, there was ample reason to question the segregation placement. For example, for Patient LL [redacted], MHP Allaman wrote on August 26 that segregation placement was "likely contraindicated" for a patient who was psychotic and who during previous

lockdown stays had failed to attend to her ADLs, covering herself and her cell in her own blood.

250. In short, I found no instance—in all of my record reviews—in which a CHS note indicating that a patient's placement in segregation was contraindicated actually resulted in diverting the patient from segregation or discontinuing the patient's stay in a segregation unit.

251. In all, I reviewed 20 relevant records in which a detainee was placed into segregation within the six-month reporting period. Of those, 10, or 50%, were noncompliant with the consultation requirement. As described above, many of these records included multiple segregation placements which were not preceded by a mental health consultation. Many of the placements are not included in Defendants' TechCare data. Furthermore, even where a mental health consultation did take place prior to a segregation placement, the consultations consist of boilerplate language that is not consistent with CHS policy. Defendants have not shown compliance with this provision.

Subparagraph 5(a)(21)

252. Subparagraph 5(a)(21) requires that all "[s]eriously mentally ill pretrial detainees who are confined to single cells for 22 or more hours a day will have face-to-face communication with mental health staff at least twice per week." *Id.*

253. In its Findings of Fact and Conclusions of Law, the Court noted that "[t]he longer a pretrial detainee with mental illness is in isolation, the greater the risk the pretrial detainee's mental condition will deteriorate." Dkt. 2283 at 48. Further, "[s]ome pretrial detainees do not manifest symptoms of serious mental illness until after placement in segregated confinement." *Id.* at 49. The Court noted that "face-to-face communication with mental health staff" could "mitigate the risks of isolation" for seriously mentally ill prisoners and found that Defendants had failed to show that

such prisoners "have face-to-face communication with mental health staff at least twice per week." *Id.* at 50.

254. Defendants revised their policies and procedures to require that mental health staff "[h]ave twice weekly face to face contact with all seriously mentally ill or mental health chronic care patients who are confined to single cells for 22 hours or more a day." SOP J-E-09 (Dkt. 2304-1 at 188). "Contact includes 1:1, group psychoeducational sessions, and/or rounds; . . . mental health assessments and updates, [and] psychiatric provider appointments." *Id.* Contact must be documented in patients' electronic health records. Mental health staff must "conduct[] rounds at cell front that consist of verbal interaction, mental status and observations. Each patient is given the opportunity to communicate health care concerns." *Id.* Rounds must be documented, including patient refusals. *Id.*

255. Defendants determined compliance by creating TechCare reports for each month of all those seriously mentally ill pretrial detainees "who appeared to be in some type of segregation during that month." Dkt. 2333 at 31. Defendants then performed manual audits of the third week of each month to determine compliance. *Id.* An entry was deemed compliant where the patient was seen two times in the week. Defendants reported compliance rates of 99.6% in June, 98% in July, and 95% in August.

256. As with Subparagraph 5(a)(20), Defendants' data provides no indication whether the contacts comply with the revised policy regarding content and quality. Defendants assert compliance based on whether mental health rounds occurred at all, without regard to their compliance with policy. These rounds do not comply with CHS policy requiring that they include "verbal interaction, mental status and observations." My review shows that prisoners in segregation are still denied meaningful face-to-face communication by qualified mental health staff as required by the remedial provision and CHS policy. They therefore remain at risk of deteriorating

without being identified by mental health staff as in need of either more assertive treatment, or removal from isolation.

257. Patient FA [redacted] was in segregation in Estrella B Tower from June 2-13 and from June 15-29. Written notes from segregation rounds by MHP Otero during this time suggest that the patient received only cursory mental health assessments that are not consistent with CHS policy. A typical assessment relied on a short form under which the boxes for "no health concerns noted" and "no observable change in status" were checked. Occasionally, MHP Otero would use a longer form, in which boxes were checked for "no health concerns noted," "well groomed," "mood congruent," "cooperative," and "no observable change in mental status." The only written comments came on a June 25 form, where MHP Otero noted, "pt refusing psych meds and says she will refuse them for 30 days." The segregation rounds notes stand in contrast to other assessments during that time from following referrals from detention—one after the patient made DTS statements and reported hearing voices telling her to hurt herself, and another after she was observed with cuts on her neck and arms. There was one rounds assessment that did have a meaningful finding: on June 25, patient FA told MHP Otero during rounds she is refusing medications and would refuse medications for the next month. The rounds form does not indicate a provider referral or any follow-up was ordered.

258. Patient HB [redacted]'s record shows similarly bare assessments during her time in Estrella segregation. For most of April and May 2015, mental health staff saw the patient regularly but only checked the standard boxes noting no concerns. An April 20 note reported that the patient "appears delusional and her cell is a mess with food and clutter around." No provider referral was made. During her stay in Estrella segregation in June 2015, the quality of the segregation rounds was much the same. Meanwhile, a June 7 assessment reported that she was seen screaming, spoke about voices telling her things, and expressed delusions about cameras and people watching

her. The MHP wrote that, given her psychotic behavior and behavioral problems, the patient would be better suited to a step-down unit of the MHU. The very next day, MHP Fischer conducted a chart review and wrote, "[N]o contraindications for segregation noted at this point in time." This note is difficult to understand, given that the day before another MHP had recommended that the patient be transferred to the MHU.

259. The record of Patient NF [redacted] includes mental health segregation rounds performed by RNs. Rounds by mental health staff are meaningless encounters. For example, forms on April 21, April 28, May 21, May 26, June 9, June 23, July 15, and August 19 by MHA Uribe have simply checked the box for "no health concerns noted" and "no observable change in mental status," with no comments or observations noted. Again, other assessments over that time period show a very symptomatic patient. A MHP note from May 30 reported that patient was non-oriented and that there was a pile of feces in the corner of his cell. On multiple occasions, it was noted that food or spit was smeared in the window of the patient's cell, and that his cell was dirty, with trash littered on the floor. The patient was also non-verbal.

260. Patient DG [redacted] provides another example of the lack of meaningful access to mental health care for patients in segregation. For both of her stays in Estrella segregation, notes from rounds generally consisted of the aforementioned long or short forms with the boxes checked off indicating no mental health issues or changes in status. This is in sharp contrast to other notes covering patient DG's condition during her lockdown stay. Five times detention staff referred this patient to mental health staff after she exhibited bizarre and erratic behavior. On June 9, MHP Griemsmann, utilizing the short form, wrote nothing on the form, only checking off the boxes for no health concerns noted, and no observable change in behavior. That same day, Dr. Drapeau saw the patient after a crisis call from detention that patient DG

was yelling in her unit. On exam, the patient was irritable, malodorous, psychotic, and possibly manic. She was transferred from segregation to the MHU that day.

261. As with her previous lockdown stay, Patient DG's segregation rounds were not meaningful monitoring during her June 12-July 30 lockdown stay. For example, on July 28, MHP Otero on rounds used the short form, wrote no findings, and merely checked off the boxes for no health concerns noted and no observable change in mental health status. She was not referred for follow-up. The next day, Patient DG was seen cell side for a prescheduled appointment because detention staff refused to pull her out of her cell because she was difficult to manage. She had been refusing to go to court. On exam, she was delusional and yelling at staff. She was refusing her medications and refusing to comply with a TB test.

262. Even the two segregation rounds for Patient DG that did have significant findings did not result in any follow-up. A May 21 note indicated that the patient was agitated; however, no provider referral was made, and there was no follow-up noted. A June 4 note indicated that the patient was seen responding to internal stimuli and was behaving inappropriately; still, no provider referral was made.

263. Similarly, Patient LL [redacted] did not receive adequate mental health rounds during her stays in Estrella segregation. Again, mental health staff relied on the same forms and merely checked boxes indicating no change in mental status and no health concerns noted. During the patient's April 23 to May 4 placement, a string of toothless mental health notes from segregation rounds came amid other assessments demonstrating the patient's deteriorating condition. For example, a referral from detention led to a May 3 assessment by MHP Griemsmann, who noted that the patient was letting her menstrual blood drip onto the floor of her cell and that she had put her clothes in the toilet. This pattern repeated during the patient's early June stint in segregation. Mental health notes from the segregation rounds were meaningless, noting no health concerns, whereas, on assessment following referral from MCSO, she

was found pulling her hair out and eating it, laughing inappropriately, and displaying inappropriate behavior.

264. Patient AW [redacted] was seen for segregation rounds on several occasions during her placements in segregation; as with many other patients, the rounds were but meaningless encounters. Notes on June 4 and June 9 from MHPs used the standard forms and each marked "no health concerns noted." Meanwhile, when she was assessed by a provider on June 5, the patient reported auditory and visual hallucinations and was apparently talking out loud to voices. She laughed inappropriately. Two days later, she was referred by detention for her odd behavior—her cell was dirty, she was malodorous, she appeared to have toothpaste in her hair, and had been standing naked in her cell the previous night. The incongruence of these depictions of the patient demonstrates that the mental health rounds do not comply with CHS policy.

265. Patient AD [redacted] similarly received inadequate mental health rounds during her stays in segregation. For example, a March 19 note following rounds from relied on the long form and checked the boxes to indicate "no health concerns noted" and "no observable change in mental status." Just the day before, however, the patient was seen for her post-MHU assessment, during which she reportedly was speaking softly and looking off to the side. She did not respond when asked if she was talking to someone else. On March 24, MHA Goodroad saw the patient for segregation rounds, using the short form and checking the same boxes. That very same day, however, the patient was seen by Dr. Drapeau, where she reported auditory and visual hallucinations and further stated she believed she was being fed people in her food. This pattern repeated during her August stay in segregation. An August 11 segregation round note reported "no health concerns" and "no observable change in mental status." Just three days later, when seen by Dr. Drapeau, the patient was actively symptomatic, reportedly stating to Dr. Drapeau: "People are eating other

people outside the jail? . . . . Are people trying to get inside the jail? . . . . I am tortured by the Devil in Phoenix . . . . You can pick up the phone and the demons come out."

266. The care of Patient RG [redacted] while he was in the SMU further demonstrates the poor quality of mental health segregation rounds. This patient has languished in the SMU since December 2014. Despite his extremely psychotic state—which I observed when I personally evaluated him in October 2015—notes from segregation rounds from March through July 2015 still routinely indicated "no health concerns noted" and "pt doing okay." At most, some of the notes included a comment about the state of the patient's cell, which was littered with trash. His infrequent assessments by Dr. Fangohr reveal a different picture. On March 24, the patient reportedly stated, "I don't eat none of your bullshit ever. Energy is well, concentration who gives a fuck. Bitch I am being watched." The patient then became agitated and hit the window. A July 17 note from Dr. Fangohr reported that the patient was minimally cooperative, somewhat paranoid, and somewhat depressed, and began banging on the cell door shortly after the provider approached. Dr. Fangohr did not offer a private assessment due to security concerns about the patient. A segregation check performed the following day by MHP Fedotova has nothing written on it, and only includes check marks for no health concerns noted, well groomed, mood congruent, and cooperative. Even on the few occasions where there were positive findings on rounds, they did not result in a timely referral to a provider. For example, MHA Uribe noted that the patient had trash all over his cell and food/substances smeared on his cell window on April 7 and July 24, but did not refer the patient to a provider. My own evaluation of this patient is similar to Dr. Fangohr's February 26 evaluation; that this patient is psychotic and agitated, living in extremely unsanitary conditions, and suffering needlessly. His long-term housing in the SMU is contraindicated.

267. The record of Patient CB [redacted] includes segregation progress notes on March 14, March 19, March 28, April 5, and April 12. There are also segregation round sheets by CHTs on April 17 and April 20. The only note in the round sheets is a check box with "no health concerns noted." There is no indication as to whether the patient was engaged, and the checks are completed by a health tech, rather than mental health staff. Additionally, the notes are at odds with the clinical notes. For example, a March 25 note by CHT Clari has a check mark for "no health concerns noted"; however, the very next day, a provider note shows a symptomatic patient. The patient was again placed in segregation following his release and subsequent re-booking. During segregation rounds in July and August, mental health staff utilized the same forms and checked off "no health concerns noted," with only sparse notes, if any at all.

268. Several other patient records revealed the same minimal and non-compliant mental health rounds: FO [redacted]; TW [redacted]; and SH [redacted].

269. I also identified some discrepancies between the records and Defendants' data. Patient MG [redacted] has been housed in the SMU since his February 26, 2015, discharge from the MHU. Though Defendants include him in their TechCare reports for April, May, and June, the patient should be included in the March, July, and August reports as well; he is absent from those. Patient FO [redacted] has been housed in the SMU since May 31, 2015. This patient does not appear in Defendants' TechCare reports for June, July, or August 2015. Patient CB [redacted], according to her housing logs, was in Estrella segregation from March 24 through her release on August 5; she is not included in Defendants' TechCare reports for April, May, June, or July. Patient DG [redacted] appears to have been in segregated housing for all of April 2015; she is not included in Defendants' data.

270. In all, I identified 39 records in which a patient was housed in segregation. Of those, I looked closely at the mental health rounds for 13 of the patients and found that Defendants had failed to comply with their own policy

regarding segregation rounds in each case. The relevant CHS policy requires meaningful face-to-face communication between mental health staff and patients in isolation; though patients are generally seen by mental health staff, the encounters are meaningless and do not allow for the interaction and observation the policy and the Court's remedy requires.

Subparagraphs 5(a)(22) and 5(a)(23)

271. Subparagraphs 5(a)(22) and 5(a)(23) pertain to use of force or involuntary treatment on seriously mentally ill prisoners. Subparagraph 5(a)(22) requires that a "mental health provider or professional will be consulted before each planned use of force or involuntary treatment on a seriously mentally ill pretrial detainee." Dkt. 2299 at 5. Subparagraph (5)(a)(23) requires that "[m]ental health staff will be involved in the implementation of any planned use of force or involuntary treatment on a seriously mentally ill pretrial detainee." *Id.*

272. The use of force on a seriously mentally ill prisoner is traumatic; it can damage the relationship between mental health staff and the patient and reinforce the patient's delusions of victimization by jailers and treatment staff. For these reasons, prisons and jails around the country require that mental health staff be involved in planned use of force incidents involving prisoners with mental illness. Mental health staff is often in a better position than detention staff to de-escalate the situation so that force need not be used. For example, mental health staff in the MHU should already have a relationship with the patient, be specially trained to develop a rapport with their patients, and use this specialized training to de-escalate a potential confrontation with detention staff. Mental health staff can also provide critically important feedback to detention staff. Some patients may not be able to comply readily with orders because they are delusional or hallucinating, and may perceive an order to exit his cell or to offer his hands for handcuffs as a threat. The patient may not even understand the

officer's order. Mental health staff can give this critical assessment to detention staff, which can result in a different approach that obviates the need for force.

273. Involuntary treatment includes the use of restraints, the use of seclusion, and forced medication. When treatment is forced on a patient improperly it harms the therapeutic relationship between patient and provider, which can have far-reaching consequences to the patient's prognosis and further course of treatment, as the Court recognized in 2014. *See* Dkt. 2283 at 50 ¶ 188 ("Involuntary treatment . . . can place pretrial detainees at substantial risk of serious harm.").

274. Given these serious considerations, the Court ordered that Defendants develop and implement compliant policies and procedures. Dkt. 2299 at 5.

275. Defendants adopted policies and procedures to comply with the mandates of the Court. The updated policies and procedures require that MCSO "consult with CHS before each planned use of force or involuntary treatment on a seriously mentally ill or mental health chronic care patient." SOP J-A-08 (Dkt. 2304-1 at 193). MCSO must "maintain a log of all referrals/requests," and CHS staff must "document the MCSO request including time, location, CHS interventions and outcome in the electronic health record on MCSO-CHS Correspondence form." *Id.* Further, mental health staff "will be involved in the implementation of [any] planned use of force or involuntary treatment." *Id.*

276. Defendants generated monthly rates of compliance for both provisions together by compiling the number of instances in which CHS was consulted on a planned use of force involving a prisoner deemed SMI or MHCC. *See* Dkt. 2333 at 32. Defendants compared the time the consultation was requested against the time force was used "with mental health involvement." *Id.* Entries were deemed compliant where the consultation occurred before the planned use of force. *Id.* Defendants reported compliance rates of 100% for all months.

277. Defendants' assertion of compliance with these provisions is not reliable in several respects. First, Defendants drew their compliance data only from instances in which MCSO consulted with CHS—The reports are keyed off of consultations, not actual planned use of force incidents. *See* Dkt. 2333 at 32. Thus, the data does not capture any planned use of force incidents for which CHS was not contacted. Defendants should have instead cross-referenced all planned use of force incidents against the lists of SMI and MHCC prisoners, and then evaluated whether those incidents of use of force on mentally ill prisoners were preceded by consultation with CHS and involved mental health staff. Additionally, the data is drawn from those already identified as SMI or MHCC. It excludes those suspected of—though not yet designated as—being seriously mentally ill. As the Court noted, "The fact that a pretrial detainee has not been designated Seriously Mentally Ill by the county public mental health provider does not mean the pretrial detainee does not have serious mental illness." Dkt. 2283 at 51. Furthermore, with respect to Subparagraph 5(a)(23), which requires the involvement of mental health staff in the implementation of any use of force, Defendants provide no data to indicate whether such involvement actually occurred. In their underlying compliance data, Defendants include a single column indicating "Date/Time of Planned use of Force with Mental Health Involvement." Defendants appear to conflate the use of force incident itself with mental health staff involvement. There is no stand-alone data indicating whether mental health staff was actually involved at all, let alone involved in a meaningful manner in the application of force. Staff involvement is a discrete measure relating to compliance with Subparagraph 5(a)(23), and it was apparently not treated as such by Defendants.

278. A closer look at the underlying data further indicates the shallowness of Defendants' asserted compliance. The data provide no indication of what "involvement" of mental health staff entails. Additionally, for many of the entries, no time is included at all in the consultation column. For those entries, there is no way to

know from the data whether the consultation even took place before the use of force. Even by Defendants' own purported standards, there is no way to measure compliance for these entries.

279. A comparison of Defendants' TechCare data against underlying patient records revealed discrepancies. For example, with respect to Patient MG [redacted], Defendants' data indicates a compliant planned use of force event on July 31, 2015, with mental health involvement following a consultation earlier that day. The patient's record does include documented correspondence between MCSO and CHS; MHA Urquidez noted, "[D]etention referral for patient refusing to go to court or to go back to his cell. Pt adamant he wants his hair tie." There is no indication from this note, however, that the MHA assessed the patient, was involved in the use of force incident, or otherwise responded in any way. The patient's record does not evidence compliance with the requirements of these provisions.

280. The underlying records for Patient NF [redacted] include a planned use of force incident. A Use of Force Report dated April 21, 2015 notes that, on March 30, the patient was removed from his cell in the MHU and relocated. Due to his "behavior and noncompliance," force was used "to gain compliance and remove [the patient] from his assigned jail cell." There is nothing in this patient's medical record indicating consultation with or involvement of mental health staff before force was used. This incident is not included in Defendants' TechCare reports.

281. Patient JP [redacted]'s record shows a use of force incident on March 15. The patient was, in fact, seen by mental health staff following notification from MCSO. However, this incident is not reflected in Defendants' data, further underscoring the unreliability of Defendants' assertion of compliance with these provisions.

282. In my 47 record reviews, I identified 5 planned use of force incidents. Of those, 2 evidenced non-compliance. In addition, 2 of the 5 incidents were absent from Defendants' TechCare reports.

Subparagraphs 5(a)(24)-(26)

283. Subparagraphs (24), (25), and (26) pertain to the use of discipline and disciplinary segregation on seriously mentally ill prisoners. As the Court recognized in 2014, Defendants lacked the policies and procedures necessary for an adequate disciplinary system that protected the mentally ill from exacerbation of their mental illnesses and other harms. The Court noted that "[s]eriously mentally ill pretrial detainees should not be disciplined for behavior resulting from mental illness without the approval of a mental health provider." Dkt. No. 2283 at 50 ¶ 193. It further found that that "[s]eriously mentally ill pretrial detainees should not be placed in isolation as a disciplinary sanction." *Id.* at 51 ¶ 194.

284. Subparagraph 5(a)(24) requires that Defendants "adopt and implement a written policy regarding the use of discipline for behavior resulting from serious mental illness." Dkt. 2299 at 5. Defendants submitted SOP J-A-08 to demonstrate compliance with the Court order. Dkt. 2333 at 32. The updated procedures require that CHS mental health staff receive from MCSO a "written referral, Disciplinary Action Report (DAR) . . . regarding discipline of any seriously mentally ill patient." SOP J-A-08 (Dkt. 2304-1 at 217). CHS must then "provide recommendations to MCSO," which are to be documented on the DAR. *Id.* The recommendations must "assess[the] relationship of mental illness to the behavior"; indicate the "[p]otential impact of discipline, particularly if the sanction includes use of isolation in disciplinary segregation"; and make recommendations regarding the use of discipline. *Id.* at 217-18.

285. The Court stated in its Findings of Fact that isolation should not be used as a disciplinary sanction against seriously mentally ill prisoners. Dkt. 2283 at 51 ¶

194. Subparagraph 5(a)(25) requires Defendants to "adopt and implement a written policy regarding the use of isolation in a disciplinary segregation unit as a sanction against seriously mentally ill pretrial detainees." Dkt. 2299 at 5. Defendants submitted in response SOP J-A-08, which sets out procedures that must be following before employing discipline on seriously mentally ill individuals. *See supra* ¶ 286. Defendants also submitted SOP J-E-09, which sets out "procedures that must be followed 'before a patient is placed in segregation.'" *Id.* For all patients designated as seriously mentally ill, mental health staff must "review and document considerations regarding impact of segregation in the patient's health record and provide written considerations to MCSO." SOP J-E-09 (Dkt. 2304-1 at 233-34).

286. Subparagraph 5(a)(26) requires that Defendants "adopt and implement a written policy requiring that mental health staff be consulted regarding discipline of any seriously mentally ill pretrial detainee." Dkt. 2299 at 6. Again, the Court's remedy emanates from its findings that "[s]eriously mentally ill pretrial detainees should not be disciplined for behavior resulting from mental illness without the approval of a mental health provider," and that "[s]eriously mentally ill pretrial detainees should not be placed in isolation as a disciplinary sanction." Doc. 2283 at 50 ¶ 193, 51 ¶ 194. Defendants submitted in response SOP J-A-08, which requires MCSO to consult with CHS mental health staff regarding the use of discipline on any seriously mentally ill individual. *See supra* ¶ 285.

287. Defendants have asserted compliance with these provisions by pointing to their amended policies and procedures. Despite the mandate in each of these provisions that Defendants must not only adopt, but also "implement" the procedures, Defendants have provided no compliance data that suggests implementation.

288. Additionally, my record review revealed instances in which sanctions were assessed against seriously mentally ill prisoners in violation of the Court's Judgment and CHS policy.

289. Sanctions were assessed against Patient CB [redacted] on or about March 30, 2015. That day, MHP Bass was contacted by a hearing officer about sanctions. MHP Bass wrote that the patient's chart had been reviewed and "sanctions will not interfere with treatment at this time." There was no discussion in the consultation about the extent to which the patient's serious mental illness contributed to the behavior that resulted in sanctions. There was no consideration of his culpability, as required by Subparagraph 5(a)(24).

290. Patient SH [redacted]'s record includes a note from MHP Fischer following MCSO–CHS correspondence. According to Sgt. Emans, the patient was to be placed on restrictions due to her behavior. There is no indication that mental health staff or a provider was consulted or assessed the clinical impact on the patient, or culpability.

291. On two occasions while Patient LL [redacted] was in Estrella, she was placed on restrictions due to her behavior. On June 17, Sgt. Means placed her on restrictions. On June 26, Sgt. Henry did the same. There was no corresponding mental health note for either incident included in the patient's record.

292. Finally, Patient FA [redacted] was placed in disciplinary segregation from June 2 to June 13, 2015, according to a June 3 note by a MHP. There was no documented consultation with CHS staff before the patient was placed into segregation. Furthermore, the June 3 note—entered after the patient was already in segregation—includes the same boilerplate language, as described above with respect to Subparagraph 5(a)(20), stating no contraindications to segregation.

293. Among the 47 total records I reviewed, I identified 8 instances in which disciplinary sanctions were imposed, among 6 patients. I identified violations of these provisions in 6 of the 8 instances, or 75%.

Subparagraphs 5(a)(27)-5(a)(28)

294. In its Findings of Fact and Conclusions of Law, the Court noted that there were five suicides each year from 2009-2011, and two suicides in the first eight months of 2013. Dkt. 2283 at 51 ¶ 199. The Court cited language in Defendants' own policies and procedures noting that most suicides occur within the first 48 hours of incarceration and that isolation "greatly increases the likelihood of suicide." *Id.* at 52 ¶¶ 206-07. The Court found that Defendants failed to show compliance with their own policies and procedures requiring that potentially suicidal inmates placed in isolation must be "constantly supervised" and those placed in a safe cell must be under "continuous observation until a treatment plan" is developed. *Id.* at 53 ¶ 210.

295. Subparagraph 5(a)(27) requires that "[a] potentially suicidal pretrial detainee will not be placed in isolation without constant supervision." Dkt. 2299 at 6.

296. Defendants submitted updated policies and procedures regarding potentially suicidal prisoners. With respect to Subparagraph 5(a)(27), SOP J-E-05 mandates that all prisoners identified at intake to be "actively suicidal" "[w]ill not be placed in isolation without constant supervision." SOP J-E-05 (Dkt. 2304-1 at 258). Defendants further updated SOP J-G-05 to require that, at intake and receiving screening, "[a]ll patients at imminent risk for suicide will not be placed in isolation without constant supervision." SOP J-G-05 (Dkt. 2304-1 at 261). Defendants' Policy DA-5 further mandates that, because "[i]solation greatly increases the likelihood of suicide[,] . . . a potentially suicidal inmate shall never be placed into isolation unless the inmate is constantly supervised." Policy DA-5 (Dkt. 2304-1 at 268).

297. Defendants define "Active Suicide Watch" patients as "those who are engaging in self-injurious behavior and/or are threatening suicide with a specific plan." *See* SOP J-G-05 (Dkt. 2304-1 at 266). Defendants define "Potentially Suicidal" patients as those "not actively suicidal but [who] express suicidal ideation and/or have a recent history of self-destructive behavior." *See id.* For patients on active watch, CHS or MCSO staff must be "physically present and maintain[ ] visual inspection of

the patient continuously." *Id.* at 290. For patients on potential watch, "[m]onitoring is at staggered intervals not to exceed every 15 minutes by Detention." *Id.* "Closed circuit television can be used as part of monitoring at Intake and MHU provided that CHS licensed staff are onsite and immediately available to respond." *Id.*

298. To assess compliance with this provision, Defendants generated data reports for every prisoner "admitted to active suicide watch during the reporting month." Dkt. 2333 at 35. Defendants evaluated compliance by conducting "manual audits" for each prisoner on suicide watch in a given month; the audit process included reviewing suicide watch flow sheets and therapeutic restraint flow sheets to "determine whether each [prisoner] received constant supervision while in isolation." *Id.* In their compliance data, for each prisoner, Defendants indicate the date of admission to active suicide watch and a "yes/no" indication of whether the prisoner received constant supervision. Defendants asserted compliance rates of 72% in March, 86% in April, 72% in May, 89% in June, 97% in July, and 95% in August. *Id.* Four out of six months that fall below a 90% threshold demonstrate a failure to comply with this remedy.

299. Subparagraph 5(a)(28) requires that "[a] potentially suicidal pretrial detainee will be placed into a suicide-resistant cell or safe cell only with 'direct, continuous observation until a treatment plan is determined by medical staff.'" Dkt. 2299 at 6.

300. With respect to Subparagraph 5(a)(28), Defendants updated SOP J-E-05 to mandate that, at intake, all "actively suicidal" patients "[w]ill be placed in a safe cell only with direct, continuous observation until a treatment plan is determined by CHS mental or medical staff." Dkt. 2304-1 at 285. They further updated SOP J-G-05 to require that, at intake and receiving screening, all patients "at imminent risk for suicide" "[w]ill be placed in a safe cell only with direct, continuous observation until a treatment plan is determined by medical staff." SOP J-G-05-01 further provides that,

"at acute risk suicidal patient[s]" at intake "will be assigned a Safe Cell Monitor Observer," who will "keep [the] patient under direct, continuous observation until a treatment plan is determined by CHS mental health or medical staff." Dkt. 2304-1 at 296-97. The Observer must document "in 15 minute intervals on the Suicide Watch Log." *Id.* at 297. Defendants further submitted Policy DS-1, Safe Cell Placement, which requires that, when detention staff implements a safe cell placement, "[a]n officer will be assigned to conduct observations of the inmate every 15 minutes and maintain a record of the observations on a *Notification of Inmate Isolation Form*." Dkt. 2304-1 at 301.

301. As with Subparagraph (27), Defendants conducted manual audits to evaluate whether every prisoner on suicide watch in a given month was under continuous observation and whether a treatment plan was determined for each. Dkt. 2333 at 36. As with Subparagraph (27), compliance was determined by looking to suicide watch flow sheets and therapeutic restraint flow sheets. *Id.* Defendants asserted compliance rates of 72% in March, 91% in April, 72% in May, 89% in June, 97% in July, and 100% in August. *Id.* Again, reaching a 90% threshold in only three of six months does not show compliance.

302. Defendants' asserted measure of compliance with these two provisions presents several problems. As an initial matter, Defendants report that their data captures only those prisoners who were on "active suicide watch" in a given month. Dkt. 2333 at 35. Thus, it does not include any prisoners who are "potentially suicidal." The implementing provisions and, indeed, Defendants' own policies provide that "potentially suicidal" prisoners are to be under constant supervision when in isolation and under continuous observation while in a safe cell. This oversight eliminates a potentially significant number of prisoners from the calculation of Defendants' compliance.

303. My own review of prisoner records revealed that Defendants have not implemented these two provisions or their own compliant policies and procedures.

304. According to a note from NP Lily, Patient WI [redacted] was seen on July 8 "for safe cell placement" after he made suicidal statements in pre-booking. NP Lily further noted that the patient was informed that he would be checked on every 15 minutes, in addition to hourly nursing checks. However, there is no medical order from NP Lily about suicide checks. The patient's suicide watch flow sheet shows that hourly nursing checks were begun at 2252 hrs. on July 8 and continued to 1200 hrs. on July 9. In violation of Subparagraph 5(a)(28), there was not continuous observation of the patient while he was in intake under suicide precautions before he was seen by NP Lily. 15-minute checks were also not documented pre policy. This patient is not listed in Defendants' TechCare data for that provision.

305. Patient LW [redacted] was placed on suicide watch on March 31, after MCSO called psych at 1848 hrs. to report that he had placed a sheet around his neck and had apparently jumped off his desk. He was moved into a safe cell in the MHU. At 1916 hrs., his record shows that he was assessed by a MHP in a second-floor holding cell. The patient's suicide watch flow sheets show hourly checks beginning at 1925 hrs. on March 31. Nothing in the patient's record explains what happened between the time psych was called, at 1848 hrs., and 1916 hrs., when he was assessed by the MHP. Further, there is no order for or documentation of a 1:1 sitter, and no indication in the patient's record that one was provided. Despite this, Defendants' TechCare data includes this as a compliant incident with respect to both provisions.

306. Patient NF [redacted] was placed on suicide watch, according to a suicide watch flow sheet in his record, on April 8. He was housed in MHU P-3. The flow sheet indicates that he was observed by nursing staff on an hourly basis. An April 9 note from Dr. Jaffe indicated that the patient had a 1:1 sitter; however, there is no corresponding suicide watch flow sheet that shows a 1:1 sitter. I was told by CHS that

the flow sheet would indicate whether there was a 1:1 sitter and, indeed, Defendants' Compliance Report states that they relied on flow sheets to compile their TechCare data. *See* Dkt. 2333 at 35-36. This patient's sheet showed only hourly checks. Defendants' TechCare data includes this as a compliant incident with respect to both provisions.

307. Patient KD [redacted] was booked on April 23, 2015, and placed on suicide watch that day after she refused to dress out at intake and expressed delusional beliefs. She was transferred to MHU P-5. Suicide watch was discontinued on April 24, after Dr. Worthen assessed her. This was the patient's first provider assessment. The suicide watch flow sheets in the patient's record show hourly checks from her initial placement on April 23 at 2300 hrs. until her discontinuation on April 24 at 1145 hrs. The patient should have been under "continuous observation" until she was seen by a provider—until a treatment plan was developed. There is no indication in the patient's record that she was continuously observed. This incident is not included in Defendants' TechCare data.

308. Patient JD [redacted] was booked on July 10, 2015 at 1610 hrs. His intake screen was positive for mental health and noted previous suicide attempts while in custody. The patient's suicide watch flow sheet from that day showed that he was placed in a safe cell at 1748 hrs. on July 10. He was assessed by a provider at 1759 hrs. The patient then received hourly checks until 2240 hrs. Nothing in his record indicated that the patient was continuously observed between his intake screen and his being assessed by a provider. There are no nursing notes for this period. The first nursing note is at 1817 hrs., noting the patient had been placed in a safe cell. This incident is not documented in Defendants' TechCare data.

309. Patient ES [redacted] was booked on July 25; his intake screen, entered at 1911 hrs., was negative for mental health. In a note written at 0246 hrs. on July 26, RN Matteson stated that the patient was placed in an isolation cell after having issues

with other inmates in the GP tank. Once placed in the isolation tank, he reportedly became angry and stated, "I want to kill myself." He was subsequently seen by a provider and determined to be DTS; a note from NP Lily at 0249 hrs. noted the patient was in the isolation tank. There is no indication from the patient's record of when the patient went into the isolation cell. Further, there is no indication in the record of a 1:1 sitter while the patient was in the isolation tank, before his provider assessment. Defendants' TechCare data reports this as a compliant incident.

310. Patient DB [redacted] refused to answer intake questions during her August 16 booking and was referred to mental health. She was seen by a MHA at 1013 hrs. and noted as potentially suicidal. MHA Heninz's note stated, "Author staffed the patient with NP Conn on site at the time of the safe cell placement." It is not clear from the patient's record, however, whether this happened immediately, or how long after the meeting with the MHA it occurred. It is impossible to tell from the patient's record whether there was a gap in time, during which the patient should have been under continuous observation. Defendants' data lists the incident as compliant.

311. Patient CS [redacted] was booked on June 6 at 0041 hrs. During her intake screen at 0019 hrs., the patient jumped out of her chair and had to be removed by detention for medical bay. A note from RN Matteson at 0227 hrs. states that the patient was seen in pre-booking, when she became combative. She was placed in an isolation cell when she became self-injurious, beating her head against the wall, biting herself, and spitting blood at officers. NP Lily's note at 0305 hrs. stated that the patient was seen in a holding cell following a request from mental health for safe cell placement. The patient's suicide watch flow sheet shows safe cell placement on active suicide watch beginning at 0545 hrs., with hourly checks until the watch was discontinued at 0945 hrs. The gap between the patient's placement in the isolation cell and her subsequent move to a safe bed is of an unknown duration; the patient's record

includes no indication of a 1:1 sitter during this time period, particularly before she was seen by the NP. The patient is included in Defendants' data as a compliant entry.

312. Patient JG [redacted] was admitted on June 12, 2015; at intake, a previous suicide attempt by hanging, in December 2014, was noted. On June 16, emergency services were called after the patient attempted to hang himself. The patient's suicide watch flow sheet shows he was placed on active suicide watch on June 17, beginning at 1400 hrs. and ending at 2230 hrs. It noted hourly checks by nursing staff. There is no indication in the flow sheet of a 1:1 sitter or continuous observation. EMAR does not show an order for a 1:1 sitter or continuous observation. The patient's suicide watch was discontinued on June 17 at 2325 hrs. via a speed letter from Dr. Picardo. On June 30, emergency services were called after the patient again attempted suicide by hanging. Active suicide watch was ordered by Dr. Worthen on June 30, according to the patient's EMAR record. The patient's suicide watch flow sheet shows active suicide watch from June 30 at 1320 hrs. to July 1 at 1830 hrs. The flow sheet showed hourly nursing checks. A note from RN McLaughlin indicated the presence of a 1:1 sitter at the patient's cell side; however, his record does not include an order for a 1:1 sitter. The patient's suicide watch flow sheet does not note a 1:1 sitter, and there is no other documentation of a 1:1 sitter in the patient's record. Nor does his record note continuous observation. Dr. Worthen discontinued active watch on July 1 and ordered potential watch. On July 3, the patient was found hanging from a shower head and was sent to the ER. Active suicide watch was ordered that day. A note from RN McLaughlin indicated the presence of a 1:1 sitter, but his record contains no other documentation of a 1:1 sitter. Defendants' TechCare data reported all three incidents as compliant with the provisions.

313. Patient XA [redacted] was booked on August 19. He apparently had indicated at the scene of his arrest that he would kill himself if placed in a cell alone, and reportedly had told the cops to shoot him. His intake further revealed a suicide

attempt just three months prior. He stated to MHP Berman in pre-intake that he was actively suicidal and would hang himself. The MHP ordered placement in a safe cell. He was placed on active suicide watch. The patient's suicide watch flow sheet shows his initial safe cell placement at 1130 hrs. on August 19; his status was changed to potential suicide watch at 1530 hrs; he was removed from the safe cell at 1925 hrs. The flow sheet otherwise shows hourly checks. During his safe cell placement, he was examined by PA Bunkers, who noted the plan was for the patient to remain in the safe cell. A note from RN Hoban from that day does not document a 1:1 sitter. There is no indication of a 1:1 sitter in the patient's record before he was seen by a provider. The incident is included as a compliant entry in Defendants' data.

314. Patient JG [redacted] was placed on active suicide watch on August 8. Her suicide watch flow sheet shows that she was placed on active watch and placed in a safe cell at 1527 hrs. on August 8; she was removed from the safe cell at 0115 hrs. on August 9. Otherwise, the flow sheet shows hourly checks. The patient was moved to MHU P-5 on August 9 at 0826 hrs. The patient's first documented provider assessment is from PA Bunkers, who wrote that the patient was examined during her safe cell placement. RN Duconn's note at 1559 hrs. does not indicate the presence of a 1:1 sitter at the time the provider conducted the assessment. Defendants' TechCare data lists this as a compliant entry.

315. I also reviewed a number of cases where patient were deemed "potentially suicidal," but Defendants did not follow Provision 28 or CHS policy regarding the frequency of checks. For example, Patient JA [redacted] was noted by Dr. Jaffe as potentially suicidal and ordered to be transferred into a P-3 flat cell on March 23. A suicide watch flow sheet in the patient's record shows hourly checks were initiated at 1548 hrs. on March 23. Because this patient was noted as "potentially suicidal," he is not included in Defendants' TechCare data. Suicide watch was discontinued on March 27. The patient was placed back on suicide watch on March

30. The suicide watch logs show that the patient was seen hourly. Suicide watch was discontinued on April 3. Similarly, Patient DO [redacted] was placed on suicide watch on March 27, according to a speed letter from that day. The suicide watch flow sheets show his initial placement on suicide watch that day at 1930 hrs. He was on hourly checks until March 29 at 0930 hrs., when the suicide watch was discontinued. His record provided no indication of a camera cell or a 1:1 sitter. Again, given that this patient was on "potential suicide watch," he is not listed in Defendants' data, despite the language of the implementing provisions. Patient JW [redacted] was placed on potential suicide watch on April 2, 2015. He was checked hourly until the potential suicide watch was discontinued the following day. His suicide watch flow sheets did not indicate that he was under continuous or constant observation. Patient JP [redacted] was placed on potential suicide watch on March 11, 2015. The suicide watch flow sheets showed that Mr. JP received hourly checks until his discharge from suicide watch the following day. Again, this patient is not reflected in Defendants' data.

316. As described above, I found scant documentation of the timing of patients' placements into isolation or safe cells or the timing of mental health assessments of these patients. Though Defendants stated that they reviewed suicide watch flow sheets and therapeutic restraint flow sheets to determine compliance with these provisions, my own reviews of patient records indicated that compliance could not be verified in this manner. It was often not possible for me to discern whether patients were under continuous observation or constant supervision while in isolation or a safe cell prior to being assessed for a treatment plan by a mental health provider. My review further showed that the presence of a 1:1 sitter routinely was not indicated in patient records.

317. I reviewed 13 records for compliance with this provision. I found 8 noncompliant records (62%). I also looked at another sample of 8 additional records, taken from Defendants' June, July, and August 2015 TechCare data for these

provisions. For the reasons described above, I could not verify compliance with respect to 7 of these additional records. In total, I found non-compliance with 15 of 21 records reviewed (71%). Defendants have not shown compliance with Subparagraphs 5(a)(27) and 5(a)(28).

Subparagraph 5(a)(29)

318. Subparagraph 5(a)(29) requires that, "[w]hen a pretrial detainee is discharged from suicide watch or a safe cell, the pretrial detainee will be assessed by mental health staff within 24 hours of discharge." Dkt. 2299 at 6. In its Findings of Fact, the Court wrote that "Defendants have not shown that mental health staff consistently assesses each pretrial detainee discharged from a safe cell within 24 hours of discharge." Dkt. 2283 at 52 ¶ 204.

319. Defendants revised SOP J-G-05 to require that "[p]atients discharged from Suicide Watch are scheduled to be seen for Mental Health Follow up within 24 hours." Defendants evaluated compliance by comparing, for all prisoners released from suicide watch in a given month, the date and time of the release against the date and time of assessment by mental health staff. Dkt. 2333 at 37.

320. In its original compliance report, Defendants never reported a compliance rate above 82%. Dkt. 2333 at 37. Following these poor compliance rates, Defendants revised their methodology to add the percentage of prisoners who were released from custody within 24 hours of being discharged from suicide watch to the "compliant" entries. Dkt. 2336 at 10-11. As with other of its compliance calculations, Defendants erroneously inflated its rates of compliance by including prisoners who were released. This population of prisoners is not material to the calculation of whether prisoners were timely evaluated following discharge from suicide watch; they should have been removed from the calculation altogether. Therefore, the original rates Defendants report, which never exceed 82%, are more accurate, and show that Defendants have not complied with this remedy. Even with the flawed methodology

employed in its Supplemental Report, Defendants were unable to report a compliance rate above 91% overall six months, reporting revised compliance levels of 84% in June, 87% in July, and 91% in August. Dkt. 2336 at 11. These rates do not amount to compliance with this remedy.

321. In my own review of patient records, I identified discrepancies between Defendants' TechCare data and underlying patient records that call into question the reliability of the data on which Defendants relied to produce rates of compliance.

322. Patient FA [redacted], for example, is reported in Defendants' data as having been seen by mental health staff the day of her August 6 discharge from suicide watch; in fact, her record shows that she was not seen by mental health staff until August 8, in violation of the provision. Similarly, a July 18 entry for Patient HB [redacted] indicates that she was timely seen by mental health staff that day following her discharge; her record, by contrast, shows that her first documented progress note from mental health staff following the discontinuation of suicide watch occurred three days later, on July 21, when she was seen by a provider. Patient JF [redacted] is shown in Defendants' TechCare data as having had a compliant assessment by mental health staff following his April 24 discharge; his record shows, however, that he was not seen by mental health staff following his discharge until April 28, when he was seen cell-side during morning medication rounds. Defendants' data further shows a compliant assessment for this patient following a June 26 discharge from suicide watch. There is nothing in the patient's record indicating that he was on suicide watch as of June 26 or discharged that day; rather, his records show that he was on suicide watch until June 23, when it was discontinued. Patient BI [redacted] was discharged from suicide watch on June 22; his record contains no documented mental health staff assessment within 24 hours of his discharge. Defendants' data lists this discharge as "compliant." Defendants' data indicates that Patient WI [redacted] was seen by mental health staff within 24 hours of his July 16 discharge from suicide watch. His record shows that,

following his discharge, he was not seen by mental health staff until July 19, three days later, when he was assessed by NP Duckett.

323. Several other incidents are either missing from Defendants' data or inaccurate as compared with underlying patient records. Patient AG [redacted] was placed on suicide watch on multiple occasions, with discharges on June 2 and July 7; neither instance is included in Defendants' data. Patient JA [redacted] was discharged from suicide watch on April 3, according to his record; the closest incident listed in Defendants' data is an April 10 discharge. Defendants' data for this patient also lists a compliant August 28 discharge; however, the patient's record does not include a suicide watch flow sheet indicating placement on suicide watch on or around that date. Two of the four post-discharge assessments for Patient RO [redacted] included in Defendants' data are inaccurate. Defendants' data shows a compliant assessment following an August 2 discharge; the patient's record shows that he was discharged on August 3. Defendants' data also shows a compliant assessment following his August 11 discharge; this was not corroborated in his record.

324. I reviewed 18 records for compliance with this provision. Five of those records were non-compliant (28%). This equates to a 72% compliance rate, which is comparable to the original, more accurate compliance rates Defendants reported.

Subparagraph 5(a)(31)

325. Subparagraph 5(a)(31) requires that "[a] pretrial detainee's psychotropic medications will not be prescribed, altered, renewed, or discontinued without a face-to-face examination by a psychiatrist, psychiatric physician assistant, or psychiatric nurse practitioner in an area that affords sound privacy." Dkt. 2299 at 6.

326. The Court, in its 2014 findings, identified ongoing problems with Defendants' continuity of care, including continuing prescription medications. The Court found that "Defendants [had] not shown that as of August 9, 2013, pretrial detainees who presented with serious mental health needs at intake consistently were

timely assessed by a mental health provider to initiate or to continue necessary mental health treatment, including continuation of psychotropic medications prescribed before arrest." Dkt. 2283 at 32. Those "who were prescribed psychotropic medications before entering the Jail may not be receiving medication without interruption." *Id.* Defendants further failed to show "that psychotropic medications are administered without interruption." *Id.* at 55.

327. Defendants updated SOP J-G-01-01 to require that "[p]atients with verified psychotropic medications will be seen face-to-face by a Psychiatric Provider within 24 hours in an area that affords sound privacy." SOP J-G-01-01 (Dkt. 2304-1 at 323). Further, patients must be seen for "medication management appointments" at least every 90 days. *Id.* at 325. Orders, renewals, adjustments, and discontinuations of psychotropic medications "are made only during face-to-face visits with a Psychiatric Provider in an area that affords sound privacy, unless there is a security [or psychiatric] rationale that is noted." *Id.*

328. Defendants measured compliance with this provision by conducting manual audits of a sample of prisoner records each month. Dkt. 2333 at 39. For each month, Defendants selected 20 pretrial detainee charts per day over a three-day period, for 60 total reviews. *Id.* Defendants determined monthly compliance rates by evaluating whether each audited prisoner was seen privately face-to-face, cell side face-to-face, or was not seen face-to-face "prior to psychotropic medications being prescribed, altered, renewed, or discontinued." *Id.* Defendants initially reported poor compliance rates, at 80% in June, 85% in July, and 80% in August. *Id.*

329. In their Supplemental Report, Defendants bolstered their compliance rates by using several exceptions to the "sound privacy" requirement. As they noted, their original compliance numbers did not include those who were seen cell-side "when they refused the sound privacy area, when it was not safe to move the patient, when the patient would be at risk if moved, or for legitimate security reasons." Dkt.

2336 at 11-12. Defendants further audited the noncompliant entries and reported revised compliance rates of 96% in June, 100% in July, and 98% in August.

330. A closer look at Defendants' underlying data reveals that it is not an accurate assessment of compliance with this provision. Defendants purport to measure whether a provider conducted an assessment of a given prisoner before ordering a psychotropic medication. However, for a number of the compliant data entries, the asserted face-to-face assessment occurred so far in advance of the medication order that the assessment seems wholly unrelated to the medication order. For example, Patient FA [redacted] is listed in the TechCare data as having a provider assessment on January 15, 2015; his medication order date, though, is listed as February 24, 2015—more than a month later. Similarly, Patient MD [redacted] was assessed on December 30, 2014, according to the data, but her medication order was not entered until January 21, 2015. The TechCare reports show that Patient SV [redacted] was assessed on July 7, 2015; the date of his medication order is listed as July 24, 2015. Each of these entries was indicated as compliant with the mandate of Subparagraph 5(a)(31). These discrepancies suggest either poor data or a serious implementation problem. If the dates are inaccurate, Defendants' compliance rates are not reliable. If the provider assessments are taking place that far in advance of the actual medication order, they can hardly be construed as carrying out the purpose of this provision. The purpose of face-to-face assessments—particularly of seriously mentally ill prisoners—is to assess their clinical presentation and make medication determinations based on that presentation. An evaluation that occurs a month out does not ensure that the provider has an accurate picture of the prisoner's mental health status to make medication decisions. Further, it indicates that these patients are likely suffering and decompensating without access to their psychotropic medications. I found 10 such discrepancies in Defendants' data.

331. Defendants' TechCare data also includes several entries deemed "compliant," even though they indicate that the provider assessment occurred after the psychotropic medication was ordered. Patient RW [redacted] was assessed on March 10, 2015, though his medication order was entered several days earlier, on March 2, 2015. Patient TV [redacted] was assessed on May 7, 2015; his medication had already been ordered as of April 30, 2015. There are several other instances of this pattern in Defendants' data, further highlighting the unreliability of the compliance rates that Defendants have reported. I found 11 such violations in Defendants' data.

332. I also reviewed the electronic medical charts for a selection of the entries that were originally deemed noncompliant but were subsequently changed to compliant or removed from the data in Defendants' Supplemental Report, when they reported updated rates of compliance. *See* Doc. 2336 at 11-13. I identified several discrepancies. Defendants provided a list of 9 changed from noncompliant to compliant because, as they asserted, these patients were seen cell-side, rather than in a confidential setting, due to patient refusal, safety, risk to the patient, or legitimate security reasons. In the medical charts of the 5 patients seen cell-side due to a "legitimate security reason," there was no documentation of any security reason with respect to 2 patients; the other 3 stated that the patient was seen cell-side due to "shortage of officers." Additionally, Defendants provided a selection of 14 medical charts for the 19 patients whose entries were changed from noncompliant to compliant in Defendants' revised compliance data because, as they reported, the provider visit occurred on a different date than the medication order. *See* Doc. 2336 at 12. In my review of the medical charts, I found no evidence of a face-to-face provider visit for 11 of the 14 entries. In 6 of the patient charts, medication orders were entered after a chart review only, with no indication of a face-to-face assessment. In 5 of the patient charts, I found a note from a provider ordering a medication change, but no

corresponding provider evaluation or appointment under the sick call entries to suggest that the patient was first seen face-to-face.

333. The methodological issues I have detailed above suggest that Defendants have not shown compliance with this provision.

B. Opinion Two: Defendants Have Failed to Comply with the Requirement that Prisoners at Maricopa County Jail Have Ready Access to Care to Meet their Serious Mental Health Needs.

334. On September 30, 2014, in its Revised Fourth Amended Judgment, the Court ordered that "[a]ll pretrial detainees confined in the jails shall have ready access to care to meet their serious medical and mental health needs. When necessary, pretrial detainees confined in jail facilities which lack such services shall be transferred to another jail or other location where such services or health care facilities can be provided or shall otherwise be provided with appropriate alternative on-site medical services." Dkt. 2299 at 2.

Hospitalization and Inpatient Treatment

335. Defendants have failed to adhere to this provision with respect to hospitalization and inpatient treatment of the most seriously mentally ill prisoners at its facility. Given the number of detainees housed at the Jail, it is entirely foreseeable that there will be a population of prisoners who will need to be hospitalized, or need access to inpatient care, to receive adequate treatment. This includes prisoners in need of acute stabilization, as well as those who need more long-term inpatient care. This population includes the most seriously and chronically ill prisoners at the Jail. The Jail does not provide an inpatient level of care to many of the men and women who are housed in the MHU. To comply with the specific remedial requirement of Subparagraph 2 of the Revised Fourth Amended Judgment, the Jail must ensure access

to an outside facility that can provide this level of care. *See* Dkt. 2299 at 2. It has failed to do so.

336. In my 2013 Declaration, I noted that, although "the Jail refers to the MHU as an inpatient facility, it does not resemble any hospital I have ever been associated with. This is particularly true for the most acute and restrictive units (P-5, P-3, P-1-B), which operate as lockdown units." Stewart 2013 Decl., ¶ 75. In its Findings of Fact, the Court noted that the MHU "is not a licensed inpatient psychiatric hospital." Dkt. 2299 at 46. Those prisoners in need of inpatient care "may be placed in the [MHU] while CHS staff attempts to get them admitted to the state psychiatric hospital." *Id.* "Defendants are responsible for identifying those detainees and making reasonable efforts to obtain their admission to the state psychiatric hospital." *Id.* It remains my opinion that Defendants do not provide inpatient care at the MHU or anywhere in the Jail.

337. Sheriffs and county officials around the country have developed a number of ways to ensure the timely hospitalization of prisoners in need of inpatient care. Some operate jail units located at local hospitals, others execute contracts with hospitals to accept prisoners. Rikers Island, NY has a jail unit in Bellevue Hospital for prisoners in need of hospital-level care. Prisoners there remain under the custody of the Jail but are housed at Bellevue where they can receive hospital-level care. (Mar. 5, 2014 TT at 34:8-18, 37:11-17 (Burns)).

338. In San Francisco, county officials likewise created a jail unit at the county hospital for seriously mentally ill prisoners, one that was staffed by the sheriff's deputies to ensure security. I was responsible for administering this unit while I worked for the County.

339. The Franklin County, OH Jail sends its prisoners in need of hospital care to a forensic unit at the state psychiatric hospital. (Mar. 5, 2014 TT at 34:8-18

(Burns)). These prisoners likewise remain in the custody of the sheriff though they are hospitalized. (Mar. 5, 2014 TT at 65:10-19 (Burns)).

340. Unlike the officials in these counties, Defendants fail to timely hospitalize those patients in need of an inpatient level of care. As a result, prisoners in need of this treatment unnecessarily suffer, as they are warehoused in lockdown units without access to adequate treatment.

341. The problems with Defendants providing timely access to hospitalization are well-known and longstanding. In her remedial plan, Dr. Burns recommended that "Defendants . . . ensure that prisoners are timely transferred to a psychiatric facility when they cannot be adequately treated at the Jail." Remedial Plan at 6. Dr. Burns further recommended that staff "continue to make efforts to hospitalize prisoners . . . even if previous efforts have failed," and that staff "address all efforts they have made and plan to make in monthly treatment team meetings [and] document their ongoing and planned efforts in these prisoners' treatment plans." *Id.* In my 2013 Declaration, I noted that many patients in the MHU languished there in need of a higher level of care. Stewart 2013 Decl. ¶ 85. I further stated that full implementation of Dr. Burns' recommendations would be essential to providing timely hospitalization to those prisoners in need of that care. *Id.* ¶ 96. This remains my opinion today.

342. When symptomatic prisoners in need of an inpatient level of care remain housed at the Jail, they are often left in one of the acute units of the MHU or in other segregation housing. In such units, the patients are locked down for up to 24 hours a day. Warehoused in these lockdown units, the patients are denied access to important psychosocial rehabilitation services, a critically important aspect of caring for seriously mentally ill prisoners. Without such programming, the patients are at risk of growing more ill, or not responding fully to the limited treatment they do receive. This lack of treatment may result in increased symptoms, namely hallucinations or delusions; self-harm behavior; and non-compliance with treatment and medication.

These patients often end up failing to attend to their own hygiene. They often end up living in their own squalor. The living conditions they are exposed to, particularly the isolation and lack of effective treatment, combine to exacerbate their illness. Their clinical deterioration takes many damaging forms, from increased psychosis, including hallucinations, to refusing treatment and medications, to increasing episodes of self-harming behaviors, including suicide attempts.

343. Prisoners in the Jail's Restoration to Competency (RTC) Program are often the most severely impacted by lack of timely hospitalization. From March-August 2015, there were 235 prisoners enrolled in the program. These are the most seriously mentally ill prisoners in the Jail's population. While other jail systems around the country transfer prisoners deemed incompetent to proceed in their criminal cases to a forensic facility to be restored to competency, Maricopa has chosen to keep its RTC program at the Jail. As a result, Maricopa RTC patients do not have access to the hospital-level care provided to RTC patients in other systems. Further, as I testified in 2014, prisoners in the RTC Program will not be approved for involuntary treatment. Many of these patients refuse treatment and end up warehoused in the Jail's lockdown units. By the time these patients do receive care, it has been so long delayed that it harms their recovery. Not only have the patients suffered unnecessarily while waiting to be transferred to an inpatient facility, but also delays in treatment may result in lengthier recovery periods and less complete recovery. My findings echo those of Dr. Burns, the Court's mental health expert.

344. In her ninth report, Dr. Burns wrote:

> In spite of CHS' efforts, the most seriously and acutely ill inmates in the jail are those involved in the competency to stand trails evaluation/restoration program and their access to an appropriate level of care—psychiatric hospitalization and involuntary medication—is delayed. This causes needless suffering and, in fact, clinical studies have demonstrated that delays in providing treatment result in slower and less complete or robust responses to treatment when it is eventually provided.

Ninth Report at 13. I agree with Dr. Burns' conclusions.

345. The Jail has transferred a small group of prisoners to hospitals for a court-ordered evaluation to determine if they should be subject to an involuntary treatment order called a COT Order. For the most part, these prisoners have been transferred after refusing treatment and presenting as dangerous to themselves or others. As I testified in 2014, the COT process is not an adequate substitute for providing access to an inpatient level of care to patients who need it. The COT process is designed to determine if a patient should receive involuntary treatment; it is not designed to provide inpatient care. Prisoners transferred to a hospital for a court-ordered evaluation generally have had short hospital stays, which ended once the COT Order was secured. They were then transferred back to the Jail. Because of the harsh conditions and inadequate treatment at the Jail, any short-term gains from the brief period of hospitalization are often lost. There are other prisoners for whom involuntary treatment orders are not timely sought or secured.

346. In her most recent report, Dr. Burns noted that CHS has reported expediting the COE/COT process and more timely transfers of patients to this level of care. *See* Burns Eleventh Report at 3, 8. CHS had reportedly developed a system to utilize Arizona State Hospital for any RTC inmate requiring acute care beyond that which can be provided at the jail. *Id.* However, Dr. Burns noted, as of the date of her Eleventh Report, CHS had not found any inmate to require such care, and had not transferred any RTC inmate into inpatient care at Arizona State Hospital (ASH). *Id.* at 3. Maricopa County also operates the Desert Vista psychiatric facility that provides in-patient treatment, but that facility, too, has not been effectively utilized to accept prisoners in need of inpatient care. Dr. Burns concluded, "[f]rankly, without actual data to support CHS reports of improvement, there is no basis on which to conclude that access has been improved or that wait time has been decreased." *Id.*

347. Dr. Burns' own site visits and chart reviews "directly contradict[ed]" Defendants' "anecdotal reports of improvement" with respect to expedited access to inpatient care. *Id.* She found that "seriously ill, psychotic inmates requiring a higher level of care have been held in the MHU for weeks or months, virtually without treatment, while the intricacies of the RTC and COT processes are weighed or worked through before they are sent out for inpatient care." *Id.* I continued to find the same harmful pattern for the patients whose records I reviewed from March-August 2015. I did not find that patients in need of psychiatric hospitalization were timely transferred to either ASH or the Desert Vista facility or any other appropriate psychiatric facility.

348. It is my opinion now, as it was when I submitted my 2013 Declaration, that the Jail does not have a reliable system in place to ensure the timely transfer of seriously ill prisoners to an inpatient psychiatric facility. The problems are particularly acute with regard to RTC patients in need of hospitalization. In my own most recent record reviews, I found numerous prisoners in need of acute stabilization who were not petitioned for a COT Order, or whose COT petitions were unnecessarily delayed. I also found prisoners whose COT Orders were not timely renewed or were not fully utilized to address their non-compliance with treatment. Nor was there a reliable process in place to transfer to an inpatient facility those prisoners in need of that care who could otherwise not be adequately treated at the Jail. Many of these prisoners spend months locked alone in their cells for up to 24 hours daily, with no significant treatment offered to them other than medications. They include prisoners who refuse treatment and are actively psychotic. Their living conditions, coupled with the lack of appropriate care, results in their unnecessarily suffering. It is also my opinion that prisoners returning from the hospital are at risk of deteriorating once back at the Jail. I attribute this risk of deterioration to the conditions at the Jail coupled with the inadequate treatment they are likely to receive.

349. Among the 47 records I reviewed, looking at a six-month window, I identified 34 patients in need of a higher level of care who were not receiving adequate treatment at the Jail. Below I have provided examples of seriously mentally ill prisoners in need of a higher level of care than provided at the Jail suffering as a result of inadequate treatment. The sheer number of these men and women I was able to identify in such a short compliance window (six months) shows the excessive risk of harm Defendants place on the seriously mentally ill in need of hospitalization. For these patients, they are often warehoused in the most punitive and isolated housing units, growing more ill by the day, while the Jail awaits the resolution of their criminal charges via the RTC program. While many of these men and women are eventually hospitalized, that only happens after they are deemed incompetent, their criminal charges are dismissed and they are civilly committed. The delays in providing hospital-level treatment result in slower and less complete or robust responses to treatment when it is eventually provided.

350. Patient CB [redacted] was booked on August 19, 2014. He deteriorated at the 4th Avenue facility, where he did not have adequate access to care given his condition. A note from an early February 2015 assessment by Dr. Fangohr reported that the patient was refusing his medications; his Haldol prescription had been discontinued after his repeated refusals. During assessments over the next several months, the patient was often reported as agitated, uncooperative, and verbally abusive, yelling obscenities. A March 14 note from mental health staff reported that he did not appear capable of understanding or expressing an understanding of the alternatives to the particular treatment offered. Dr. Fangohr's next follow-up, on March 26, found that the patient's cell was littered with debris. He continued to refuse his psych medication and continued to be uncooperative through April and May 2015, with infrequent and ineffective provider assessments. His record includes multiple notes suggesting a PAD petition should be considered; the patient had previously been

on COT for PAD in 2010. MHA Herrera on March 14 wrote that a PAD petition should be considered "when Rule 11 is completed." The patient was found incompetent and unrestorable and was ordered civilly committed on May 28, 2015. He was released on June 4 to Desert Vista Hospital.

351. The patient was re-booked on June 29, 2015 (booking # [redacted]). The patient was moved into segregation, where he remained. In segregation, though the patient's medications from Desert Vista were continued, the patient showed signs of deterioration. On July 23, the patient reportedly told an MHP, "A racist is in my head" and reported hearing voices daily. He was also reportedly paranoid regarding his detention. During an assessment on August 28, the patient reported that he sometimes heard voices, and "they cuss at me." Notes after August 31 show the patient's deterioration. A November 17 note from Dr. Fangohr stated that Mr. CB was seen cell-side after refusing a confidential visit. He refused to talk, appeared unkempt, and his cell was full of trash. He stated that his medications were working okay.

352. This is a story of a patient who presented with severe psychotic and mood symptoms for four months before he received any meaningful treatment. The fact that a patient was participating in the RTC program via Rule 11 should have no influence on whether he receives adequate care while incarcerated. The patient was left to suffer from significant psychotic and mood symptoms until he was hospitalized after being found incompetent and unrestorable, and having his criminal charges dismissed. The jail mental health staff should have petitioned for a COT Order due to PAD immediately after his booking due to the severity of his clinical presentation and his refusal to take medications voluntarily. If this action did not result in his clinical improvement, then he should have been referred to an outside psychiatric hospital. To Mr. CB's great distress, these steps were not taken.

353. Patient DC [redacted] was booked on March 27, 2015. He was confirmed SMI in the community, receiving services and medications via Choices-Townley

before his arrest. From intake, the patient was admitted to the MHU, where he remained—moving among MHU sub-levels—for the duration of his incarceration. In assessments on March 28 and March 29, the patient displayed tangential and illogical thought processes, as well as grandiose and persecutory delusions. He had food smeared over the cell-front window, and his living space was not well-maintained. Mr. DC was released in April, and rebooked on May 9, 2015 (Booking #[redacted]). During assessments in May, the patient was reported as manic, easily distracted, and talking gibberish. A May 29 note by Dr. Jaffe reported that the patient was "obviously not doing well." His living space was in squalor, he was whispering non-coherent remarks, and has only shown sporadic compliance with his Risperdal. The patient remained symptomatic in June. He was noted on June 11 as severely impaired and totally distracted, with a constant flow of ideas. On June 15, his thoughts were grossly disorganized and he was speaking in word salad. The patient had to be moved into another cell within the MHU P-3 because his previous cell was left in squalor. A note from June 25 stated that the patient had torn up his mattress and his cell was filled with Styrofoam containers.

354. The patient continued to deteriorate into July. On July 4, he was seen by Dr. Jaffe at his cell front. The patient, according to an RN, had covered himself with feces and covered a camera with tissue paper. Dr. Jaffe noted that he continued to display grossly disorganized behavior, gibberish speech, and mood instability. Throughout this time, the patient was moved among units in the MHU, including multiple stints during which he was placed on suicide watch. When he was seen by Dr. Jaffe on July 12, the patient was spreading feces throughout his body. Food and garbage were shoved under his cell door. He was reportedly picking at an old scar on his right foot. His thought process was derailed, and he was mostly incoherent. On July 24, the patient stated he felt suicidal. On exam, he reportedly jumped up and slammed into his cell door. He was angry, agitated, and not redirectable, and he

reportedly called MHP Faircloth a child molester. Assessments in August indicated that the patient's cell was in squalor, with food smeared on the cell window. The patient was again reported as speaking gibberish, with little coherence and a grossly derailed thought process. This patient was not seen by a provider between August 2-September 12. That day, Dr. Jaffe saw him cell side. His cell was in squalor, his thoughts were grossly derailed and his behavior disorganized. On September 8, 2015, the patient was deemed incompetent and unrestorable and was civilly committed.

355. During my review, I noted problems with this patient's medication regimen. The Risperdal dosage initially prescribed to the patient was clinically inadequate, given that he was noted to be significantly psychotic and was severely symptomatic. It was later increased. Additionally, on July 4, the patient's Haldol dosage was scaled down to 5 mg BID, from 15 mg q day. This is an inappropriate use of Haldol as Mr. DC had only been on the Haldol D for two weeks and had yet to achieve therapeutic blood levels. His dose of the oral Haldol should have actually been increased until the Haldol D was at therapeutic blood levels.

356. The review of this patient's treatment records reveals that he is psychiatrically very impaired and that he received less than adequate care during his prolonged incarceration. The psychiatrists involved in his care prescribed a variety of medications that produced little to no positive clinical effects. When it became obvious that his psychiatric illness exceeded the ability of the jail staff to adequately address, he should have been referred to an outside psychiatric hospital. Instead, he was left to suffer needlessly, often spreading feces on himself and otherwise living in squalor.

357. Patient AG [redacted] was moved between the MHU and GP, all while remaining symptomatic and refusing treatment. In the MHU from intake, the patient reportedly stated "everybody knows about spirits. The spirits talk to me. They try to make me bad. But I am the good guy." He further stated he did not need medications,

as they make him worse. In an assessment on May 6, while in GP, the patient stated he wanted to refuse the session. He was argumentative, paranoid, and possibly delusional. On May 18, the patient stated he did not need any psych medications and does not need to see a provider. During the assessment that day, he spoke rapidly and in a choppy manner. His thinking was mostly linear, but at times was loose. He ended the session abruptly by walking out. The patient was placed on suicide watch on May 22; the previous day, the patient had been mute and unresponsive to staff. When seen by a MHP, he reportedly stated that others are trying to take his identity, using his house and money. He became intense when he said others should believe in him. He further reported that different voices come out of his mouth. Into June, the patient continued to state that he did not need medication or mental health follow-up. The patient returned to the MHU on June 30. After briefly taking some medication, the patient again was medication and treatment non-compliant by July 7, when he was nevertheless discharged back to GP. On July 23, 2015, the patient was deemed incompetent and was civilly committed by court.

358. My review of this case found that the care provided to the patient was sporadic, haphazard and lacked any meaningful coordination among the treatment providers. I could not find any evidence of the mental health staff collaborating with the RTC staff. He was transferred in and out of the MHU, often being sent to GP straight from a suicide watch. Also, I could not find a comprehensive diagnostic workup or a treatment plan in the record. An accurate diagnosis is the basis upon which a treatment plan is formulated. This patient was not provided an adequate level of care at the Jail.

359. Patient JW [redacted] was admitted on January 26, 2015. The patient was moved to the MHU following an initial exam during which he was disorganized, talking to himself, and appeared to be responding to internal stimuli. By February 4, the patient stated that he did not need to be on his medications, and stated he would

take his Risperdal only a few more days. He repeatedly refused his medications between from February 14 to February 17, at which point his prescription ended without written explanation for the failure to renew it. While off his psychotropic medications, the patient deteriorated. He was noticeably disheveled and appeared to be responding to internal stimuli during a March 12 assessment. A few days later, he was referred from MCSO for being naked in his cell and refusing to come out of his cell for hour out. The patient again denied medication. He was moved back to the MHU on April 2 after he reportedly displayed threatening behaviors towards detention staff, refused to answer questions, and would not leave his cell. On assessment by Dr. Balaji that day, he appeared to be psychotic, though he denied symptoms. The patient was finally petitioned for COT. While awaiting the outcome of the petition, the patient continued to be uncooperative with staff and refused his medication. He remained symptomatic over the next several weeks; he was disheveled, responding to internal stimuli, and refusing all medical treatment.

360. On June 20, officers attempted to get the patient into a confidential room for a provider assessment. The patient spit at them and tried to fight them. He was internally preoccupied and talking to himself. He spit at Dr. Balaji behind his closed cell door and punched the door. Dr. Balaji noted that he remained psychotic and severely agitated, presenting an imminent DTO. Dr. Balaji entered an order to force meds and noted that the patient needed to be re-petitioned due to DTO and uncontrolled psychosis.

361. By July 11, the patient, after a brief stint of compliance, again began refusing his medications. Of note, his temporary compliance with medication followed involuntary medications being administered. Dr. Balaji noted that the patient's petition "was denied due to pending court case." He remained noncompliant into August. On August 15, Dr. Balaji noted that the patient appeared more

disorganized and psychotic and noted a plan to continue offering the patient medication and "await outcome of RTC."

362. It took the staff almost five months to initiate an involuntary medication order. The patient responded well to these involuntary medications. The staff did not follow up with an appropriately aggressive treatment plan that involved medications. He then was allowed to return to his previous level of psychotic decompensation. The patient needlessly suffered for the eight months he was incarcerated due to the inaction of the staff. His RTC status should not have resulted in the inadequate care he received. He required a higher level of care than he received at the Jail.

363. Patient JA [redacted] was booked on January 16, 2015, and moved to the MHU from intake, where he remained until his release. During his stay at the MHU, he was placed on suicide watch on multiple occasions. He was under COT from a previous petition. A March 11 note reported that the patient had to be moved to a clean cell after he smeared feces over his own cell. An April 3 assessment found that the patient again had scattered excrement all over his cell. He was reportedly oblivious to his surroundings. This pattern continued in May, with a May 2 assessment finding feces spread over the patient's cell walls and noting that the patient was experiencing ongoing auditory hallucinations. He was described by Dr. Jaffe as "globally impaired," suffering from a "chronic psychosis with a poor prognosis." A provider did not assess Patient JA from May 15-July 31, 2015. When the patient was seen on July 31, he was observed kneeling with his head dunked into the toilet bowl. He stated "I need help," and then subsequently spoke in Spanglish with a derailed chain of thought. The patient was released on October 8, 2015.

364. This case represents very poor care of a seriously mentally ill patient. My review of the chart clearly reveals that the patient's mental condition exceeded the level of care that the jail staff could provide. He was allowed to needlessly suffer for the entire nine months he was incarcerated due to receiving less than adequate

psychiatric care. Standard of care dictates that he should have been referred to a psychiatric hospital early in his incarceration. This was not done.

365. Patient CB [redacted] was booked on January 22, 2015. The patient was moved to the MHU from Estrella segregation on March 17 after she made suicidal statements to mental health staff. While in the MHU, the patient reportedly improved but was still hearing voices. On March 30, the patient reported mood outbursts and said she was still hearing voices daily. She was also experiencing paranoia that someone was out to get her and her twins and was going to murder them. She continued to report auditory hallucinations into April, stating, "He's hurting my heart. He is turning my heart into garbage. The voice is [redacted]." The patient was reportedly visibly upset by her hallucinations; she was tearful, crying, and agitated. The patient continued to complain of her hallucinations through April and into May. On May 19, following a referral from MCSO, the patient told a MHP that her voices were telling her that her son is being cooked in the jail kitchen. A June 29 assessment noted that the patient continued to have auditory hallucinations, visual hallucinations, and delusions, in addition to her depression and anxiety. During the exam that day, the patient was slurring her words and stuttering. She described the voices she was hearing as those of her ex-boyfriend and "Wolfie." She further reported that one week ago, she thought her babies were kidnapped from the foster home by Frankie, their father; she saw her baby sitting on a bed, and Frankie was slapping him so hard his head almost came off. On July 23, the patient was found incompetent, her charges were dismissed, and she was ordered civilly committed by court. She remained jailed until August 5. The day before her release detention officers referred her to mental health for hallucinating that her husband was ripping the heads off her children.

366. This is yet another example where a seriously mentally ill patient should have been referred to a psychiatric hospital early in her incarceration. Especially noteworthy is the fact that mental health staff did not evaluate her prior to her release

from custody. Overall, the patient suffered needlessly due to the staff not referring her to a psychiatric hospital.

367. Patient DO [redacted] was booked on March 3, 2015. He was minimally responsive on exam and has an extensive mental health history, including history of suicide attempts and assaultive behavior while in custody. From his intake, the patient refused CIWA assessments and refused an HIV test. The patient also refused to go to a confidential space to be assessed. During provider assessments throughout March, the patient often spoke in a low or unintelligible voice. Detention staff noted that he had been seen naked in his cell on multiple occasions. His cell was reportedly dirty. He was occasionally compliant with his medication, but by March 30, Dr. Jaffe reported that the patient was overtly responding to internal stimuli and displaying grossly disorganized behavior. Assessments in May and June noted that the patient was actively responding to internal stimuli. On July 7, Mr. DO was found incompetent and unrestorable, and he was ordered civilly committed.

368. Although notes in the patient's record indicated that he was medication compliant, the patient's EMAR shows routine medication refusals: March 12, 13, 16, 19, and 25; April 3, 6, 9-13, 15-16, 18-19, and 22-24; May 2-4, 6-9, 14, 16-18, 21; June 3-4, 10, 18, and 25-26; and July 17-18. The patient's EMAR is inconsistent with the psychiatric progress notes, which indicates that the provider did not thoroughly review the record prior to writing his note. Also, it explains in part why the patient's clinical picture was not improving. This represents extremely poor care. A prescribing psychiatrist needs to have an intimate understanding of his patient's care, which certainly was not the situation in this case. This patient was actively symptomatic, refused treatment, and required a higher level of care than could be provided at the Jail.

369. Patient JP [redacted] was booked on February 21, 2015. From his booking, the patient was very symptomatic. While incarcerated, the patient

consistently refused treatment, medications, and meals. By mid-March, he had lost 20 lbs. The patient was referred from detention on February 27 after he was seen spitting and urinating on the floor. During a March 3 assessment, the patient said that he had voices that try to speak through him; he stated he was drooling or burping in an attempt to keep the voices from speaking through him. He further reported feeling that there were devices in him, and he declined to start an antipsychotic drug. A March 11 report further noted that the patient was unaware of his situation and had a paucity of thought content. A March 13 note from Dr. Stalcup described the patient's poor state: He was unable or unwilling to meet his own basic needs; he was not showering, eating, or taking his prescribed medications. Two days later, MCSO used force on the patient, who by now was housed in a lockdown unit. The patient continued to refuse treatment and medications through April, including medication to treat his high blood pressure. MCSO could not find a cellmate for him because of his psychotic behavior and lack of hygiene. His psychotic episode and hallucinations continued. An April 28 note described his behavior as grandiose and psychotic. He continued to refuse his medication for hypertension. His blood pressure that day was 172/104. Despite the patient's state, he was assessed by a provider infrequently. Scheduling a follow-up assessment for four weeks out, when a patient has life threatening medical and psychiatric concerns, is unconscionable.

370. The patient's EMAR shows consistent refusals of Inderal from March 2 until his discharge. It also shows consistent refusals of Risperdal from March 16 to May 10. His weight loss, high blood pressure, and medication refusals make a strong case for PAD. He remained housed at the Jail, in a lockdown unit, despite his acuity and need for hospitalization.

371. Patient VW [redacted] provides another example of a patient who refused treatment and did not receive adequate care. He was booked on February 24. He was moved to the MHU after displaying bizarre behavior in court and reportedly stating he

wanted to kill other people. Shortly after his booking, the patient began to refuse treatment and refuse medication. He presented as delusional, grandiose, and paranoid. The patient's psychosis persisted, even as he was moved from the MHU into segregation. The patient filed an HNR on June 11, writing "I find myself feeling worked up and struggling a bit to keep aggression down. There is something about this place that pulls me to the tail rather than the head." The written response stated, "This is not what psych is for. You can ask for PC if you are afraid for your safety and that is through MCSO." The patient was moved back to the MHU after he was noted responding to internal stimuli and reported that he wanted to go after his cell-mate.

372. His record indicates that some effort was made to secure a court-ordered evaluation for Patient VW, but he was not hospitalized. On June 16, MHA Lee wrote that there was no completed petition in Mr. VW's medical file. The next day, Patient VW threatened to harm his cellmate and custody staff. On exam, he was responding to internal stimuli.

373. The additional suffering experienced by Mr. VW by not receiving timely psychiatric care could have been avoided by the staff if they had properly interpreted his HNR's. He was incarcerated for five months and only received medications during the last two weeks of his stay. He required a higher level of care than he received at the Jail.

374. Patient PW [redacted] was booked on January 29, 2015. On March 28, Dr. Pathan noted that the patient was psychotic and had agreed to a trial of Risperdal. When he was seen on May 5, the patient expressed some concern that he would not be able to get into court because he no longer had his "door card." By this point, he had stopped taking his medications. He was responding to internal stimuli. The patient continued to decompensate. On May 31, he reportedly claimed that an officer ate his green door card with a sandwich and that the officer has been playing games with him. He continued to refuse to take his medications and remained psychotic. The patient

was on Rule 11. He was deemed incompetent and unrestorable and was discharged from RTC on June 17, 2015.

375. This case is troubling as it is another example of the staff not providing adequate psychiatric services to an overtly psychotic patient. There was no apparent coordination between the mental health treatment staff and the RTC staff. The Jail was not equipped to provide the level of care this patient required. He should have been hospitalized. He needlessly suffered from being improperly treated for over six months.

376. Patient DY [redacted] was booked on January 29, 2015; his intake confirmed a lengthy mental health history. The patient twice assaulted a cell-mate, on January 31 and March 8. He was held in the MHU lockdown unit for two days after the January 31 assault, and then discharged out of the MHU. He was not seen by a provider for the next month and a half. The patient was assessed on March 17 following the second assault, after he was discharged from the MHU for the second time; on exam, the patient appeared internally preoccupied, laughed for no apparent reason and talked to himself, was not processing information fully, and was using nonsensical speech. He declined medication. Incredibly, the provider did not initiate emergency involuntary medication after these two unprovoked assaults. His plan included "discuss possible COE with mental health staff." The patient was involved in another assault on May 11; on exam, in spite of his history of assaults and concurrent symptomatology, the provider found the patient not to be DTS or DTO. He was dismissed as incompetent and unrestorable and was civilly committed by the court on July 21, 2015.

377. The patient was re-booked on August 11, following treatment at Desert Vista. While at Desert Vista, Patient DY was treated with Haldol and Risperdal. There is a COT Order in the record for inpatient treatment for a period of 180 days from August 11, 2015. Under this Order, the patient cannot receive involuntary

medications in the Jail because it is not licensed as an inpatient facility. To address this problem the order would have to be modified to indicate "outpatient involuntary medications." I found no documented effort to amend this order in the medical record.

378. After intake, despite his extensive treatment history, he was cleared for lockdown housing at the 4th Avenue Jail. Once again, the "boilerplate" language was used to clear Patient DY for lockdown. This is especially problematic in this case given the patient's degree of psychiatric impairment, which isolation only exacerbates. Patient DY began refusing treatment and medications immediately upon being re-booked. He also began engaging in self-harm behaviors (banging his head on his cell wall).

379. This patient is yet another case where the Jail mental health staff failed the patient by not providing timely and appropriate psychiatric care. I am well aware of the legal restrictions regarding the use of involuntary psychiatric medications in a custody setting. It is my opinion, however, that the staff were presented with numerous opportunities to evoke the exception for emergency psychiatric medication administration due to the patient being a danger to others. They also did not attempt to modify his court ordered treatment. The patient and the facility is very lucky that someone was not more seriously injured or killed due to this lapse in proper psychiatric care.

380. Patient TW [redacted] was booked on May 9, 2014. He was a confirmed SMI patient in the community via the Capitol Clinic, according to records in his medical file. He was seen the following day by Dr. Balaji, who prescribed Abilify and Benadryl. This treatment remained basically unchanged for several months of his incarceration, even though he remained symptomatic and uncooperative with the staff as he remained in segregation until his September 2015 release. He was housed in a lockdown unit during his entire jail stay. On March 19, Dr. Fangohr noted that the patient's Abilify prescription was discontinued following his consistent refusals.

Assessments from May through August noted that the patient's room was full of trash and food containers. The patient was also observed talking to himself. He consistently refused to engage, declining to go to confidential treatment space, not responding to staff and providers, refusing his medications, and refusing his labs. On August 19, 2015, he was deemed incompetent and unrestorable and was discharged from RTC.

381. This is a case of a seriously mentally ill individual who was allowed to languish in segregation. He was refusing his antipsychotic medication and was noted to be displaying overt signs of psychosis but nothing was done. I have personally observed cases like this where an extremely disturbed patient is kept in segregation without any meaningful treatment while the trash and filth piles up in his cell. Early on in his incarceration, the patient should have been referred to a psychiatric hospital where he could have been properly assessed and treated. The course of his "treatment" in the Maricopa County Jail did not meet any standards for adequate psychiatric care.

382. Patient FA [redacted] was booked on May 27, 2015. She was moved between the MHU and segregation and never received adequate care. On May 31, she was found tying a towel around her neck and was transferred to the MHU. Shortly after her discharge from the MHU, she reported that she was hearing voices, which sometimes tell her to do things. She continued to report hearing voices, and she reported that they were commanding her to hurt herself. She was again moved to the MHU on June 13 after she was observed with cuts on her neck and arms. The patient remained psychotic. On assessment in the MHU, she reportedly stated "I think you put a microchip in me that makes me think people are out to get me. I'm just telling the truth." She had to be restrained after she continuously banged her head against the steel cell door. Beginning around June 17, the patient began to occasionally refuse her Zyprexa. She continued to hear voices and experience racing thoughts and anxiety. While in segregation, she was seen infrequently by providers, despite multiple

referrals by detention staff, as well as ongoing medication refusals, and her contacts with mental health staff were insubstantial. She was moved back to the MHU after she was found with long cuts to her neck and arms from a razor blade that had been distributed.

383. This case demonstrates that unstable mentally ill individuals are prematurely discharged from MHU and placed at serious risk for self-harm. Also, there is inadequate mental health follow up for mentally ill individuals housed in the Estrella lockdown units. As of October 27, when I saw the patient, she denied hearing voices but appeared to be responding to internal stimuli. She also appeared to be overmedicated. She should have been hospitalized rather than subjected to the inadequate care she received at the Jail.

384. Patient RB [redacted] was booked on June 1, 2014. From September 3, 2014, the patient has been housed in the SMU. In November 2014, the patient began to refuse his medications. He also complained of hearing voices through the vents daily. Despite his continued medication non-compliance, during a December assessment, PA Fleming scheduled a follow-up for six weeks out. In February 2015, Dr. Fangohr renewed the patient's Zyprexa prescription, originally ordered in November 2014. The patient was episodically non-compliant with his medication throughout his entire course of treatment; yet, I found no evidence from the record that the prescribing physician was cognizant of this problem. His prescription for Zyprexa was allowed to expire on May 11. He was seen by MHA monthly at his cell and was seen by a provider every sixty days. The only variance occurred when his brother died in 2015. During the infrequent assessments, the patient continued to report hearing voices, but reported he was okay without medications. He was mostly unresponsive to attempts to assess him on July 17 and again on July 28. During the monitoring period, all of his clinical contacts while in the SMU were cell-side; sometimes staff noted

patient RB refused a private room, other times a private assessment evidently was not even offered to this patient.

385. I evaluated Mr. RB on October 26, 2015. When I spoke with the patient, he said he saw people on the ceiling and saw Bigfoot, endorsing an earlier note in his record about a hallucination. When I assessed him, I noted that he was extremely psychotic, standing in the middle of his cell, staring off into space. When I attempted to engage him in conversation, he assumed a catatonic-like posture and did not respond. He appeared to be in a great amount of distress. A review of his medication record reveals that he has not received any psychotropic medication for almost six months. This is a very sick individual who requires an immediate transfer to a higher level of psychiatric care.

386. Patient HB [redacted] was booked on April 11, 2015. She has a well-documented mental health history, both while incarcerated and in the community, was confirmed SMI, and had a COT Order entered for her on April 7, 2015 (four days before her arrest), authorizing involuntary treatment. She was not re-started on her medications, including Seroquel—a confirmed active involuntary medication at the time of her arrest—following her intake. The patient was moved briefly to the MHU at intake after making nonsensical statements, including stating that she had an animal living inside her stomach. Over the next several days, the patient frequently asked to be prescribed the medications she had been on before her arrest. On April 15, Dr. Drapeau entered an order for medications. However, by then, the patient began to refuse her medications, and did so for two weeks, during which she was not seen by a provider. During that time, she was reportedly difficult for MCSO to manage. She had run out of her cell naked and had screamed and yelled delusional material from her cell.

387. The patient remained in segregation until May 11, where she was found flooding her cell. She was reportedly odorous, loud, and unresponsive to attempts to

redirect her. She claimed someone was raping her in her lockdown cell. She remained symptomatic back in the MHU, where she was reported as paranoid and delusional and periodically refused her medications. On May 26, Dr. Patel reported that Ms. HB "hears people upstairs through vent—hallucinations. She is also paranoid that she does not want to take medication at night because [if] someone comes in her room at night and sexually assaulted her, she would not know. She was laughing and laughing for no reason." Nevertheless, she was discharged to outpatient care in Estrella segregation. The patient continued to deteriorate in segregation. On June 7, she reportedly appeared actively psychotic and talked about hearing voices telling her things. She expressed delusions about cameras and people watching her. A note from a MHP that day wrote that, given her behavioral problems stemming from her psychosis, she should not be in isolation. "[I]t seems the most effective treatment for this patient would be to reside in stepdown MHU, as she is in Rule 11 and continues to be actively psychotic." The patient continued to periodically refuse to take her medications, was often observed yelling or screaming in her cell, and was placed on suicide watch on July 16 after being observed running around naked in her cell. On July 23, the patient was found incompetent and unrestorable in RTC.

388. This is a case where the patient suffered needlessly because she was not continued on her community medications when she entered the Jail. The majority of the initial problems in this case could have been avoided by the psychiatric staff had they followed their own protocol of continuing a patient's community medications as soon as the medications are verified. Ms. HB remained at the Jail though she required a higher level of care than she could receive there. This case is also an example of the Jail failing to utilize a COT Order that had been secured by patient HB's community provider. Despite the COT Order, her multiple medication refusals were not timely addressed. This case represents tremendously poor and dangerous care.

389. Patient JB [redacted] was booked on June 8, 2015. He was moved to the MHU that day for his psychotic behavior and potential danger to himself or others, and he remained there. While in the MHU, the patient refused to eat and repeatedly refused medical tests, including CIWA monitoring, weight checks, and vital signs. On July 1, he threatened to rape a medical technician who attempted to administer a TB test and draw blood for an HIV test. His cell became littered with large piles of trash. He regularly refused meals, believing his food was poisoned and made with body parts. No medications were ever offered to the patient. During assessments in June and July, he remained symptomatic. He spoke in word salad, rambled, and could not be re-directed. On one occasion, he reportedly stated that his "dad is president and grandfather George Washington, so I am immune. They are trying to feed me food made of fingernail filing and body parts." On another occasion, he stated that he had a computer and research lab, and the government was stealing his books. He stated that he believed his food was made of body parts and made other references to his food being poisoned. He responded to internal stimuli. He had poor hygiene and his cell remained messy. The patient's record indicated that he would be petitioned for DTS on July 23, after he was assessed by a psychologist and found to be disorganized, delusional, paranoid, and he had regularly refused half his food. However, there was no DTS petition in the file, and the file indicates that he was released on July 23.

390. There was a lack of urgency displayed by the psychiatric staff in dealing with this very mentally ill individual. Any number of actions should have been taken by the staff, including, but not limited to, the administration of psychotropic medications on an emergency basis as well as transferring the patient to a psychiatric hospital. This case is another example of very poor and potentially dangerous care that resulted in undue suffering for the patient.

391. Patient JF [redacted] was booked on April 20, 2015. He was moved to the MHU from intake after he smeared feces on his cell wall. A Mercy Hospital report

for the patient listed a diagnosis of schizoaffective disorder and listed recent injections of Haldol Dec, last given on April 1. On May 11, the patient was placed back on suicide watch after he threatened detention officers. The patient was reportedly putting toilet water in cups, pouring it on his wrists, and possibly drinking it; he appeared to be attempting to flood his cell. The patient was preoccupied with vampires and religious themes. While in the MHU, the patient was not offered groups while on P-3, and though he was housed for some time on P-1, he was often excluded from groups offered there due to being too symptomatic. The patient was moved to P-3 in early May 2015 because he was unable to function in P-1; he required a spit mask for his transfer.

392. The patient remained symptomatic and refused his medications on May 16 and May 17. On May 17, he reportedly stated, "I am Jesus I opened the skies. I sit on the right side of the father." On June 22, he was again placed on suicide watch after he ripped up his mattress and flooded his cell. He was preoccupied with the idea of his father being a member of the CIA. He again refused his medications on June 22 and June 23. A note from Dr. Worthen on July 7 indicated that the patient was again medication non-compliant and noted the patient's increasingly disruptive behavior when off his medications. He had again ripped up his mattress. The patient continued to refuse medications in July; a July 28 assessment by Dr. Worthen indicated that he was difficult to redirect, hypomanic, hyperverbal, and delusional. On July 30, the patient was released to the streets.

393. This case is an example of the staff's failure to refer this potentially dangerous individual to a higher level of care. The severity of his illness necessitated that he be placed on an involuntary hold and admitted to a psychiatric hospital. Not only did the patient suffer because his mental illness was not properly addressed in a timely manner, but he was released to the streets, which placed the general public at risk.

394. Patient WI [redacted] was booked on July 8, 2015. This patient had a confirmed history of community-based mental health treatment. His record includes a scanned record from Mercy Healthcare noting a diagnosis of schizophrenia, paranoid type. Following a positive intake screening and after the patient made suicidal statements in intake, the patient was moved to the MHU on suicide watch. Since this patient's booking, he has consistently refused treatment and medication (Risperdal). In a July 21 assessment, the patient refused to go to a confidential room or come to his cell window. He was observed responding to internal stimuli. He remained off his medications and was refusing court. On July 23, the patient again refused a confidential room and refused to engage cell-side. This is another case of a patient with documented psychiatric treatment in the community not having his medication initiated in a timely manner. He was also noted to be psychotic and uncooperative with staff but yet he was discharged from the MHU and sent to GP. Finally, not enough effort was documented in the mental record to engage him in treatment.

395. Patient LL [redacted] was booked on April 4, 2015. On multiple occasions in April, the patient was referred to mental health from detention officers. On one occasion, she reportedly had been arguing with others, appeared unstable, and was talking to herself. On other occasions, she was reported as disoriented and acting "schizo." On one instance, she stated that she did not need mental health services. Between April 17 and May 3, the patient was not seen by any mental health staff.

396. On May 3, she was seen following another referral from detention. She reportedly had blood on the floor of her cell and on her clothing and she had put her uniform in the toilet, stating that the clothes were dirty. Her cell was messy and littered with trash. The patient was refusing her medications. The following day, she was seen by NP Burgett, who noted she was having menses and letting blood drip on the floor. She was disoriented, confused, and agitated. The patient was finally transferred that day back to the MHU from segregation. Even in the MHU, the patient

remained symptomatic. Over the next three months, she continued to decompensate. During a June 5 assessment, she reportedly stated, "There are people out there jumping on my mom I can hear her crying for me." Two days later, she was found pulling her hair out and eating it. She continued to display inappropriate behavior, including uncontrollable laughter, random crying fits, and incoherent rambling. Again, on July 1, the patient was found menstruating but not using hygienic products. Her bunk had been changed out four times that morning, and the bunk of the inmate below her had been changed once. She was smearing blood on her hands, face, and hair.

397. The patient was offered medications for the first time on July 1. Dr. Patel noted that the patient was not able to give consent due to her confusion. Notwithstanding Dr. Patel's note on consent, the medication order was completed and she was offered the medication. From the time medications were offered through July 10, the patient regularly refused her medications, with some intermittent compliance. Subsequently, her medication compliance improved.

398. Of note, it took the mental health staff one month before they transferred this very impaired patient into the MHU. After her brief stay in the MHU, she was returned to Estrella segregation without being properly stepped down. This inappropriate discharge resulted in placing her at risk for self-harm and further psychiatric decompensation. This, in fact, occurred which necessitated her returning to the MHU but yet she was never really engaged in treatment. Throughout her entire course of treatment, this patient should have been referred to an inpatient level of care due to the overwhelming severity of her mental illness. Instead, she was housed mostly in lockdown units, which exacerbated her illness.

399. Patient RO [redacted] was booked on April 24, 2014. She was referred from detention in mid-February 2015 and was sent to the MHU for pushing urine and feces out of her door and smearing feces over her body. This became a pattern. Back in outpatient segregation, she again was noted to have feces smeared in her cell; she

refused to engage with the provider on assessment, and was sent back to the MHU. Days later, she was seen at her cell in segregation, where urine and feces were on the floor, and the patient was naked and rubbing feces on her face. She was mute, would not respond, and made no eye contact; she was moved back to the MHU. On March 10, Dr. Patel noted that the patient had a bald spot on her head from pulling her hair out. She was noted as psychotic and poorly functioning. Assessments on March 19 and March 30 indicated that the patient continued to smear feces and blood in her cell and under her door. She was observed pulling out her pubic hair. On April 8, Dr. Patel saw her cell side in the MHU's lockdown unit. On exam, she was defiant and psychotic. She pushed liquid beneath her cell door. Her water had been turned off in her cell. On April 13, patient RO was again seen cell side, this time by MHA Merker Alster. She had a brown substance smeared on her hair, face, and neck. The patient reported her toilet had been shut off. She was released on April 17, 2015.

400. Although the patient was on COT to take Risperdal, a February 18 note indicated that she was compliant only half the time. A note from March 19 indicated that she had again been refusing her medications. She did not engage with providers or mental health staff.

401. The patient was found incompetent and unrestorable on April 7, and she was released on or about April 17. This case was problematic from the very beginning. The patient displayed extremely psychotic behavior throughout her entire stay. Her psychosis should have prompted staff to take an appropriately aggressive approach to her treatment. This never occurred. Instead, she spread feces, urine and blood; pulled out her scalp and pubic hair; and caused severe disruptions in every housing unit where she was placed. She was housed in lockdown units in both Estrella and the MHU, which exacerbated her illness. Based on my review of the medical record, it is difficult to understand the bases of the staff's ongoing inaction with this unremittingly psychotic patient. She needed to be hospitalized.

402. Patient TS [redacted] was booked on May 14, 2015, and he was moved to the MHU the following day. His history showed that he was being treated with Risperdal Consta 50 mg q 2 wks. For reasons that are not clear from the medical record, this course of treatment was not continued after he was booked. Instead of continuing the medication that he received in the community, NP Duckett started him on oral Risperdal 1mg BID. He was reported as making nonsensical, rambling, and delusional statements during a provider assessment on May 29. He was also reported as aggressive and unpredictable. A June 18 assessment reported a similar presentation and noted the patient was laughing hysterically as the provider approached his cell. The patient refused his medication. A July 10 assessment noted that the patient made DTO statements, referring to ideas about a killing spree. He was noted by the provider as "not stable; he is psychotic and unwilling to accept treatment or medications." His condition remained that way, and he continued to refuse his medications, through July.

403. On July 24, a non-emergent PAD petition was completed and faxed to EMPACT. I found no evidence in the chart during the month of August that this petition was ever acted on. Throughout the month of August, Mr. TS continued to refuse medication and remained very psychotic in the MHU. A review of the record reveals that the staff did little to actually engage this difficult patient in treatment. Basically, he was left alone in his cell, severely psychotic and not receiving any meaningful treatment.

404. Patient MT [redacted] was booked on July 18, 2015. During her suicide risk assessment, her mental health history and SMI inactive status was noted, and the patient reported that she did not want to take medication. The patient was moved to the MHU after she was found agitated, tangential, and disorganized on assessment following a referral from detention. While in the MHU, the patient remained psychotic and non-compliant. The patient had a prior COT Order from February 13, 2015, along with community medication orders for Risperdal 2 mg. Records from

Desert Vista show a diagnosis of schizoaffective disorder. Still, a July 28 note from Dr. Patel indicated that it was difficult to get information about her injectable medication, and she refused to take oral medication. Dr. Patel wrote, "she is psychotic and uncooperative with medications as she does not believe she needs them." Dr. Patel nonetheless discharged the patient from the MHU. In a July 29 assessment, the patient presented as very delusional and reported that her parents were Dorothy Hamill and Burt Reynolds. This case once again demonstrates the inability of the psychiatric staff to continue a patient's community medications when they are admitted to the jail. It also shows a premature discharge from the MHU.

405. Patient AD [redacted] was booked on March 4, 2015. The patient was placed on suicide watch from intake after she was observed biting her wrists. On March 9, the patient reported auditory hallucinations but stated she was okay. She was prescribed Zyprexa, but refused it two days later because it made her too anxious. Over the next few days, according to the EMAR, the patient also refused, on multiple occasions, CIWA, medications, and a TB test. Through March, in Estrella segregation, the patient remained symptomatic. On March 24, the patient reported auditory and visual hallucinations. She further stated that she believes she is being fed people in her food. On March 31, the patient was transported to the ER after she strangled herself. Following this incident, the patient was moved back to the MHU. She continued to display symptoms. She was observed talking to unseen others; she stated "you eat people here," and she spoke intermittently in a baby-type voice. On April 14, the patient was given an injection of Haldol and Benadryl, after being seen cell side and judged to be decompensating. On exam, she was disorganized, paranoid, and suffering from hallucinations. Despite her acuity, she was discharged from the MHU back to Estrella lockdown on June 5. She periodically refused her medications through August 2015, and they were discontinued on September 8 due to non-compliance.

406. She refused to cooperate in assessments on June 7 and June 9 following her discharge. When Dr. Drapeau saw her on August 14, she made a number of bizarre statements. She remained very psychotic.

407. I personally evaluated her on October 27 and observed her to be very psychotic in that she was hearing voices and speaking to God and other supernatural entities. She was calm and sitting quietly in the recreation yard when I spoke with her although she stated that I frightened her. My review of her records coupled with my personal evaluation convinced me that she should be watched very closely as she has the potential for serious self-harm. I could not determine from her medical record that this was taking place. She is not receiving adequate care at the Jail, and her placement in lockdown housing exacerbates her mental illness.

408. Patient RG [redacted] was booked on October 7, 2012; he has been housed in the SMU since December 9, 2014. During infrequent provider assessments, the patient's psychotic state was apparent, and his medication refusals were noted. On February 26, Dr. Fangohr saw the patient cell side in the SMU, and wrote, "statements do not make sense. Pt has not cooperated with any meds since at the jail. many tattoos. Cell has lots of debris. Yelling profanities at times. Some agitation. . . . Pt. appears psychotic." On March 24, he reportedly stated, "Bitch I am being watched," and then became agitated and hit the window of the cell. On April 28, the patient came to the door, yelled profanities, and then began kicking the door. A similar note was entered on July 17 by Dr. Fangohr, who ordered a provider follow-up in three months. On August 7, the patient reportedly stated, "I don't work or play with others I don't care nigger. The light in my room is my clock and my knee is the year. I've been here for over 90 days and that is kidnapping no control over 90 days. I need a psych eval. Don't turn nothing off nigger." MHA Uribe wrote identical (word-for-word) entries under the assessments tab of his notes for this patient on June 10, July 10, August 7, and September 4, 2015.

409. This case is a travesty. I personally evaluated this patient on October 26, 2015. My evaluation is exactly similar to Dr. Fangohr's February 26 assessment. That means that for the past eight months, the patient has been extremely psychotic and agitated, living in extremely unsanitary conditions in his cell, not eating adequately and needlessly suffering. This patient requires immediate transfer to an inpatient psychiatric facility for acute medication stabilization. While MHA Uribe noted that the patient presented as stable, he actually presents with a tremendously unstable mood and is a serious risk to harm others.

410. Patient FO [redacted] was admitted on May 19, 2015. He was transferred to the SMU on May 31, where he remains housed. He was moved to the SMU after he tried to leave his unit, appeared fearful, and refused to speak with officers. He was examined that day by MHA Herrera, who noted that the patient presented as anxious and "internally preoccupied at times." A July 10 assessment noted that he was non-verbal during the encounter. There are no documented mental health assessments of patient FO from July 10 to August 20, though he remained in the SMU. The patient was first seen by a provider on August 20. Dr. Raikhelkar noted that he did not talk much, showed a lot of hypervigilance and paranoia, and did not respond to questions. He presented as paranoid and responding to internal stimuli. He was prescribed Risperdal, but a September 1 note indicated that he refused it, so it was discontinued. When he was seen on October 1, the patient was very verbal and made a number of delusional statements. The patient was found incompetent and unrestorable on October 13, 2015.

411. I personally evaluated the patient on October 26, 2015. My evaluation is consistent with Dr. Raikhelkar's August 20 assessment. The patient is very psychotic and disabled but presents as very quiet and withdrawn. Dr. Raikhelkar appropriately ordered an antipsychotic, but it was discontinued 10 days later because the patient refused to take it. There is no evidence from the chart that any mental health staff

attempted to engage the patient in treatment. His mental health assessments on May 27, May 31, and July 10 all document this patient suffering from psychosis, but mental health staff failed to refer him to a provider. The patient continues to suffer needlessly due to this lack of treatment. His SMU placement exacerbates his mental illness. He needs a higher level of care than he is being provided at the Jail.

412. Patient LW [redacted] was admitted on July 19, 2014. At intake, his active SMI status and current prescriptions, including a recent Haldol Dec injection, were noted. He received a Haldol injection on July 26, shortly after his admission; this was the only dose of Haldol given to him. Over the course of his incarceration, the patient was on a variety of antipsychotic medications. He was prescribed at various times Haldol, Abilify, Loxapine, Zyprexa, Prolixin and Trilafon. A review of the medical record shows that the patient had various problems with each of these medications. The biggest problem being that they did not adequately address his psychotic symptoms and/or that they were discontinued haphazardly.

413. On March 31, 2015, the patient was transferred to the MHU after he tied a sheet around his neck. In the MHU, Dr. Jaffe discontinued all of his medications. On April 14, Dr. Newson saw the patient, who said, "yesterday morning I woke up like a screw loose. No air in my lungs like my brain was being squeezed." When asked why, he stated, "Between some big people and what they call floats. They got earth. I don't know. They got floats that just seem like a planet." On exam, the patient's insight and judgment were impaired, and he had disorganized thoughts. On April 30, Dr. Fangohr changed the patient's medication from Abilify to Risperdal Consta without clinical justification. In his progress note on April 30, Dr. Fangohr wrote that Abilify would be discontinued because it is a "non preferred medication in the jail." During assessments in June and July, the patient reported auditory hallucinations.

414. I personally evaluated this patient on October 26, 2015, and found him to be very psychotic. He displayed prominent thought blocking and complained of auditory hallucinations. He told me "On a scale of 1-50, my voices are a 49!" He went on to state that the voices are "driving me nuts." It is readily apparent from my review of this case that the patient's medications have been mismanaged throughout his entire stay in the Jail. My immediate concern is due to the severity of his auditory hallucinations; the patient is a risk of harm to himself and/or others. An experienced neuropsychiatrist should conduct a thorough review of his medication history and recommend a course of treatment.

415. Patient NF [redacted] was booked on March 14, 2015. He was moved to the MHU after assaulting a fellow prisoner while in GP. When he was seen by a provider the following day, the patient refused to acknowledge or converse during the assessment. A provider note on April 11 indicated that Mr. NF was "a challenge to formally assess." He again refused to acknowledge the provider and kept his eyes closed despite the provider's multiple attempts to assess him. Assessments by mental health staff from April 22, May 13, and May 29 reported that the patient refused to respond to questions, except for nodding his head. The patient presented a great risk of assault. An April 14 note indicated that "extreme caution" should be exercised, as the patient presented a "high DTO risk, acts as the aggressor, and will charge at others unprovoked." Notes by mental health staff from June through August reported that Mr. NF's cell window was smeared with food and spit and that his cell was littered with food debris, containers, and trash. The patient remained mostly non-verbal during assessments. The patient was found incompetent and unrestorable and was discharged from the RTC Program on July 30, 2015. This patient presented a serious risk of assault. If he was as assaultive as described by staff in their notes, antipsychotic medication should have been administered on an emergency basis. This patient did not receive an adequate level of care while jailed.

416. Patient TH [redacted] was booked on January 31, 2015; at intake, his long mental health history in the community and on previous jail stays was noted. His record included a prior COT Order. Over the course of the next several months, the patient remained symptomatic, living in his own squalor, as no appropriate treatment plan was developed. During assessments from March through July, the patient appeared internally preoccupied, mumbled to himself, laughed inappropriately, and responded to internal stimuli. His thoughts remained loose and disorganized, and he did not engage meaningfully with assessment questions by providers. Throughout this time, the patient's living space became filthy and the patient was reported as malodorous. Mr. TH was deemed incompetent and unrestorable, and he was discharged on July 15.

417. This case demonstrates a lack of coordination between the Jail mental health staff and the RTC staff. It also demonstrates the lack of appropriate psychiatric care for this very ill individual. He was begun on 37.5 mg IM of Risperdal Consta on February 12 and the dose was never changed even though the patient continued to exhibit a variety of significant psychotic symptoms. The standard for psychiatric care requires a modification of the treatment if the patient does not improve. This is another case where the patient suffered needlessly due to incompetent and inadequate psychiatric care.

418. Patient DG [redacted] was booked on May 18, 2015. While held in Estrella segregation, she began to display psychotic behavior. Detention staff made no fewer than five separate referrals of this patient to mental health due to her bizarre behavior while housed in Estrella lockdown. Detention staff refused to allow her confidential visits while in lockdown due to her threatening and erratic behavior. She was reported as talking to herself and did "not appear to be fully in touch with reality." She also began refusing medications. She was moved to the MHU on June 9 after she was reportedly yelling and screaming in her cell; she was noted as psychotic, possibly

manic, irritable and malodorous. In the MHU, the patient denied medication, stating that she was allergic to all medications. She also refused to be assessed by mental health staff. During one assessment, Ms. DG reportedly stated the ceiling in her cell was a monster. On June 10, Dr. Patel noted she was irrational with disorganized, loose thoughts, possibly paranoid, and that she refused all medications. She was nonetheless discharged back to Estrella lockdown two days later. When she was seen on June 22, several days after her MHU discharge, she was less irritable but still symptomatic—she appeared disheveled, her speech was loud and rapid, and her thoughts were loosely organized. The patient continued to refuse any psychotropic medications. On July 8, she was referred by the treatment team to an MHP for an assessment for a possible PAD petition, but there was no corresponding MHP assessment, and no documentation indicating a petition was filed. On July 21, the patient refused to be assessed, telling the MHP to get away from her door. She was responding to internal stimuli, agitated, and continued to refuse mental health services. On July 29, Dr. Drapeau saw the patient cell-side as detention refused to allow her out of her cell due to her erratic behavior. The patient continued to yell at staff, was delusional, and refused medications as well as a TB test.

419. This patient needlessly suffered from not having her mental illness properly addressed in a timely manner. She was noted to be psychotic upon booking, yet she never received adequate treatment throughout the pertinent period. Although she was displaying very impaired behavior, it took a month for her to be admitted to the MHU and then she was only held there for a few days. The patient continually refused medication and treatment; she required a higher level of care. Instead, she was housed in a lockdown unit for almost her entire jail stay, which exacerbated her mental illness.

420. Patient BI [redacted] was brought from intake to the MHU on June 3, 2015, where a provider assessment noted loose associations, paranoia, and tangential

thoughts. He remained in the MHU until June 12, 2015. He was discharged that day, though three days before his discharge he was delusional and threatening, accusing an MHA who saw him cell side of stealing his checks. The patient remained housed at Durango until June 19, 2015. While there, the patient was symptomatic. He was referred by detention on one occasion after he was seen wandering around, talking to himself, and making nonsensical statements. During an assessment, the patient stated that he "knows all the members of star trek" and has been offered a job with the federation when he gets out of jail. He displayed delusional and paranoid thinking; rapid, pressured, and loud speech; and a labile mood. A provider assessment on June 19 described the patient's thought processes as "so derailed" that the provider was unable to follow his chain of thought. The patient was moved into the MHU on suicide watch on June 19. During a June 29 assessment, he was too agitated to be seen in a confidential room, and his thoughts were loose, agitated, and labile. On July 14, the patient stated he did not want to take his medications; the patient was agitated and had loose and tangential thoughts. A similar note was entered on July 28; the patient again refused his medications and appeared easily agitated. The patient remained unstable and medication non-compliant into August. He was deemed incompetent and unrestorable and was discharged from the RTC Program on September 2, 2015. He had continued to refuse his medication through his October 1 discharge.

421. Patient BI was prematurely discharged from the MHU, which placed him and fellow detainees at risk. In this patient's case, he had to be returned to the MHU on suicide watch. He remained symptomatic and non-complaint while held in the MHU, where he was housed in what is essentially a lockdown unit on P-3. He required a higher level of care than he was provided at the Jail.

422. Patient DG [redacted] was booked on January 14, 2015; at intake, previous treatment via People of Color Network and a diagnosis of schizoaffective disorder were noted. The patient reported receiving a shot the previous week. The

patient, while housed in outpatient segregation, was taken off her medications to monitor her for possible side effects. Without her medications, she became symptomatic. Among other things, she stated, "Technology is being used on me. They can listen to the mind. The thing they did to Christ . . . They made him black." She further reported being afraid to eat the food and believed someone was trying to poison her. The patient was seen infrequently by a provider. By the time a provider assessed her, on April 22, the patient had grossly decompensated. Her mouth was "opening frequently" and she was reportedly rambling, disorganized, and tangential. Her hygiene was poor. Despite this, she was found stable for outpatient care.

423. The patient was moved to the MHU for hair-pulling and psychosis. During her assessment on May 3, she was noted as psychotic and was engaging in self-harming behaviors. She was suffering from hallucinations. Despite her presentation, a provider note indicated that Ms. DG would be discharged back to outpatient care in segregation because she was "playing games" to remain in the MHU. During an assessment following her discharge, the patient reported experiencing racing thoughts and had been pulling out her hair.

424. Ms. DG was found incompetent and unrestorable on May 7 and was ordered civilly committed. This case of an extremely mentally ill young woman was mishandled from the time of her intake. The staff should have continued the meds she was receiving in the community immediately upon intake. She should have been transferred to a higher level of care than the Jail can provide. The patient suffered needlessly due to the incompetent nature of her care.

425. Patient MG [redacted] was booked on January 14, 2014. This patient has been housed in the SMU since his February 26, 2015 discharge from the MHU. During a June 10 assessment, the patient reportedly stated, "I hear SRT under the floor, they cut off my phone and shine a red dot laser at me. They are using gas to try to poison me." Despite this presentation, no provider referral was made. On June 26,

the patient reportedly stated he had electronic devices implanted on him when he was young, and that once they are taken out, he will be "ripped." He was hyper verbal and difficult to re-direct. He spoke nonstop under his breath at times. He continued to make such statements during future assessments. On July 27, he reportedly stated, "I have equipment in my head a baby monitor which they put in me when I was at the hospital along with camera flashes . . . . The light has been shining amber lasers for muscle repair and locked on to scar tissue and muscle . . . ." On two occasions in June, the patient was seen by a RN for hand injuries after he reportedly punched a wall due to PTSD and night terrors. This patient, at various times, presented with serious incidents of self-harm as well as psychotic symptoms. He was denied timely access to a mental health provider and did not receive sufficient care. He was also kept in the most punitive unit at the Jail, which exacerbates his illness. The patient suffered needlessly due to these omissions.

426. Patient GL [redacted] was booked on June 7, 2015. She was transferred to the MHU on June 28 after mental health assessments and referrals reporting that she was acting "bizarre" and "disturbed." While in the MHU, on July 6, the patient was given a forced injection after being deemed DTS. Dr. Patel noted that she was hyper, agitated, and paranoid. She had disorganized, loose, and rapid thought processes. She was also reportedly smearing her cell walls and window with peanut butter and/or feces. She refused her medications. Just three days later, on July 9, she was discharged from the MHU. Back in Estrella segregation, the patient's condition deteriorated. On July 10, she reportedly stated that she wanted to pull her hair out and felt that she might go crazy. She reported to NP Bankson on July 15 that she felt like she was going to kill herself and stated that she "can't be in that little room anymore." She reported that she had been striking her neck with a comb to try to kill herself. She further reported hearing voices instructing her to just do it and not to trust the provider. She was sent back to the MHU that day. She was kept on the acute unit (P-5) on

lockdown status, and repeatedly complained about her isolation and living conditions. On July 20, she asked to be discharged from the MHU because her current living conditions in her unit were lonely and depressing, and she could not use any privileges. She was again discharged to Estrella. She was not stepped down in the MHU. She returned to the MHU just two days later, on July 22, for being potentially suicidal. She was reportedly paranoid, delusional, and was hearing voices. The patient was again discharged and subsequently re-admitted after threatening to harm herself or others. She had loose and disorganized thoughts and speech and was "very psychotic." On August 5, she was reportedly threatening officers and staff, was psychotic, and reported auditory hallucinations. The patient showed a pattern of DTS and self-injurious statements and behavior as well as other psychotic symptoms. Her housing in lockdown units in both the MHU and Estrella exacerbated her illness, and contributed to her self-harming behavior. She was not receiving sufficient care.

427. Patient AW [redacted] was moved to MHU P-5 from booking on May 8, 2015, after a positive mental health intake screening that noted schizophrenia but no current medications, a prior suicide attempt in February 2015, and bizarre statements and behavior during booking. She refused to cooperate with treatments or assessments for the first three days she was in the MHU. The patient was discharged from the MHU on May 14, despite her disheveled appearance, reported hallucinations, and latent responses to questions asked by the provider. The patient reported auditory and visual hallucinations during a June 5 assessment. The patient's first psychotropic medication prescription was ordered that day—nearly a month after the patient's admission. The patient remained symptomatic. On June 16 during an assessment following a referral from detention, she reported that she cut off her hair because voices were speaking through it. She was nevertheless deemed stable for lockdown housing. Ms. AW was moved back into the MHU on multiple occasions in July after making suicidal and DTS statements. On July 20, she asked for a higher dosage of

medication, and reported feeling hopeless, but said she did not want to be transferred back to the MHU from Estrella lockdown. NP Bankson wrote, "she was feeling like she could not cope anymore. But given the option of P-5, she wants to remain in C Tower." Five days later, she was transferred back to the MHU after making DTS statements. Dr. Patel then discharged her from MHU two days later, despite the patient "report[ing] voices telling her she is no good and hopeless." This transfer was canceled after nursing staff reported that the patient was suicidal. This patient was actively psychotic and episodically suicidal. She did not receive appropriate care in the MHU or in outpatient segregation. Her ongoing housing in lockdown units—both in the MHU and Estrella—are exacerbating her mental illness and putting her at risk of harm.

1. **My Rate:** I charge [$300] per hour for time spent on this case, with a daily cap of $2,500.00.

2. **Testimony:** A list of the cases in which I have provided expert testimony in the last four years is attached as **Exhibit B**.

Dated 1st Day of April, 2016, at San Francisco, California.

/s/ Pablo Stewart, M.D.

CURRICULUM VITAE

PABLO STEWART, M.D.
824 Ashbury Street
San Francisco, California 94117
(415) 264-0237; fax (415) 753-5479; e-mail: pab4emi@aol.com
(Updated February 2016)

EDUCATION:

University of California School of Medicine, San Francisco, California, M.D., 1982

United States Naval Academy, Annapolis, MD, B.S. 1973, Major: Chemistry

LICENSURE:

California Medical License #GO50899
Hawai'i Medical License #MD-11784
Federal Drug Enforcement Administration #BS0546981
Diplomate in Psychiatry, American Board of Psychiatry and Neurology, Certificate #32564

ACADEMIC APPOINTMENTS:

September 2006-Present	Academic Appointment: Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
July 1995 - August 2006	Academic Appointment: Associate Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1989 - June 1995	Academic Appointment: Assistant Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1986 - July 1989	Academic Appointment: Clinical Instructor, Department of Psychiatry, University of California, San Francisco, School of Medicine.

EMPLOYMENT:

December 1996-Present	Psychiatric Consultant Provide consultation to governmental and private agencies on a variety of psychiatric, forensic, substance abuse and organizational issues; extensive experience in all phases of capital litigation and correctional psychiatry.

EXHIBIT A

January 1997- September 1998	Director of Clinical Services, San Francisco Target Cities Project. Overall responsibility for ensuring the quality of the clinical services provided by the various departments of the project including the Central Intake Unit, the ACCESS Project and the San Francisco Drug Court Also responsible for providing clinical in-service trainings for the staff of the Project and community agencies that requested technical assistance.
February 1996 - November 1996	Medical Director, Comprehensive Homeless Center, Department of Veterans Affairs Medical Center, San Francisco. Overall responsibility for the medical and psychiatric services at the Homeless Center.
March 1995 - January 1996	Chief, Intensive Psychiatric Community Care Program, (IPCC) Department of Veterans Affairs Medical Center, San Francisco. Overall clinical/administrative responsibility for the IPCC, a community based case management program. Duties also include medical/psychiatric consultation to Veteran Comprehensive Homeless Center. This is a social work managed program that provides comprehensive social services to homeless veterans.
April 1991 - February 1995	Chief, Substance Abuse Inpatient Unit, (SAIU), Department of Veterans Affairs Medical Center, San Francisco. Overall clinical/administrative responsibility for SAIU.
September 1990 - March 1991	Psychiatrist, Substance Abuse Inpatient Unit, Veterans Affairs Medical Center, San Francisco. Clinical responsibility for patients admitted to SAIU. Provide consultation to the Medical/Surgical Units regarding patients with substance abuse issues.
August 1988 - December 1989	Director, Forensic Psychiatric Services, City and County of San Francisco. Administrative and clinical responsibility for psychiatric services provided to the inmate population of San Francisco. Duties included direct clinical and administrative responsibility for the Jail Psychiatric Services and the Forensic Unit at San Francisco General Hospital.
July 1986 - August 1990	Senior Attending Psychiatrist, Forensic Unit, University of California, San Francisco General Hospital. Administrative and clinical responsibility for a 12-bed, maximum-security psychiatric ward. Clinical supervision for psychiatric residents, postdoctoral psychology fellows and medical students assigned to the ward. Liaison with Jail Psychiatric Services, City and County of San Francisco. Advise San Francisco City Attorney on issues pertaining to forensic psychiatry.

July 1985 June 1986	Chief Resident, Department of Psychiatry, University of California San Francisco General Hospital. Team leader of the Latino-focus inpatient treatment team (involving 10-12 patients with bicultural/bilingual issues); direct clinical supervision of 7 psychiatric residents and 3-6 medical students; organized weekly departmental Grand Rounds; administered and supervised departmental residents' call schedule; psychiatric consultant to hospital general medical clinic; assistant coordinator of medical student education; group seminar leader for introduction to clinical psychiatry course for UCSF second-year medical students.
July 1984 - March 1987	Physician Specialist, Westside Crisis Center, San Francisco, CA. Responsibility for Crisis Center operations during assigned shifts; admitting privileges at Mount Zion Hospital. Provided psychiatric consultation for the patients admitted to Mount Zion Hospital when requested.
April 1984 - July 1985	Psychiatric Consultant, Marin Alternative Treatment, (ACT). Provided medical and psychiatric evaluation and treatment of residential drug and alcohol clients; consultant to staff concerning medical/psychiatric issues.
August 1983 - November 1984	Physician Specialist, Mission Mental Health Crisis Center, San Francisco, CA. Clinical responsibility for Crisis Center clients; consultant to staff concerning medical/psychiatric issues.
July 1982- July 1985	Psychiatric Resident, University of California, San Francisco. Primary Therapist and Medical Consultant for the adult inpatient units at San Francisco General Hospital and San Francisco Veterans Affairs Medical Center; Medical Coordinator/Primary Therapist - Alcohol Inpatient Unit and Substance Abuse Clinic at San Francisco Veterans Affairs Medical Center; Outpatient Adult/Child Psychotherapist; Psychiatric Consultant - Adult Day Treatment Center - San Francisco Veterans Affairs Medical Center; Primary Therapist and Medial Consultant - San Francisco General Hospital Psychiatric Emergency Services; Psychiatric Consultant, Inpatient Medical/Surgical Units - San Francisco General Hospital.
June 1973 - July 1978	Infantry Officer - United States Marine Corps. Rifle Platoon Commander; Anti-tank Platoon Commander; 81mm Mortar Platoon Commander; Rifle Company Executive Officer; Rifle Company Commander; Assistant Battalion Operations Officer; Embarkation Officer; Recruitment Officer; Drug, Alcohol and Human Relations Counselor; Parachutist and Scuba Diver; Commander of a Vietnamese Refugee Camp. Received an Honorable Discharge. Highest rank attained was Captain.

HONORS AND AWARDS:

June 2015	Recognized by the Psychiatry Residents Association of the University of California, San Francisco, School of Medicine, Department of Psychiatry for "Excellence in Teaching" for the academic year 2014-2015.
June 1995	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1994/1995.
June 1993	Selected by the class of 1996, University of California, San Francisco, School of Medicine as outstanding lecturer, academic year 1992/1993.
May 1993	Elected to Membership of Medical Honor Society, AOA, by the AOA Member of the 1993 Graduating Class of the University of California, San Francisco, School of Medicine.
May 1991	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1990-1991.
May 1990	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1989-1990.
May 1989	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1988-1989.
May 1987	Selected by the faculty and students of the University of California, San Francisco, School of Medicine as the recipient of the Henry J. Kaiser Award For Excellence in Teaching.
May 1987	Selected by the graduating class of the University of California, San Francisco, School of Medicine as Outstanding Psychiatric Resident. The award covered the period of 1 July 1985 to 30 June 1986, during which time I served as Chief Psychiatric resident, San Francisco General Hospital.
May 1985	Selected by the graduating class of the University of California, San Francisco, School of Medicine as Outstanding Psychiatric Resident.
1985	Mead-Johnson American Psychiatric Association Fellowship. One of sixteen nationwide psychiatric residents selected because of a demonstrated commitment to public sector psychiatry. Made presentation at Annual Hospital and Community Psychiatry Meeting in Montreal, Canada, in October 1985, on the "Psychiatric Aspects of the Acquired Immunodeficiency Syndrome."

MEMBERSHIPS:

June 2000- May 2008	California Association of Drug Court Professionals.
July 1997- June 1998	President, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1996 - June 1997	President-Elect, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1995 - June 1996	Vice President, Northern California Area, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
April 1995 - April 2002	Associate Clinical Member, American Group Psychotherapy Association.
July 1992 - June 1995	Secretary-Treasurer, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1990 - June 1992	Councilor-at-large, Alumni-Faculty Association, University of California, San Francisco, School of Medicine

PUBLIC SERVICE:

June 1992	Examiner, American Board of Psychiatry and Neurology, Inc.
November 1992 - January 1994	California Tuberculosis Elimination Task Force, Institutional Control Subcommittee.
September 2000- April 2005	Editorial Advisory Board, *Juvenile Correctional Mental Health Report.*
May 2001- 2010	Psychiatric and Substance Abuse Consultant, San Francisco Police Officers' Association.
January 2002- June 2003	Psychiatric Consultant, San Francisco Sheriff's Department Peer Support Program.
February 2003- April 2004	Proposition "N" (Care Not Cash) Service Providers' Advisory Committee, Department of Human Services, City and County of San Francisco.
December 2003- January 2004	Member of San Francisco Mayor-Elect Gavin Newsom's Transition Team.

February 2004- June 2004	Mayor's Homeless Coalition, San Francisco, CA.
April 2004- January 2006	Member of Human Services Commission, City and County of San Francisco.
February 2006- January 2007; April 2013- January 2015	Vice President, Human Services Commission, City and County of San Francisco.
February 2007- March 2013; February 2015- present	President, Human Services Commission, City and County of San Francisco.

UNIVERSITY SERVICE:

October 1999- October 2001	Lecturer, University of California, San Francisco, School of Medicine Post Baccalaureate Reapplicant Program.
July 1999- July 2001	Seminar Leader, National Youth Leadership Forum On Medicine.
November 1998- November 2001	Lecturer, University of California, San Francisco, School of Nursing, Department of Family Health Care Nursing. Lecture to the Advanced Practice Nurse Practitioner Students on Alcohol, Tobacco and Other Drug Dependencies.
January 1994 - January 2001	Preceptor/Lecturer, UCSF Homeless Clinic Project.
June 1990 - November 1996	Curriculum Advisor, University of California, San Francisco, School of Medicine.
June 1987 - June 1992	Facilitate weekly Support Groups for interns in the Department of Medicine. Also, provide crisis intervention and psychiatric referral for Department of Medicine housestaff.
January 1987 – June 1988	Student Impairment Committee, University of California San Francisco, School of Medicine. Advise the Dean of the School of Medicine on methods to identify, treat and prevent student impairment.
January 1986 – June 1996	Recruitment/Retention Subcommittee of the Admissions Committee, University of California, San Francisco, School of Medicine. Advise the Dean of the School of Medicine on methods to attract and retain minority students and faculty.
October 1986 - September 1987	Member Steering Committee for the Hispanic Medical Education Resource Committee. Plan and present educational programs to increase awareness of the special health needs of Hispanics in the United States.

September 1983 - June 1989	Admissions Committee, University of California, School of Medicine. Duties included screening applications and interviewing candidates for medical school.
October 1978 - December 1980	Co-Founder and Director of the University of California, San Francisco Running Clinic. Provided free instruction to the public on proper methods of exercise and preventative health measures.

TEACHING RESPONSIBILITIES:

August 2014- Present	Small Group Facilitator, Foundations of Patient Care, University of California, San Francisco, School of Medicine.
July 2003- Present	Facilitate weekly psychotherapy training group for residents in the Department of Psychiatry.
January 2002- January 2004	Course Coordinator of Elective Course University of California, San Francisco, School of Medicine, "Prisoner Health." This is a 1-unit course, which covers the unique health needs of prisoners.
September 2001- June 2003	Supervisor, San Mateo County Psychiatric Residency Program.
April 1999- April 2001	Lecturer, UCSF School of Pharmacy, Committee for Drug Awareness Community Outreach Project.
February 1998- June 2000	Lecturer, UCSF Student Enrichment Program.
January 1996 - November 1996	Supervisor, Psychiatry 110 students, Veterans Comprehensive Homeless Center.
March 1995- December 20002	Supervisor, UCSF School of Medicine, Department of Psychiatry, Substance Abuse Fellowship Program.
September 1994 - June 1999	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Drug and Alcohol Abuse." This is a 1-unit course, which covers the major aspects of drug and alcohol abuse.
August 1994 - February 2006	Supervisor, Psychiatric Continuity Clinic, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Supervise 4th Year medical students in the care of dual diagnostic patients.
February 1994 - February 2006	Consultant, Napa State Hospital Chemical Dependency Program Monthly Conference.
July 1992 - June 1994	Facilitate weekly psychiatric intern seminar, "Psychiatric Aspects of Medicine," University of California, San Francisco, School of Medicine.

July 1991- Present	Group and individual psychotherapy supervisor, Outpatient Clinic, Department of Psychiatry, University of California, San Francisco, School of Medicine.
January 1991	Lecturer, University of California, San Francisco, School of Pharmacy course, "Addictionology and Substance Abuse Prevention."
September 1990 - February 1995	Clinical supervisor, substance abuse fellows, and psychiatric residents, Substance Abuse Inpatient Unit, San Francisco Veterans Affairs Medical Center.
September 1990 - November 1996	Off ward supervisor, PGY II psychiatric residents, Psychiatric Inpatient Unit, San Francisco Veterans Affairs Medical Center.
September 1990 - June 1991	Group therapy supervisor, Psychiatric Inpatient Unit, (PIU), San Francisco Veterans Affairs Medical Center.
September 1990 - June 1994	Course coordinator, Psychiatry 110, San Francisco Veterans Affairs Medical Center.
September 1989 - November 1996	Seminar leader/lecturer, Psychiatry 100 A/B.
July 1988 - June 1992	Clinical supervisor, PGY III psychiatric residents, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project.
September 1987 - Present	Tavistock Organizational Consultant. Extensive experience as a consultant in numerous Tavistock conferences.
September 1987 - December 1993	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Alcoholism". This is a 1-unit course offered to medical students, which covers alcoholism with special emphasis on the health professional. This course is offered fall quarter each academic year.
July 1987- June 1994	Clinical supervisor/lecturer FCM 110, San Francisco General Hospital and Veterans Affairs Medical Center.
July 1986 - June 1996	Seminar leader/lecturer Psychiatry 131 A/B.
July 1986 - August 1990	Clinical supervisor, Psychology interns/fellows, San Francisco General Hospital.
July 1986 - August 1990	Clinical supervisor PGY I psychiatric residents, San Francisco General Hospital
July 1986 -	Coordinator of Medical Student Education, University of

August 1990	California, San Francisco General Hospital, Department of Psychiatry. Teach seminars and supervise clerkships to medical students including: Psychological Core of Medicine 100 A/B; Introduction to Clinical Psychiatry 131 A/B; Core Psychiatric Clerkship 110 and Advanced Clinical Clerkship in Psychiatry 141.01.
July 1985 – August 1990	Psychiatric Consultant to the General Medical Clinic, University of California, San Francisco General Hospital. Teach and supervise medical residents in interviewing and communication skills. Provide instruction to the clinic on the psychiatric aspects of ambulatory medical care.

COMMUNITY SERVICE AND PRISON CONDITIONS EXPERT WORK:

June 2015-Present	Senior Fellow, University of California Criminal Justice & Health Consortium.
April 2014-Present	Plaintiffs' expert in *Hernandez, et al. v. County of Monterey, et al.*, No.: CV 13 2354 PSG. This case involves the provision of unconstitutional mental health and medical services to the inmate population of Monterey County Jail.
January-December 2014	Federal Bureau of Prisons: Special Housing Unit Review and Assessment. This was a year-long review of the quality of mental health services in the segregated housing units of the BOP.
August 2012-Present	Plaintiffs' expert in *Parsons et al. v. Ryan* et al., (District Court, Phoenix, Arizona.) This case involves the provision of unconstitutional mental health and medical services to the inmate population of the Arizona Department of Corrections.
October 2007 -Present	Plaintiffs' expert in 2007-2010 overcrowding litigation and in opposing current efforts by defendants to terminate the injunctive relief in *Coleman v. Brown,* United States District Court, Eastern District of California, Case No. 2:90-cv-00520-LKK-JFM. The litigation involves plaintiffs' claim that overcrowding is causing unconstitutional medical and mental health care in the California state prison system. Plaintiffs won an order requiring the state to reduce its population by approximately 45,000 state prisoners. My expert opinion was cited several times in the landmark United States Supreme Court decision upholding the prison population reduction order. *See Brown v. Plata,* __ U.S. ___, 131 S. Ct. 1910, 1933 n.6, 1935, 179 L.Ed.2d 969, 992 n.6, 994 (2011).
July/August 2008-Present	Plaintiff psychiatric expert in the case of Fred Graves, et al., plaintiffs v. Joseph Arpaio, et al., defendants (District Court, Phoenix, Arizona.) This case involved Federal oversight of the mental health treatment provided to pre-trial detainees in the Maricopa County Jails.

February 2006- December 2009	Board of Directors, Physician Foundation at California Pacific Medical Center.
June 2004- September 2012	Psychiatric Consultant, Hawaii Drug Court.
November 2003- June 2008	Organizational/Psychiatric Consultant, State of Hawaii, Department of Human Services.
June 2003- December 2004	Monitor of the psychiatric sections of the "Ayers Agreement," New Mexico Corrections Department (NMCD). This is a settlement arrived at between plaintiffs and the NMCD regarding the provision of constitutionally mandated psychiatric services for inmates placed within the Department's "Supermax" unit.
October 2002- August 2006	Juvenile Mental Health and Medical Consultant, United States Department of Justice, Civil Rights Division, Special Litigation Section.
July 1998- June 2000	Psychiatric Consultant to the Pacific Research and Training Alliance's Alcohol and Drug Disability Technical Assistance Project. This Project provides assistance to programs and communities that will have long lasting impact and permanently improve the quality of alcohol and other drug services available to individuals with disabilities.
July 1998- February 2004	Psychiatric Consultant to the National Council on Crime and Delinquency (NCCD) in its monitoring of the State of Georgia's secure juvenile detention and treatment facilities. NCCD is acting as the monitor of the agreement between the United States and Georgia to improve the quality of the juvenile justice facilities, critical mental health, medical and educational services, and treatment programs. NCCD ceased to be the monitoring agency for this project in June 1999. At that time, the Institute of Crime, Justice and Corrections at the George Washington University became the monitoring agency. The work remained unchanged.
July 1998- July 2001	Psychiatric Consultant to the San Francisco Campaign Against Drug Abuse (SF CADA).
March 1997- Present	Technical Assistance Consultant, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.
January 1996- June 2003	Psychiatric Consultant to the San Francisco Drug Court.
November 1993- June 2001	Executive Committee, Addiction Technology Transfer Center (ATTC), University of California, San Diego.
December 1992 - December 1994	Institutional Review Board, Haight Ashbury Free Clinics, Inc. Review all research protocols for the clinic per Department of Health and Human Services guidelines.

June 1991- February 2006	Chief of Psychiatric Services, Haight Ashbury Free Clinic. Overall responsibility for psychiatric services at the clinic.
December 1990 - June 1991	Medical Director, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Responsible for directing all medical and psychiatric care at the clinic.
October 1996-July 1997	Psychiatric Expert for the U.S. District Court, Northern District of California, in the case of Madrid v. Gomez, No. C90-3094-TEH. Report directly to the Special Master regarding the implementation of constitutionally mandated psychiatric care to the inmates at Pelican Bay State Prison.
April 1990 –January 2000	Psychiatric Expert for the U.S. District Court, Eastern District of California, in the case of Gates v. Deukmejian, No. C1V S-87-1636 LKK-JFM. Report directly to the court regarding implementation and monitoring of the consent decree in this case. (This case involves the provision of adequate psychiatric care to the inmates at the California Medical Facility, Vacaville).
January 1984 - December 1990	Chief of Psychiatric Services, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Direct medical/psychiatric management of project clients; consultant to staff on substance abuse issues. Special emphasis on dual diagnostic patients.
July 1981- December 1981	Medical/Psychiatric Consultant, Youth Services, Hospitality House, San Francisco, CA. Advised youth services staff on client management. Provided training on various topics related to adolescents. Facilitated weekly client support groups.

SERVICE TO ELEMENTARY AND SECONDARY EDUCATION:

January 1996 - June 2002	Baseball, Basketball and Volleyball Coach, Convent of the Sacred Heart Elementary School, San Francisco, CA.
September 1994 - Present	Soccer Coach, Convent of the Sacred Heart Elementary School, San Francisco, CA.
June 1991- June 1994	Board of Directors, Pacific Primary School, San Francisco, CA.
April 1989 - July 1996	Umpire, Rincon Valley Little League, Santa Rosa, CA.
September 1988 - May 1995	Numerous presentations on Mental Health/Substance Abuse issues to the student body, Hidden Valley Elementary School and Santa Rosa Jr. High School, Santa Rosa, CA.

PRESENTATIONS:

1. San Francisco Treatment Research Unit, University of California, San Francisco, Colloquium #1. (10/12/1990). "The Use of Anti-Depressant Medications with Substance-Abusing Clients."

2. Grand Rounds. Department of Psychiatry, University of California, San Francisco, School of Medicine. (12/5/1990). "Advances in the Field of Dual Diagnosis."

3. Associates Council, American College of Physicians, Northern California Region, Program for Leadership Conference, Napa, California. (3/3/1991). "Planning a Satisfying Life in Medicine."

4. 24th Annual Medical Symposium on Renal Disease, sponsored by the Medical Advisory Board of the National Kidney Foundation of Northern California, San Mateo, California. (9/11/1991). "The Chronically Ill Substance Abuser."

5. Mentoring Skills Conference, University of California, San Francisco, School of Medicine, Department of Pediatrics. (11/26/91). "Mentoring as an Art."

6. Continuing Medical Education Conference, Sponsored by the Department of Psychiatry, University of California, San Francisco, School of Medicine. (4/25/1992). "Clinical & Research Advances in the Treatment of Alcoholism and Drug Abuse."

7. First International Conference of Mental Health and Leisure. University of Utah. (7/9/1992). "The Use of Commonly Abused Street Drugs in the Treatment of Mental Illness."

8. American Group Psychotherapy Association Annual Meeting, San Francisco, California. (2/20/1993). "Inpatient Groups in Initial-Stage Addiction Treatment."

9. Grand Rounds. Department of Child Psychiatry, Stanford University School of Medicine. (3/17/93, 9/11/96). "Issues in Adolescent Substance Abuse."

10. University of California, Extension. Alcohol and Drug Abuse Studies Program. (5/14/93), (6/24/94), (9/22/95), (2/28/97). "Dual Diagnosis."

11. American Psychiatric Association Annual Meeting. (5/26/1993). "Issues in the Treatment of the Dual Diagnosis Patient."

12. Long Beach Regional Medical Education Center and Social Work Service, San Francisco Veterans Affairs Medical Center Conference on Dual Diagnosis. (6/23/1993). "Dual Diagnosis Treatment Issues."

13. Utah Medical Association Annual Meeting, Salt Lake City, Utah. (10/7/93). "Prescription Drug Abuse Helping your Patient, Protecting Yourself."

14. Saint Francis Memorial Hospital, San Francisco, Medical Staff Conference. (11/30/1993). "Management of Patients with Dual Diagnosis and Alcohol Withdrawal."

15. Haight Ashbury Free Clinic's 27th Anniversary Conference. (6/10/94). "Attention Deficit Disorder, Substance Abuse, Psychiatric Disorders and Related Issues."

16. University of California, San Diego. Addiction Technology Transfer Center Annual Summer Clinical Institute: (8/30/94), (8/29/95), (8/5/96), (8/4/97), (8/3/98). "Treating Multiple Disorders."

17. National Resource Center on Homelessness and Mental Illness, A Training Institute for Psychiatrists. (9/10/94). "Psychiatry, Homelessness, and Serious Mental Illness."

18. Value Behavioral Health/American Psychiatry Management Seminar. (12/1/1994). "Substance Abuse/Dual Diagnosis in the Work Setting."

19. Grand Rounds. Department of Oral and Maxillofacial Surgery, University of California, San Francisco, School of Dentistry. (1/24/1995). "Models of Addiction."

20. San Francisco State University, School of Social Work, Title IV-E Child Welfare Training Project. (1/25/95, 1/24/96, 1/13/97, 1/21/98, 1/13/99, 1/24/00, 1/12/01). "Demystifying Dual Diagnosis."

21. First Annual Conference on the Dually Disordered. (3/10/1995). "Assessment of Substance Abuse." Sponsored by the Division of Mental Health and Substance Abuse Services and Target Cities Project, Department of Public Health, City and County of San Francisco.

22. Delta Memorial Hospital, Antioch, California, Medical Staff Conference. (3/28/1995). "Dealing with the Alcohol and Drug Dependent Patient." Sponsored by University of California, San Francisco, School of Medicine, Office of Continuing Medical Education.

23. Centre Hospitalier Robert-Giffaard, Beoupont (Quebec), Canada. (11/23/95). "Reconfiguration of Psychiatric Services in Quebec Based on the San Francisco Experience."

24. The Labor and Employment Section of the State Bar of California. (1/19/96). "Understanding Alcoholism and its Impact on the Legal Profession." MCCE Conference, San Francisco, CA.

25. American Group Psychotherapy Association, Annual Training Institute. (2/13-2/14/96), National Instructor - Designate training group.

26. American Group Psychotherapy Association, Annual Meeting. (2/10/96). "The Process Group at Work."

27. Medical Staff Conference, Kaiser Foundation Hospital, Pleasanton, California, "The Management of Prescription Drug Addiction". (4/24/96)

28. International European Drug Abuse Treatment Training Project, Ankaran, Slovenia, "The Management of the Dually Diagnosed Patient in Former Soviet Block Europe". (10/5-10/11/96)

29. Contra Costa County Dual Diagnosis Conference, Pleasant Hill, California, "Two Philosophies, Two Approaches: One Client". (11/14/96)

30. Faith Initiative Conference, San Francisco, California, “Spirituality: The Forgotten Dimension of Recovery”. (11/22/96)

31. Alameda County Dual Diagnosis Conference, Alameda, California, “Medical Management of the Dually Diagnosed Patient”. (2/4/97, 3/4/97)

32. Haight Ashbury Free Clinic’s 30th Anniversary Conference, San Francisco, California, “Indicators for the Use of the New Antipsychotics”. (6/4/97)

33. DPH/Community Substance Abuse Services/San Francisco Target Cities Project sponsored conference, “Intake, Assessment and Service Linkages in the Substance Abuse System of Care”, San Francisco, California. (7/31/97)

34. The Institute of Addictions Studies and Lewis and Clark College sponsored conference, 1997 Northwest Regional Summer Institute, “Addictions Treatment: What We Know Today, How We’ll Practice Tomorrow; Assessment and Treatment of the High-Risk Offender”. Wilsonville, Oregon. (8/1/97)

35. The California Council of Community Mental Health Agencies Winter Conference, Key Note Presentation, "Combining funding sources and integrating treatment for addiction problems for children, adolescents and adults, as well as coordination of addiction treatment for parents with mental health services to severely emotionally disturbed children." Newport Beach, California. (2/12/98)

36. American Group Psychotherapy Association, Annual Training Institute, Chicago, Illinois. (2/16-2/28/1998), Intermediate Level Process Group Leader.

37. "Multimodal Psychoanalytic Treatment of Psychotic Disorders: Learning from the Quebec Experience." The Haight Ashbury Free Clinics Inc., sponsored this seminar in conjunction with the San Francisco Society for Lacanian Studies and the Lacanian School of Psychoanalysis. San Francisco, California. (3/6-3/8/1998)

38. "AIDS Update for Primary Care: Substance Use & HIV: Problem Solving at the Intersection." The East Bay AIDS Education & Training Center and the East Bay AIDS Center, Alta Bates Medical Center, Berkeley, California sponsored this conference. (6/4/1998)

39. Haight Ashbury Free Clinic's 31st Anniversary Conference, San Francisco, California, "Commonly Encountered Psychiatric Problems in Women." (6/11/1998)

40. Community Networking Breakfast sponsored by San Mateo County Alcohol & Drug Services and Youth Empowering Systems, Belmont, California, "Dual Diagnosis, Two Approaches, Two Philosophies, One Patient." (6/17/1998)

41. Grand Rounds, Department of Medicine, Alameda County Medical Center-Highland Campus, Oakland, California, "Medical/Psychiatric Presentation of the Patient with both Psychiatric and Substance Abuse Problems." (6/19/1998)

42. "Rehabilitation, Recovery, and Reality: Community Treatment of the Dually Diagnosed Consumer." The Occupational Therapy Association of California, Dominican College of San Rafael and the Psychiatric Occupational Therapy Action Coalition sponsored this conference. San Rafael, California. (6/20/1998)

43. "Assessment, Diagnosis and Treatment of the Patient with a Dual Diagnosis", Los Angeles County Department of Mental Health sponsored conference, Los Angeles, CA. (6/29/98)

44. Grand Rounds, Wai'anae Coast Comprehensive Health Center, Wai'anae, Hawaii, "Assessment and Treatment of the Patient who presents with concurrent Depression and Substance Abuse." (7/15/1998)

45. "Dual Diagnostic Aspects of Methamphetamine Abuse", Hawaii Department of Health, Alcohol and Drug Abuse Division sponsored conference, Honolulu, Hawaii. (9/2/98)

46. 9th Annual Advanced Pain and Symptom Management, the Art of Pain Management Conference, sponsored by Visiting Nurses and Hospice of San Francisco. "Care Issues and Pain Management for Chemically Dependent Patients." San Francisco, CA. (9/10/98)

47. Latino Behavioral Health Institute Annual Conference, "Margin to Mainstream III: Latino Health Care 2000." "Mental Illness and Substance Abuse Assessment: Diagnosis and Treatment Planning for the Dually Diagnosed", Los Angeles, CA. (9/18/98)

48. Chemical Dependency Conference, Department of Mental Health, Napa State Hospital, "Substance Abuse and Major Depressive Disorder." Napa, CA. (9/23/98)

49. "Assessment, Diagnosis and Treatment of the Patient with a Dual Diagnosis", San Mateo County Drug and Alcohol Services, Belmont, CA. (9/30/98)

50. "Assessment, Diagnosis and Treatment of the Patient with a Dual Diagnosis", Sacramento County Department of Mental Health, Sacramento, CA. (10/13/98)

51. California Department of Health, Office of AIDS, 1998 Annual AIDS Case Management Program/Medi-Cal Waiver Program (CMP/MCWP) Conference, "Triple Diagnosis: What's Really Happening with your Patient." Concord, CA. (10/15/98)

52. California Mental Health Director's Association Meeting: Dual Diagnosis, Effective Models of Collaboration; "Multiple Problem Patients: Designing a System to Meet Their Unique Needs", San Francisco Park Plaza Hotel. (10/15/98)

53. Northwest GTA Health Corporation, Peel Memorial Hospital, Annual Mental Health Conference, "Recognition and Assessment of Substance Abuse in Mental Illness." Brampton, Ontario, Canada. (10/23/98)

54. 1998 California Drug Court Symposium, "Mental Health Issues and Drug Involved Offenders." Sacramento, CA. (12/11/98)

55. "Assessment, Diagnosis and Treatment Planning for the Dually Diagnosed", Mono County Alcohol and Drug Programs, Mammoth Lakes, CA. (1/7/99)

56. Medical Staff Conference, Kaiser Foundation Hospital, Walnut Creek, CA, "Substance Abuse and Major Depressive Disorder." (1/19/99)

57. "Issues and Strategies in the Treatment of Substance Abusers", Alameda County Consolidated Drug Courts, Oakland, CA. (1/22/99 & 2/5/99)

58. Compass Health Care's 12th Annual Winter Conference on Addiction, Tucson, AZ: "Dual Systems, Dual Philosophies, One Patient", "Substance Abuse and Developmental Disabilities" & "Assessment and Treatment of the High Risk Offender." (2/17/99)

59. American Group Psychotherapy Association, Annual Training Institute, Houston, Texas. (2/22-2/24/1999). Entry Level Process Group Leader.

60. "Exploring A New Framework: New Technologies For Addiction And Recovery", Maui County Department of Housing and Human Concerns, Malama Family Recovery Center, Maui, Hawaii. (3/5 & 3/6/99)

61. "Assessment, Diagnosis and Treatment of the Dual Diagnostic Patient", San Bernardino County Office of Alcohol & Drug Treatment Services, San Bernardino, CA. (3/10/99)

62. "Smoking Cessation in the Chronically Mentally Ill, Part 1", California Department of Mental Health, Napa State Hospital, Napa, CA. (3/11/99)

63. "Dual Diagnosis and Effective Methods of Collaboration", County of Tulare Health & Human Services Agency, Visalia, CA. (3/17/99)

64. Pfizer Pharmaceuticals sponsored lecture tour of Hawai'i. Lectures included: Major Depressive Disorder and Substance Abuse, Treatment Strategies for Depression and Anxiety with the Substance Abusing Patient, Advances in the Field of Dual Diagnosis & Addressing the Needs of the Patient with Multiple Substance Dependencies. Lecture sites included: Straub Hospital, Honolulu; Maui County Community Mental Health; Veterans Administration Hospital, Honolulu; Hawai'i (Big Island) County Community Mental Health; Mililani (Oahu) Physicians Center; Kahi Mohala (Oahu) Psychiatric Hospital; Hale ola Ka'u (Big Island) Residential Treatment Facility. (4/2-4/9/99)

65. "Assessment, Diagnosis and Treatment of the Patient with Multiple Disorders", Mendocino County Department of Public Health, Division of Alcohol & Other Drug Programs, Ukiah, CA. (4/14/99)

66. "Assessment of the Substance Abusing & Mentally Ill Female Patient in Early Recovery", Ujima Family Services Agency, Richmond, CA. (4/21/99)

67. California Institute for Mental Health, Adult System of Care Conference, "Partners in Excellence", Riverside, California. (4/29/99)

68. "Advances in the Field of Dual Diagnosis", University of Hawai'i School of Medicine, Department of Psychiatry Grand Rounds, Queens Hospital, Honolulu, Hawai'i. (4/30/99)

69. State of Hawai'i Department of Health, Mental Health Division, "Strategic Planning to Address the Concerns of the United States Department of Justice for the Alleged Civil Rights Abuses in the Kaneohe State Hospital." Honolulu, Hawai'i. (4/30/99)

70. "Assessment, Diagnosis and Treatment Planning for the Patient with Dual/Triple Diagnosis", State of Hawai'i, Department of Health, Drug and Alcohol Abuse Division, Dole Cannery, Honolulu, Hawai'i. (4/30/99)

71. 11th Annual Early Intervention Program Conference, State of California Department of Health Services, Office of Aids, "Addressing the Substance Abuse and Mental Health Needs of the HIV (+) Patient." Concord, California. (5/6/99)

72. The HIV Challenge Medical Conference, Sponsored by the North County (San Diego) AIDS Coalition, "Addressing the Substance Abuse and Mental Health Needs of the HIV (+) Patient." Escondido, California. (5/7/99)

73. "Assessment, Diagnosis and Treatment of the Patient with Multiple Disorders", Sonoma County Community Mental Health's Monthly Grand Rounds, Community Hospital, Santa Rosa, California. (5/13/99)

74. "Developing & Providing Effective Services for Dually Diagnosed or High Service Utilizing Consumers", third annual conference presented by the Southern California Mental Health Directors Association. Anaheim, California. (5/21/99)

75. 15th Annual Idaho Conference on Alcohol and Drug Dependency, lectures included "Dual Diagnostic Issues", "Impulse Control Disorders" and "Major Depressive Disorder." Boise State University, Boise, Idaho. (5/25/99)

76. "Smoking Cessation in the Chronically Mentally Ill, Part 2", California Department of Mental Health, Napa State Hospital, Napa, California. (6/3/99)

77. "Alcohol and Drug Abuse: Systems of Care and Treatment in the United States", Ando Hospital, Kyoto, Japan. (6/14/99)

78. "Alcoholism: Practical Approaches to Diagnosis and Treatment", National Institute On Alcoholism, Kurihama National Hospital, Yokosuka, Japan. (6/17/99)

79. "Adolescent Drug and Alcohol Abuse", Kusatsu Kinrofukushi Center, Kusatsu, Japan. (6/22/99)

80. "Assessment, Diagnosis and Treatment of the Patient with Multiple Diagnoses", Osaka Drug Addiction Rehabilitation Center Support Network, Kobe, Japan. (6/26/99)

81. "Assessment, Diagnosis and Treatment of the Patient with Multiple Diagnoses", Santa Barbara County Department of Alcohol, Drug, & Mental Health Services, Buellton, California. (7/13/99)

82. "Drug and Alcohol Issues in the Primary Care Setting", County of Tulare Health & Human Services Agency, Edison Ag Tac Center, Tulare, California. (7/15/99)

83. "Working with the Substance Abuser in the Criminal Justice System", San Mateo County Alcohol and Drug Services and Adult Probation Department, Redwood City, California. (7/22/99)

84. 1999 Summer Clinical Institute In Addiction Studies, University of California, San Diego School of Medicine, Department of Psychiatry. Lectures included: "Triple Diagnosis: HIV, Substance Abuse and Mental Illness. What's Really Happening to your Patient?" "Psychiatric Assessment in the Criminal Justice Setting, Learning to Detect Malingering." La Jolla, California. (8/3/99)

85. "Assessment, Diagnosis and Treatment Planning for the Patient with Dual and Triple Diagnoses", Maui County Department of Housing and Human Concerns, Maui Memorial Medical Center. Kahului, Maui. (8/23/99)

86. "Proper Assessment of the Asian/Pacific Islander Dual Diagnostic Patient", Asian American Recovery Services, Inc., San Francisco, California. (9/13/99)

87. "Assessment and Treatment of the Dual Diagnostic Patient in a Health Maintenance Organization", Alcohol and Drug Abuse Program, the Permanente Medical Group, Inc., Santa Rosa, California. (9/14/99)

88. "Dual Diagnosis", Residential Care Providers of Adult Residential Facilities and Facilities for the Elderly, City and County of San Francisco, Department of Public Health, Public Health Division, San Francisco, California. (9/16/99)

89. "Medical and Psychiatric Aspects of Methamphetamine Abuse", Fifth Annual Latino Behavioral Health Institute Conference, Universal City, California. (9/23/99)

90. "Criminal Justice & Substance Abuse", University of California, San Diego & Arizona Department of Corrections, Phoenix, Arizona. (9/28/99)

91. "Creating Balance in the Ohana: Assessment and Treatment Planning", Hale O Ka'u Center, Pahala, Hawai'i. (10/8-10/10/99)

92. "Substance Abuse Issues of Runaway and Homeless Youth", Homeless Youth 101, Oakland Asian Cultural Center, Oakland, California. (10/12/99)

93. "Mental Illness & Drug Abuse - Part II", Sonoma County Department of Mental Health Grand Rounds, Santa Rosa, California. (10/14/99)

94. "Dual Diagnosis/Co-Existing Disorders Training", Yolo County Department of Alcohol, Drug and Mental Health Services, Davis, California. (10/21/99)

95. "Mental Health/Substance Abuse Assessment Skills for the Frontline Staff", Los Angeles County Department of Mental Health, Los Angeles, California. (1/27/00)

96. "Spirituality in Substance Abuse Treatment", Asian American Recovery Services, Inc., San Francisco, California. (3/6/00)

97. "What Every Probation Officer Needs to Know about Alcohol Abuse", San Mateo County Probation Department, San Mateo, California. (3/16/00)

98. "Empathy at its Finest", Plenary Presentation to the California Forensic Mental Health Association's Annual Conference, Asilomar, California. (3/17/00)

99. "Model for Health Appraisal for Minors Entering Detention", Juvenile Justice Health Care Committee's Annual Conference, Asilomar, California. (4/3/00)

100. "The Impact of Alcohol/Drug Abuse and Mental Disorders on Adolescent Development", Humboldt County Department of Mental Health and Substance Abuse Services, Eureka, California. (4/4-4/5/00)

101. "The Dual Diagnosed Client", Imperial County Children's System of Care Spring Training, Holtville, California. (5/15/00)

102. National Association of Drug Court Professionals 6th Annual Training Conference, San Francisco, California. "Managing People of Different Pathologies in Mental Health Courts", (5/31 & 6/1/00); "Assessment and Management of Co-Occurring Disorders" (6/2/00).

103. "Culture, Age and Gender Specific Perspectives on Dual Diagnosis", University of California Berkeley Extension Course, San Francisco, California. (6/9/00)

104. "The Impact of Alcohol/Drug Abuse and Mental Disorders on Adolescent Development", Thunder Road Adolescent Treatment Centers, Inc., Oakland, California. (6/29 & 7/27/00)

105. "Assessing the Needs of the Entire Patient: Empathy at its Finest", NAMI California Annual Conference, Burlingame, California. (9/8/00)

106. "The Effects of Drugs and Alcohol on the Brain and Behavior", The Second National Seminar on Mental Health and the Criminal Law, San Francisco, California. (9/9/00)

107. Annual Conference of the Associated Treatment Providers of New Jersey, Atlantic City, New Jersey. "Advances in Psychopharmacological Treatment with the Chemically Dependent Person" & "Treatment of the Adolescent Substance Abuser" (10/25/00).

108. "Psychiatric Crises In The Primary Care Setting", Doctor Marina Bermudez Issues In College Health, San Francisco State University Student Health Service. (11/1/00, 3/13/01)

109. "Co-Occurring Disorders: Substance Abuse and Mental Health", California Continuing Judicial Studies Program, Center For Judicial Education and Research, Long Beach, California. (11/12-11/17/00)

110. "Adolescent Substance Abuse Treatment", Alameda County Behavioral Health Care Services, Oakland, California. (12/5/00)

111. "Wasn't One Problem Enough?" Mental Health and Substance Abuse Issues. 2001 California Drug Court Symposium, "Taking Drug Courts into the New Millennium." Costa Mesa, California. (3/2/01)

112. "The Impact of Alcohol/Drug Abuse and Mental Health Disorders on the Developmental Process." County of Sonoma Department of Health Services, Alcohol and Other Drug Services Division. Santa Rosa, California. (3/8 & 4/5/01)

113. "Assessment of the Patient with Substance Abuse and Mental Health Issues." San Mateo County General Hospital Grand Rounds. San Mateo, California. (3/13/01)

114. "Dual Diagnosis-Assessment and Treatment Issues." Ventura County Behavioral Health Department Alcohol and Drug Programs Training Institute, Ventura, California. (5/8/01)

115. Alameda County District Attorney's Office 4th Annual 3R Conference, "Strategies for Dealing with Teen Substance Abuse." Berkeley, California. (5/10/01)

116. National Association of Drug Court Professionals 7th Annual Training Conference, "Changing the Face of Criminal Justice." I presented three separate lectures on the following topics: Marijuana, Opiates and Alcohol. New Orleans, LA. (6/1-6/2/01)

117. Santa Clara County Drug Court Training Institute, "The Assessment, Diagnosis and Treatment of the Patient with Multiple Disorders." San Jose, California. (6/15/01)

118. Washington Association of Prosecuting Attorneys Annual Conference, "Psychiatric Complications of the Methamphetamine Abuser." Olympia, Washington. (11/15/01)

119. San Francisco State University, School of Social Work, Title IV-E Child Welfare Training Project, "Adolescent Development and Dual Diagnosis." (1/14/02)

120. First Annual Bi-National Conference sponsored by the Imperial County Behavioral Health Services, "Models of Family Interventions in Border Areas." El Centro, California. (1/28/02)

121. The California Association for Alcohol and Drug Educators 16th Annual Conference, "Assessment, Diagnosis and Treatment of Patients with Multiple Diagnoses." Burlingame, California. (4/25/02)

122. Marin County Department of Health and Human Services, Dual Diagnosis and Cultural Competence Conference, "Cultural Considerations in Working with the Latino Patient." (5/21/02)

123. 3rd Annual Los Angeles County Law Enforcement and Mental Health Conference, "The Impact of Mental Illness and Substance Abuse on the Criminal Justice System." (6/5/02)

124. New Mexico Department of Corrections, "Group Psychotherapy Training." Santa Fe, New Mexico. (8/5/02)

125. Judicial Council of California, Administrative Office of the Courts, "Juvenile Delinquency and the Courts: 2002." Berkeley, California. (8/15/02)

126. California Department of Alcohol and Drug Programs, "Adolescent Development and Dual Diagnosis." Sacramento, California. (8/22/02)

127. Haight Ashbury Free Clinic's 36th Anniversary Conference, San Francisco, California, "Psychiatric Approaches to Treating the Multiple Diagnostic Patient." (6/6/03)

128. Motivational Speaker for Regional Co-Occurring Disorders Training sponsored by the California State Department of Alcohol and Drug Programs and Mental Health and the Substance Abuse Mental Health Services Administration-Center for Substance Abuse Treatment, Samuel Merritt College, Health Education Center, Oakland, California. (9/4/03)

129. "Recreational Drugs, Parts I and II", Doctor Marina Bermudez Issues In College Health, San Francisco State University Student Health Service. (10/1/03), (12/3/03)

130. "Detecting Substance Abuse in our Clients", California Attorneys for Criminal Justice Annual Conference, Berkeley, California. (10/18/03)

131. "Alcohol, Alcoholism and the Labor Relations Professional", 10th Annual Labor and Employment Public Sector Program, sponsored by the State Bar of California. Labor and Employment Section. Pasadena, California. (4/2/04)

132. Lecture tour of Japan (4/8-4/18/04). "Best Practices for Drug and Alcohol Treatment." Lectures were presented in Osaka, Tokyo and Kyoto for the Drug Abuse Rehabilitation Center of Japan.

133. San Francisco State University, School of Social Work, Title IV-E Child Welfare Training Project, "Adolescent Development and Dual Diagnosis." (9/9/04)

134. "Substance Abuse and the Labor Relations Professional", 11th Annual Labor and Employment Public Sector Program, sponsored by the State Bar of California. Labor and Employment Section. Sacramento, California. (4/8/05)

135. "Substance Abuse Treatment in the United States", Clinical Masters Japan Program, Alliant International University. San Francisco, California. (8/13/05)

136. Habeas Corpus Resource Center, Mental Health Update, "Understanding Substance Abuse." San Francisco, California. (10/24/05)

137. Yolo County Department of Behavioral Health, "Psychiatric Aspects of Drug and Alcohol Abuse." Woodland, California. (1/25/06), (6/23/06)

138. "Methamphetamine-Induced Dual Diagnostic Issues", Medical Grand Rounds, Wilcox Memorial Hospital, Lihue, Kauai. (2/13/06)

139. Lecture tour of Japan (4/13-4/23/06). "Assessment and Treatment of the Patient with Substance Abuse and Mental Illness." Lectures were presented in Hiroshima and Kyoto for the Drug Abuse Rehabilitation Center of Japan.

140. "Co-Occurring Disorders: Isn't It Time We Finally Got It Right?" California Association of Drug Court Professionals, 2006 Annual Conference. Sacramento, California. (4/25/06)

141. "Proper Assessment of Drug Court Clients", Hawaii Drug Court, Honolulu. (6/29/06)

142. "Understanding Normal Adolescent Development," California Association of Drug Court Professionals, 2007 Annual Conference. Sacramento, California. (4/27/07)

143. "Dual Diagnosis in the United States," Conference sponsored by the Genesis Substance Abuse Treatment Network. Medford, Oregon. (5/10/07)

144. "Substance Abuse and Mental Illness: One Plus One Equals Trouble," National Association of Criminal Defense Lawyers 2007 Annual Meeting & Seminar. San Francisco, California. (8/2/07)

145. "Capital Punishment," Human Writes 2007 Conference. London, England. (10/6/07)

146. "Co-Occurring Disorders for the New Millennium," California Hispanic Commission on Alcohol and Drug Abuse, Montebello, California. (10/30/07)

147. "Methamphetamine-Induced Dual Diagnostic Issues for the Child Welfare Professional," Beyond the Bench Conference. San Diego, California. (12/13/07)

148. "Working with Mentally Ill Clients and Effectively Using Your Expert(s)," 2008 National Defender Investigator Association (NDIA), National Conference, Las Vegas, Nevada. (4/10/08)

149. "Mental Health Aspects of Diminished Capacity and Competency," Washington Courts District/Municipal Court Judges' Spring Program. Chelan, Washington. (6/3/08)

150. "Reflection on a Career in Substance Abuse Treatment, Progress not Perfection," California Department of Alcohol and Drug Programs 2008 Conference. Burlingame, California. (6/19/08)

151. Mental Health and Substance Abuse Training, Wyoming Department of Health, "Diagnosis and Treatment of Co-occurring Mental Health and Substance Abuse." Buffalo, Wyoming. (10/6/09)

152. 2010 B.E. Witkin Judicial College of California, "Alcohol and Other Drugs and the Courts." San Jose, California. (August 4th & 5th, 2010)

153. Facilitating Offender Re-entry to Reduce Recidivism: A Workshop for Teams, Menlo Park, CA. This conference was designed to assist Federal Courts to reduce recidivism. "The Mentally-Ill Offender in Reentry Courts," (9/15/2010)

154. Juvenile Delinquency Orientation, "Adolescent Substance Abuse." This was part of the "Primary Assignment Orientations" for newly appointed Juvenile Court Judges presented by The Center for Judicial Education and Research of the Administrative Office of the Court. San Francisco, California. (1/12/2011, 1/25/12, 2/27/13 & 1/8/14)

155. 2011 B.E. Witkin Judicial College of California, "Alcohol and Other Drugs and the Courts." San Jose, California. (August 4th, 2011)

156. 2012 B.E. Witkin Judicial College of California, "Alcohol and Other Drugs and the Courts." San Jose, California. (August 2nd, 2012)

157. Mexican Capital Legal Assistance Program Meeting, "Issues Related to Mental Illness in Mexican Nationals." Santa Fe, New Mexico (10/12/12); Houston, Texas (4/23/13)

158. Los Angeles County Public Defender's Capital Case Seminar, "Mental Illness and Substance Abuse." Los Angeles, California. (9/27/13)

159. "Perspectives on Race and Ethnicity for Capital and Non-Capital Defense Lawyers," conference sponsored by the Administrative Office of the US Courts, New York, NY., September 18-20, 2015.

160. San Francisco Collaborative Courts, Superior Court of California, County of San Francisco sponsored training, "Personality Disorders," February 19, 2016.

PUBLICATIONS:

1) Kanas, N., Stewart, P. and Haney, K. (1988). *Content and Outcome in a Short-Term Therapy Group for Schizophrenic Outpatients*. Hospital and Community Psychiatry, 39, 437-439.

2) Kanas, N., Stewart, P. (1989*). Group Process in Short-Term Outpatient Therapy Groups for Schizophrenics.* Group, Volume 13, Number 2, Summer 1989, 67-73.

3) Zweben, J.E., Smith, D.E. and Stewart, P. (1991). *Psychotic Conditions and Substance Use: Prescribing Guidelines and Other Treatment Issues.* Journal of Psychoactive Drugs, Vol. 23(4), Oct.-Dec. 1991, 387-395.

4) Banys, P., Clark, H.W., Tusel, D.J., Sees, K., Stewart, P., Mongan, L., Delucchi, K., and Callaway, E. (1994). *An Open Trial of Low Dose Buprenorphine in Treating Methadone Withdrawal*. Journal of Substance Abuse Treatment, Vol. 11(1), 9-15.

5) Hall, S.M., Tunis, S., Triffleman, E., Banys, P., Clark, H.W., Tusel, D., Stewart, P., and Presti, D. (1994). *Continuity of Care and Desipramine in Primary Cocaine Abusers.* The Journal of Nervous and Mental Disease, Vol. 182(10), 570-575.

6) Galloway, G.P., Frederick, S.L., Thomas, S., Hayner, G., Staggers, F.E., Wiehl, W.O., Sajo, E., Amodia, D., and Stewart, P. (1996). *A Historically Controlled Trial Of Tyrosine for Cocaine Dependence.* Journal of Psychoactive Drugs, Vol. 28(3), pages 305-309, July-September 1996.

7) Stewart, P. (1999). *Alcoholism: Practical Approaches To Diagnosis And Treatment.* Prevention, (Newsletter for the National Institute On Alcoholism, Kurihama Hospital, Yokosuka, Japan) No. 82, 1999.

8) Stewart, P. (1999). *New Approaches and Future Strategies Toward Understanding Substance Abuse.* Published by the Osaka DARC (Drug Abuse Rehabilitation Center) Support Center, Osaka, Japan, November 11, 1999.

9) Stewart, P. (2002). *Treatment Is A Right, Not A Privilege.* Chapter in the book, *Understanding Addictions-From Illness to Recovery and Rebirth,* ed. by Hiroyuki Imamichi and Naoko Takiguchi, Academia Press (Akademia Syuppankai): Kyoto, Japan, 2002.

10) Stewart, P., Inaba, D.S., and Cohen, W.E. (2004). *Mental Health & Drugs.* Chapter in the book, *Uppers, Downers, All Arounders, Fifth Edition*, CNS Publications, Inc., Ashland, Oregon.

11) James Austin, Ph.D., Kenneth McGinnis, Karl K. Becker, Kathy Dennehy, Michael V. Fair, Patricia L. Hardyman, Ph.D. and Pablo Stewart, M.D. (2004) *Classification of High Risk and Special Management Prisoners, A National Assessment of Current Practices.* National Institute of Corrections, Accession Number 019468.

12) Stanley L. Brodsky, Ph.D., Keith R. Curry, Ph.D., Karen Froming, Ph.D., Carl Fulwiler, M.D., Ph.D., Craig Haney, Ph.D., J.D., Pablo Stewart, M.D. and Hans Toch, Ph.D. (2005) *Brief of Professors and Practitioners of Psychology and Psychiatry as AMICUS CURIAE in Support of Respondent: Charles E. Austin, et al. (Respondents) v. Reginald S. Wilkinson, et al. (Petitioners), In The Supreme Court of the United States, No. 04-495.*

13) Stewart, P., Inaba, D.S., and Cohen, W.E. (2007). *Mental Health & Drugs.* Chapter in the book, *Uppers, Downers, All Arounders, Sixth Edition*, CNS Publications, Inc., Ashland, Oregon.

14) Stewart, P., Inaba, D.S. and Cohen, W.E. (2011). *Mental Health & Drugs.* Chapter 10 in the book, *Uppers, Downers, All Arounders, Seventh Edition,* CNS Publications, Inc., Ashland, Oregon.

15) Carl Fulwiler, M.D., Ph.D., Craig Haney, Ph.D., J.D., Pablo Stewart, M.D., Hans Toch, Ph.D. (2015) Brief of *Amici Curiae* Professors and Practitioners of Psychiatry and Psychology in Support of Petitioner: *Alfredo Prieto v. Harold C. Clarke, et al., On Petition For A Writ of Certiorari To The United States Court of Appeals For The Fourth Circuit, In The Supreme Court of the United States, No. 15-31.*

PABLO STEWART, M.D.
Psychiatric Consultant
824 Ashbury Street
San Francisco, CA 94117
(415) 753-0321
(Fax) 753-5479
E Mail pab4emi@aol.com

TESTIMONY/DEPOSITIONS January 2000-Present

1. People versus Juan Duarte Gonzales (Lincoln County, Washington, January 2000)
2. People versus Jerry Lane Davis (Stanislaus County, California, September 2000)
3. James Andrew Melton versus Arthur Calderon, et al. (United States District Court, Los Angeles, California, December 2000)
4. Fremont Unified School District versus James Parks (Deposition taken in San Francisco, California, April 2001)
5. People versus Pablo Lomeli (Douglas County, Arizona, August 2001)
6. Dunlap versus County of Mendocino (Deposition taken in Oakland California, September 2001)
7. Maxwell Hoffman versus A.J. Arave, Warden, et al. (Deposition taken in San Francisco, October 2001)
8. People versus Michelle Michaud (Alameda County, California, April 2002)
9. People versus David Attias (Santa Barbara County, California, May/June 2002)
10. People versus Larry Christopher Graham (Contra Costa County, California, October 2002)
11. People versus Miguel Enrique Diaz (San Mateo County, California, November/December 2002)
12. United States versus Eugene Frederick Boyce, III (District Court, Honolulu, Hawai'i December 2002)
13. People versus Robert Daniel Weston (Stanislaus County, California, April/July 2003)
14. People versus Vincent Sanchez (Ventura County, California, August 2003)
15. Armstrong Petition JW01-6450 (San Francisco Juvenile Court, December 2003)
16. People versus Daniel Mugnolo (San Francisco City and County, December 2003)
17. Brandon Astor Jones versus Frederick Head, Warden (Deposition taken in San Francisco, January 2004)
18. David Perkins versus Frederick Head, Warden (Deposition taken in San Francisco, March 2004)
19. People versus Marino Hernandez (San Mateo County, California, June 2004)
20. Raphael Camargo versus Larry Norris, Director, Arkansas Department of Correction (Deposition taken in San Francisco, July 2004)
21. People versus Ronald Mathews (King County, Washington, August 2004)
22. People versus Huberto Mendoza (Stanislaus County, California, December 2004)
23. People versus James Essick (San Diego County, California, June 2005)

EXHIBIT B

24. People versus Jesse Ignacio Sanchez Gomez (Ada County, Idaho, July/August 2005)
25. People versus Adrian Camacho (San Diego County, California, October 2005)
26. People versus Huberto Mendoza (Stanislaus County, California, November 2005)
27. People versus Paul Speer (Maricopa County, Arizona, January 2006)
28. People versus Mark Thigpen (San Mateo County, California, January 2006)
29. United States versus Tommy Ray Elam (District Court, Los Angeles, California, February 2006)
30. Enrique Arevalo versus Frederick Head, Warden (Deposition taken in San Francisco, March 2006)
31. United States versus Danny Lee Jones (District Court, Phoenix, Arizona, March 2006)
32. People versus Omar Dent, III (Los Angeles County, California, May 2006)
33. People versus Delaney Marks (Alameda County, California, May 2006)
34. People versus Angel Maturino Resendiz (Harris County, Texas, June 2006)
35. People versus Antonio Nicolosi (San Mateo County, California, July 2006)
36. Gregory Paul Lawler versus Frederick Head, Warden (Deposition taken in San Francisco, July 2006)
37. United States versus Todd Sarver (District Court, San Francisco, California, August 2006)
38. United States versus Eugene Frederick Boyce, III (United States District Court, Honolulu, Hawaii, October 2006)
39. Arthur Torlucci versus W.A. Duncan, (District Court, Santa Ana, California, November 2006)
40. Joaquin Enrique Arevalo versus William Terry, Warden, (Butts County, Georgia, December 2006)
41. People versus Jerry Cabonce, (San Mateo County, California, January 2007)
42. People versus Rodrigo Paniagua, (Santa Clara County, California, February 2007)
43. Gregory Paul Lawler versus William Terry, Warden, (Butts County, Georgia, February 2007)
44. United States versus Francisco Rodriguez, (District Court, Santa Ana, California, April 2007)
45. People versus O'Neal Durgin, (San Mateo County, California, June 2007)
46. Sepulveda versus Beard et al., (Bartonsville, Pennsylvania, June 2007)
47. Webster versus Ayers et al., (District Court, Sacramento, California, September 2007)
48. Ronald Deere versus Jeanne Woodford, et al., (District Court, Los Angeles, California, October 2007)
49. People versus Eric V. Hall (Ada County, Idaho, October 2007)
50. Rickey Dale Newman versus Larry Norris, Director, Arkansas Department of Correction (District Court, Fort Smith, Arkansas, November 2007
51. Ralph Coleman, et al. versus Arnold Schwarzenegger, et al. (Deposition taken in Sacramento, December 2007)
52. People versus Matthew Cunningham (Maricopa County, Arizona, January & February 2008)
53. People versus Alfredo Prieto (Fairfax County, Virginia, February 2008)

54. People versus Edward Gutierrez (Santa Clara County, California, May 2008)
55. Fred Graves, et al., Plaintiffs v. Joseph Arpaio, et al., Defendants. (Deposition taken in Phoenix, Arizona, July 2008). A supplemental deposition was also taken in July 2008 approximately 2 weeks after the initial deposition.
56. Fred Graves, et al., Plaintiffs v. Joseph Arpaio, et al., Defendants (District Court, Phoenix, Arizona, August 2008)
57. Ralph Coleman, et al. versus Arnold Schwarzenegger, et al. (Deposition taken in Sacramento, California, September 2008)
58. United States versus Naeem Williams (District Court, Honolulu, Hawaii, November 2008)
59. Ralph Coleman, et al. versus Arnold Schwarzenegger, et al. (Three Judge Panel, District Court, San Francisco, California, December 2008)
60. United States versus Michael Behenna (United States Army Court Marshall, Fort Campbell, Kentucky, February 2009)
61. United States versus Steven Green (District Court, Paducah, Kentucky, May 2009)
62. People versus Francisco Merino (San Mateo County, California, July 2009)
63. Milton Lewis versus State of California (District Court, Sacramento, California, October 2009)
64. People versus Adrian Sedano (San Mateo County, California, November 2009)
65. United States versus Noshir S. Gowadia (District Court, Honolulu, Hawaii, November 2009)
66. Johnny A. Johnson versus State of Missouri (St. Louis, Missouri, December 2009)
67. Martin Kipp versus State of California (District Court, Los Angeles, California, December 2009)
68. David Welch versus State of California (Martinez, California, September 2010)
69. State of Arizona versus Eddy Rose (Phoenix, Arizona, September 2010)
70. State of Delaware versus Gary Ploof (Dover, Delaware, October 2010)
71. State of Arizona versus Steven Ray Newell (Phoenix, Arizona, March 2011)
72. State of Arkansas versus Ricky Lee Newman (Fort Smith, Arkansas, March 2011)
73. People versus Kerri Livingston (San Mateo County, California, March 2011)
74. People versus Alexander Youshock (San Mateo County, California, April 2011)
75. United States versus Francisco Rodriguez (District Court, Santa Ana, California, May 2011)
76. State of Connecticut versus Robert Breton (Hartford, Connecticut, July 2011)
77. United States versus Billie Allen (St. Louis, Missouri, December 2011)
78. People versus Mohammed Ali (San Mateo County, California, February 2012)
79. Clemency Hearing re: Robert Towery (Florence, Arizona, March 2012)
80. United States versus Danny John, Jr. (Prescott, Arizona, March 2012)
81. State of Ohio versus Abdul H. Awkal (Cleveland, Ohio, June 2012)
82. People versus Monica McCarrick (Solano County, California, June 2012)
83. People versus Robert Hall (Ada County, Idaho, October 2012)
84. People versus Alamoti Finau (San Mateo County, California, November 2012)
85. United States versus Merrell Hobbs (District Court, Philadelphia, Pennsylvania, November 2012)

86. Ex Parte Juan Lizcano, W05-59563-S(A) (Dallas, Texas, November 2012)
87. People versus David Vanalstine (San Mateo County, California, December 2012)
88. Sinisterra versus the United States (District Court, Kansas City, Missouri, January 2013)
89. People versus Jing Hua Wu (San Jose, California, February & March 2013)
90. Coleman versus Brown (Deposition taken in San Francisco, California, March 2013)
91. Coleman versus Brown (District Court, Sacramento, CA, June 2013)
92. Tate versus Humphrey (Deposition taken in San Francisco, California, June 2013)
93. Coleman versus Brown (District Court, Sacramento, CA, October 2013)
94. People versus Alegria (Tucson, Arizona, October 2013)
95. Commonwealth v. Michael Pruitt (Reading, PA, November 2013)
96. Coleman versus Brown (District Court, Sacramento, CA, December 2013)
97. Fred Graves, et al., Plaintiffs v. Joseph Arpaio, et al., Defendants (District Court, Phoenix, Arizona, March 2014)
98. Deposition taken in Parsons, et al v. Ryan. March 28, 2014, San Francisco, CA.
99. Evidentiary hearing in State of Arizona v. Albert Martinez Carreon. Phoenix Arizona, April 21 & 22, 2014.
100. United States v. Naeem Williams, (District Court, Honolulu, HI, April 29 & 30, and June 3, 2014
101. Deposition taken in Hernandez v. County of Monterey, San Francisco, CA July 8, 2014
102. United States v. Thomas Steven Sanders, (District Court, Alexandria, LA, September 22 & 23, 2014)
103. Deposition taken in Kurian David, et al., plaintiffs v. Signal International, LLC, defendant, San Francisco, California, October 2014)
104. People v. Dennis McGraw (Vallejo, California, November 2014)
105. People v. Leticia Serna (San Jose, California, December 2014)
106. Wilridge v. Marshall, (District Court, San Francisco, California, February 2015)
107. People v. Hugo Munguia-Hernandez (Redwood City, California, July 2015)
108. Deposition taken in Goddard v. State of California, et al., San Mateo, California, September 2015.
109. People v. Bryan Thomas (Redwood City, California, October 2015)
110. Carlos Gutierrez v. E.K. McDaniel, Warden, et al. (Reno, Nevada, January 2016)
111. State of Arkansas v. Rickey Dale Newman (Fort Smith, Arkansas, January 2016)
112. Deposition taken in Roscoe Walker v. Ford Motor Company, et al., San Mateo, California, February 2016.