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UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,  
Plaintiffs,  
v.  
EDMUND G. BROWN, JR., et al.,  
Defendants.

No. CIV. S-90-520 LKK/DAD (PC)

**ORDER**

On April 11, 2013, plaintiffs filed a motion for enforcement of court orders and affirmative relief related to inpatient treatment for members of the plaintiff class, including those condemned to death and housed at San Quentin State Prison (hereafter San Quentin or SQSP). (ECF No. 4543). The issue was also tendered as grounds for denying defendants' January 7, 2013 motion to terminate the court's ongoing supervision of the remedial effort (ECF No. 4275). See Pls. Corr. Opp. To Defs. Mot. to Terminate, filed Mar. 19, 2013 (ECF No. 4422) at 82-85. The court denied the defendants' motion, see Coleman v. Brown, 938 F. Supp. 2d 955 (E.D. Cal. 2013), and, separately, set an evidentiary hearing on plaintiffs' motion to enforce the court's

1 previous judgment. Nonetheless, this order, in addition to  
2 resolving the instant motion, also inevitably addresses the  
3 propriety of defendants' motion to terminate.

4 An evidentiary hearing on plaintiffs' motion as it relates  
5 to inpatient care for seriously mentally ill inmates in  
6 California's condemned population commenced on October 1, 2013  
7 and continued over fourteen court days, concluding on November 6,  
8 2013.<sup>1</sup> Following filing of closing briefs the matter was  
9 submitted for decision and is resolved herein.<sup>2</sup>

10 As this court has explained,

11 [p]laintiffs are a class of prisoners with  
12 serious mental disorders confined in the  
13 California Department of Corrections and  
14 Rehabilitation ("CDCR"). In 1995, this court  
15 found defendants in violation of their Eighth  
16 Amendment obligation to provide class members  
17 with access to adequate mental health care.  
18 Coleman v. Wilson, 912 F.Supp. 1282  
19 (E.D.Cal.1995). To remedy the gross systemic  
20 failures in the delivery of mental health  
21 care, the court appointed a Special Master to  
22 work with defendants to develop a plan to  
23 remedy the violations and, thereafter, to  
24 monitor defendants' implementation of that  
25 remedial plan. See Order of Reference, filed  
26 December 11, 1995 (Dkt. No. 640). That  
27 remedial process has been ongoing for over  
28 seventeen years.

Coleman v. Brown, 938 F.Supp.2d at 958.

Over a decade of effort led to development of  
the currently operative remedial plan, known  
as the Revised Program Guide. The Revised  
Program Guide "represents defendants'  
considered assessment, made in consultation

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<sup>1</sup> Approximately nine of those days were spent on testimony related to  
plaintiffs' motion concerning use of force and disciplinary measures (ECF No.  
4543). That motion will be resolved by separate order.

<sup>2</sup> The remainder of plaintiffs' motion concerning inpatient care was resolved  
by order filed July 11, 2013 (ECF No. 4688).

1 with the Special Master and his experts, and  
2 approved by this court, of what is required  
3 to remedy the Eighth Amendment violations  
4 identified in this action and to meet their  
5 constitutional obligation to deliver adequate  
6 mental health care to seriously mentally ill  
7 inmates." February 28, 2013 Order (ECF No.  
8 4361) at 3. [Footnote omitted.] Over seven  
9 years ago, this court ordered defendants to  
10 immediately implement all undisputed  
11 provisions of the Revised Program Guide.  
12 [Footnote omitted.]

13 Id. at 972.<sup>3</sup>

14 CDCR's Mental Health Services Delivery System Program Guide  
15 provides four levels of mental health care services:  
16 Correctional Clinical Case Management System (CCCMS); Enhanced  
17 Outpatient (EOP); Mental Health Crisis Bed (MHCB) and inpatient  
18 hospital care, which is offered in two programs, intermediate  
19 care facilities (ICF) and acute psychiatric programs (APP).  
20 Mental health crisis beds are inpatient beds to treat acute  
21 mental health crises and stays in MHCB units are generally  
22 limited to ten days. Program Guide at 12-5-1.<sup>4</sup> Acute hospital  
23 care "is a short-term, intensive-treatment program with stays  
24 usually up to 30 calendar days to 45 days provided." Id. at 12-  
25 6-2. Intermediate hospital care programs (ICF) "provide longer-  
26 term mental health intermediate and non-acute inpatient treatment  
27 for inmate-patients who have a serious mental disorder requiring  
28 treatment that is not available within CDCR." Id. at 12-6-6.

<sup>3</sup> Defendants are currently operating under the Mental Health Services Delivery System Program Guide, 2009 Revision (hereafter Program Guide). All references to the Program Guide in this order are to the 2009 Revision, a copy of which has been entered in the record in these proceedings as Plaintiffs' Exhibit 1200.

<sup>4</sup> Exceptions to the ten day length of stay must be approved by "[t]he Chief Psychiatrist or designee." Id.

1 Plaintiffs contend that defendants are denying condemned inmates  
2 necessary access to inpatient hospital care.<sup>5</sup>

3 I. Facts

4 Pursuant to California Penal Code § 3600, condemned male  
5 inmates are housed at San Quentin. In relevant part, the statute  
6 provides:

7 A[] [condemned] inmate whose medical or  
8 mental health needs are so critical as to  
9 endanger the inmate or others may, pursuant  
10 to regulations established by the Department  
11 of Corrections, be housed at the California  
12 Medical Facility or other appropriate  
13 institution for medical or mental health  
14 treatment. The inmate shall be returned to  
15 the institution from which the inmate was  
16 transferred when the condition has been  
17 adequately treated or is in remission.

18 Cal. Penal Code § 3600(b)(4). Citing California Penal Code §  
19 3600, the Program Guide contains a separate section governing EOP  
20 treatment for condemned inmates. See Program Guide at 12-4-17 to  
21 12-4-21. In relevant part, that section provides that  
22 “[c]ondemned male inmate-patients who experience decompensation  
23 in the form of a crisis shall be referred to the DMH Inpatient  
24 Program at CMF for a MHCB level of care or DMH inpatient level of  
25 care.” Id. at 12-4-20, 21. Defendants interpret § 3600(b)(4) as  
26 limiting the DMH inpatient level of care for condemned inmate-  
27 patients to that provided in the APP, i.e., the Acute Psychiatric  
28 Program.<sup>6</sup>

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26 <sup>5</sup> In their post-trial brief, and at the hearing, plaintiffs raised additional  
27 issues concerning the adequacy of mental health care provided to condemned  
28 inmates at the EOP and CCCMS level of care at San Quentin. For the reasons  
explained infra, the court will not make any specific orders concerning those  
issues at this time.

<sup>6</sup> MHCB care is available to condemned inmate-patients at San Quentin.

1 It is undisputed that defendants have not historically "had  
2 a viable option" for condemned inmate-patients in need of an  
3 intermediate level of hospital care. Pls. Ex. 1043 at 1. Dr.  
4 Eric Monthei, the Chief of Mental Health at San Quentin,  
5 testified that when he assumed his position six or seven years  
6 ago he began a "gradual transition" of identifying condemned  
7 inmate-patients in need of a higher level of services. RT at  
8 1199:2-10. Approximately three years ago, the process became  
9 more formalized and mental health staff at San Quentin were  
10 "tasked with researching and developing a specialized care  
11 regimen tailored to the subcategory of Condemned inmates who may  
12 have met criteria" for referral to an intermediate level of  
13 hospital care. Monthei Decl.(ECF No. 4593) at ¶ 4. On November  
14 8, 2010, the mental health staff implemented "a Specialized  
15 Treatment plan for the condemned inmates at San Quentin." Id.  
16 The Specialized Treatment plan "is based on a model of assertive  
17 community treatment" and reflects defendants' asserted belief  
18 that "[d]ue to the unique nature of the condemned inmate  
19 population, . . . providing services near the inmate's home and  
20 within their community is clinically indicated." Id. at ¶¶ 5-6.<sup>7</sup>

21 In early 2011, Dr. Monthei "prepared a written version of  
22 the Specialized Treatment plan" which identified the following  
23 treatment "indicators":

24 Significant difficulties with hygiene.

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26 Reporter's Transcript re: Evidentiary Hearing (RT) at 1180:7-1181:4.

27 <sup>7</sup> While the court has reservations about whether the condemned regard E block  
28 in San Quentin as their home, acceptance or rejection of that clinical  
indication is not material to resolution of the motion and will not be further  
considered.

1 Non-compliance with voluntary medication to a  
2 degree that it impaired functioning.

3 Rarely leaves cell.

4 Other behaviors or events that are indicative  
5 that additional treatment and clinical time  
6 may be beneficial to the inmate, including  
7 but not limited to:

8 Disruptive to the treatment milieu.

9 Repeated rules violation reports.

10 Difficulties in maintaining eating,  
11 clothing, or housing to a degree less  
12 than requires inpatient care or 24-hour  
13 nursing.

14 Bizarre behaviors or actions that  
15 warrant increased number and modalities  
16 of treatment.

17 Ex. 1 to Confidential Vorous Decl. (ECF No. 4622-1) at 6-7<sup>8</sup>;  
18 Monthei Decl. (ECF No. 4593) at ¶ 7. The written document also  
19 identified services and treatment available under the plan,  
20 including:

21 (1) several contacts per day by mental health  
22 providers; (2) groups and daily therapy  
23 sessions; (3) daily recreational time; (4)  
24 assistance with cleaning; (5) in-cell  
25 structured therapeutic activity; (6)  
26 psychiatric technician rounds; (7) daily  
27 encouragement to complete activities of daily  
28 living; (8) objective monitoring of multiple  
areas of functioning; and (9) weekly formal  
team coordination of care meetings.

Monthei Decl. (ECF No. 4593) at ¶ 9 (citing Ex. 1 to Confid.  
Vorous Decl.).

In February 2011, the then Chief Deputy Secretary for the

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<sup>8</sup> This document is filed under seal with several other documents attached to the Confidential Declaration of Debbie Vorous filed May 20, 2013 (ECF No. 4622).

1 Division of Correctional Health Care Services of the CDCR  
2 circulated a budget change proposal (BCP) seeking funding for the  
3 program, referred to in that document and today as the  
4 Specialized Care Program for the Condemned (SCCP). Pls. Ex.  
5 1043. The BCP describes a "high risk need" for the SCCP, as  
6 follows:

7 On or about 2006 through 2011, up to 31  
8 Condemned inmate-patients were identified as  
9 those who would benefit from an ICF level of  
10 care with another 13 being monitored for  
11 possible inclusion. Approximately 20% (6 of  
12 31) inmate-patients who would have benefitted  
13 from an ICF level of care have effected  
14 suicide. Data available from March 2008 to  
15 December 2009 show approximately 120  
16 admissions to higher levels of care such as  
17 Out Patient Housing Units (OHU), Mental  
18 Health Crisis Beds (MHCB), and DMH Acute  
19 Programs. SQSP is currently compiling the  
20 2010 data but they expect that the overall  
21 referral patterns are unlikely to have  
22 changed significantly.

23 Id. The BCP described six inmate suicides in the condemned  
24 population in six years. Id. Five condemned inmates have  
25 committed suicide in the last two years. RT at 318:16-23.<sup>9</sup> The  
26 BCP also reflects defendants' acknowledgement of a need for an  
27 adequate treatment program to meet this need.<sup>10</sup>

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28 <sup>9</sup> The court heard a substantial amount of testimony concerning the annual  
suicide rate among California's condemned inmates, including whether the  
length of time inmates spend on California's death row should be "factored  
into th[e] consideration of annual suicide rates so that something more  
instructive could come out of it." RT at 1579:8-10. The court is satisfied  
that the clear weight of the evidence, including testimony from defendants'  
clinicians, demonstrates that the number of suicides in California's condemned  
population is an area of grave concern.

<sup>10</sup> The BCP states that "[a]bsent this program, CDCR will not be able to testify  
in court that the needs of the condemned inmate-patients are being met at  
SQSP" and that "it is likely that CDCR would ultimately be ordered to transfer  
inmates" to ICF beds at Salinas Valley State Prison. Pls. Ex. 1043 at 2.

1 In his Twenty-Fifth Round Monitoring Report, filed in  
2 January 2013, the Special Master reported on the SCCP. Pls. Ex.  
3 1031.<sup>11</sup> At a visit to San Quentin in August 2012, the Special  
4 Master's experts found, inter alia, that

5 [b]asic clinical requirements such as  
6 admission and discharge criteria were not  
7 articulated, although program clinicians  
8 could discuss the various treatment  
9 modalities and demonstrated that  
10 consideration had gone into determining the  
11 appropriate treatment for each inmate.  
12 However, there were space limitations and  
13 challenges with escorts which created  
14 problems with access to care. . . .

15 The medical records of each of the  
16 participants in the specialized care program  
17 were reviewed. Most of these inmates clearly  
18 needed inpatient care and were not receiving  
19 it or its equivalent. . . .

20 IDTT<sup>12</sup> meetings for the condemned care  
21 program were reportedly scheduled twice per  
22 month. Treatment plans did not focus on the  
23 primary symptoms for many inmates, and some  
24 interventions appeared to reinforce these  
25 symptoms. Some inmates did not even have  
26 treatment plans or current treatment plans. .  
27 . . .

28 Id. at 177-178. In December 2012, the Special Master and his  
staff, together with CDCR and DSH representatives and plaintiffs'  
counsel, revisited San Quentin "to further examine the condemned  
care program." Id. at 179. At that time, defendants "agreed to  
work with the special master's expert to draft a written addendum  
to the draft LOP<sup>13</sup> that would describe [the Specialized Care for

<sup>11</sup> The Twenty-Fifth Round Monitoring Report is in the record at ECF No. 4298. All citations to pages in Pls. Ex. 1031 are to the ECF page number at the top of the exhibit.

<sup>12</sup> IDTT stands for Interdisciplinary Treatment Team.

<sup>13</sup> LOP stands for Local Operating Procedure.



1 the Condemned] program, including an outline of the criteria for  
2 admission to it and the services that it offers." Id. at 184.  
3 The specific "[t]riggers for consideration for admission to the  
4 program were defined as those used in the sustainable process for  
5 identification and referral of inmates" to inpatient care. Id.;  
6 see also, e.g., Order filed July 13, 2012 (ECF No. 4214).  
7 Enhanced staffing, additional necessary services, and "a  
8 dedicated housing unit for inmates in the [SCCP]" were to be  
9 included. Pls. Ex. 1031 at 184-185.

10 There have been "multiple revisions" to the original  
11 "working document" for the Specialized Treatment plan (SCCP)  
12 since the January 2011 iteration. RT at 1212:20-1213:3. The  
13 latest, generated in early 2013, sets forth the following  
14 criteria for "consideration" of treatment in the SCCP:

- 15 1. Acute onset of symptoms or significant  
16 decompensation due to a serious mental  
17 disorder characterized by symptoms such as  
18 increased delusional thinking,  
19 hallucinatory experiences, marked changes  
20 in affect, agitated or vegetative signs,  
21 definitive impairment in reality testing  
22 and/or judgment.
- 23 2. Inability to function in the condemned  
24 population based upon any of the  
25 following:
  - 26 a. A demonstrated inability to program in  
27 and/or benefit from the Condemned EOP  
28 Treatment Program for two consecutive  
months.
  - b. A demonstrated inability to program in  
condemned correctional activities such  
as education, religious services, self-  
help programs, canteen, recreational  
activities, or visiting, as a

1 consequence of a serious mental  
2 disorder.

3 c. The presence of dysfunctional or  
4 disruptive social interaction including  
5 withdrawal, bizarre behavior, extreme  
6 argumentativeness, inability to respond  
7 to staff directions, provocative  
8 behavior, or inappropriate sexual  
9 behavior, as a consequence of a serious  
10 mental disorder.

11 d. An impairment in the activities of daily  
12 living including eating, grooming and  
13 personal hygiene, maintenance of housing  
14 area, and ambulation, as a consequence  
15 of a serious mental disorder.

16 Pls. Ex. 1014 at Monthei 03. These criteria are similar, though  
17 not identical, to several of the Program Guide criteria for  
18 admission to the intermediate level of hospital care, including:

19 1. An Axis I major (serious) mental disorder  
20 with active symptoms and any one of the  
21 following:

22 • As a result of the major mental disorder,  
23 the inmate-patient is unable to adequately  
24 function within the structure of the CDCR EOP  
25 level of care.

26 • The inmate-patient requires highly  
27 structured inpatient psychiatric care with  
28 24-hour nursing supervision due to a major  
29 mental disorder, serious to major impairment  
30 of functioning in most life areas,  
31 stabilization or elimination of ritualistic  
32 or repetitive self-injurious/suicidal  
33 behavior, or stabilization of refractory  
34 psychiatric symptoms.

35 . . . . .

36 • The inmate-patient would benefit from a  
37 comprehensive treatment program with an  
38 emphasis on skill (i.e., coping, daily  
39 living, medication compliance) development

1 with increased programming and structured  
2 treatment environment.

3 . . . .

4 • The inmate-patient's Global Assessment of  
5 Functioning indicates behavior that is  
6 considerably influenced by psychotic  
7 symptoms; OR serious impairment in  
8 communication or judgment; OR inability to  
9 function in almost all areas.

10 Program Guide at 12-6-7, 8. Program Guide criteria concerning  
11 suicidality, below, are not specifically included in the criteria  
12 for admission to SCCP:

13 2. In addition to a primary Axis I disorder,  
14 admission to VPP and SVPP shall be considered  
15 when:

16 • The patient engages in ritualistic or  
17 repetitive self-injurious/suicidal behavior  
18 that has not responded to treatment in a CDCR  
19 facility. Without inpatient mental health  
20 treatment, the inmate-patient is likely to  
21 develop serious medical complications or  
22 present a threat to his life.

23 • The patient is chronically suicidal and has  
24 had repeated admissions to a Mental Health  
25 Crisis Bed (MHCB).

26 Program Guide at 12-6-8.<sup>14</sup>

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27 <sup>14</sup> Other Program Guide criteria for ICF care not reflected in the criteria  
28 for SCCP include:

• The inmate-patient requires a  
neurological/neuropsychological consultation.

• The inmate-patient requires an inpatient diagnostic  
evaluation.

• The inmate-patient's psychiatric medication history  
indicates that a clozapine trial might be useful.

• Inmate-patients, who are deemed a significant  
assault risk, have a history of victimizing other  
inmate-patients (including inciting others to act in a  
dangerous manner) or present a high escape risk,

1 As discussed above, during evaluation of the SCCP, the  
2 Special Master's experts identified the need for a separate  
3 housing unit for this program. See, e.g., Pls. Ex. 1031 at 183-  
4 184.

5 San Quentin has a Central Health Services Building (CHSB),  
6 built under the auspices of the Receiver in Plata v. Brown, No.  
7 01-1351 TEH. The fourth floor of the CHSB is a licensed  
8 Correctional Treatment Center (CTC) containing fifty beds. Pls.  
9 Ex. 1012 at 3. Seventeen of the beds are licensed mental health  
10 crisis beds. Monthei Decl. at ¶ 16. The 17 licensed MHCBS are  
11 used by inmate-patients from prisons all over California who are  
12 in need of a crisis bed level of care. RT at 1180:7-1181:4. The  
13 license for the remaining thirty-three beds is suspended and  
14 those beds are operated as an Outpatient Housing Unit. RT at  
15 1291:9-20; see Chappell Decl. (ECF No. 4601) at ¶ 4.

16 In December 2012, the Plata Receiver "agreed to designate up  
17 to 10 beds in the Outpatient Housing Unit [(OHU)] for use by  
18 inmates receiving services under the Specialized Treatment plan."  
19 Belavich Decl. at ¶ 11. The ten OHU beds are designated as

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20  
21 shall be referred to the SVPP Intermediate Program.  
22 CDCR refers to these inmate-patients as high custody  
inmate-patients.

23 . . . .

24 • For SVPP only, the inmate-patient is medically  
25 appropriate as determined by the receiving prison  
26 medical staff. The program psychiatrist will determine  
27 mental health suitability. If agreement is not reached  
28 refer to the Coordinated Clinical Assessment Team  
(CCAT) process in Section VI. Any denial for medical  
reasons will be immediately referred to the, Assistant  
Deputy Director, CDCR, Division of Correctional Health  
Care Services (DCHCS).

1 "flexible beds" for inmate-patients in the SCCP. Monthei Decl.  
2 at ¶ 16. Dr. Monthei is aware of "pressures" to return the ten  
3 beds from mental health care to physical medical care<sup>15</sup> and has  
4 discussed with his "management team alone" what might be done if  
5 the beds are no longer available for mental health care. RT at  
6 1379:10-25. See also Pls Ex. 1011 at 31-32 (Report of court  
7 experts to Plata court regarding OHU beds).

8 Over the past two years, "[t]he census for inmates-patients  
9 receiving specialized treatment has ranged from a low of 6 to a  
10 high of 45." Monthei Decl. at ¶ 10. San Quentin staff began  
11 admitting inmate-patients into the OHU beds approximately six  
12 months before Monthei's testimony. RT at 1221:21-25. At the  
13 time of the hearing, twenty-three inmate-patients were  
14 participating in the SCCP. RT at 1211:22. Of those, ten were  
15 housed in the OHU, twelve were housed in the East Block condemned  
16 housing unit, and one was in a mental health crisis bed. RT at  
17 1211:23-1212:7.

18 Dr. Monthei testified that within the group of patients  
19 identified as requiring an SCCP level of services, "clinicians  
20 would . . . prioritize by clinical severity those individuals  
21 that were most ill. And those individuals that are most ill  
22 would be the ones we would first refer to the specialized care  
23 beds that are within the OHU." RT at 1206:21-25. He testified  
24 that "the average length of stay for somebody that we admit into  
25 [the OHU] beds will be somewhere between six months and two

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26  
27 <sup>15</sup> In March 2013, court experts in Plata reported to that court that the  
28 dedication of ten OHU beds to mental health care and the corresponding  
reduction in the number of medical OHU beds was "inappropriate" "given the  
medical mission of the facility." Pls. Ex. 1011 at 31.

1 years," and longer if necessary but "probably not" shorter. RT  
2 at 1208:12-14; 1209:22-1209:1. Because the ten OHU beds are  
3 full, Dr. Monthei envisions a "continuous rotation of  
4 individuals, in and out of the OHU in order to provide the  
5 enhanced services." RT at 1303:17-1304:1. Dr. Paul Burton, the  
6 senior psychiatrist supervisor at San Quentin, testified that  
7 while San Quentin does not "use the term 'wait list'" there was  
8 one inmate-patient waiting for admission to the OHU unit. RT at  
9 1470:15-20. Dr. Monthei testified similarly. See RT at 1326:8-  
10 15.<sup>16</sup>

11 Services are offered to inmate-patients in the OHU beds  
12 "[s]even days a week, two shifts, second watch and third watch,  
13 weekends and holidays." RT at 1214:16-20. Dr. Monthei testified  
14 that it is "a full spectrum of mental health services analogous  
15 to what you would find in an ICF-type program." RT at 1217:6-8.  
16 Twenty-four hour nursing care is also available to the inmates in  
17 the ten OHU beds through the two nursing stations that serve the  
18 seventeen MHCBS and the thirty-three OHU beds in the Central  
19 Health Services Building. RT at 1221:4-20.

20 The ten OHU beds used for the SCCP are, by definition,  
21 outpatient beds. Inpatient care for male condemned inmates is  
22 limited to the MHCBS units at San Quentin and CMF and the Acute  
23 Psychiatric Program (APP) at California Medical Facility (CMF).  
24 Evidence tendered at the hearing established that condemned  
25 inmates transferred to the APP are subject to substantial  
26 custodial restrictions which severely limit treatment options.

---

27  
28 <sup>16</sup> You can call a cat a dog, but that doesn't change the cat. Likewise denying  
the cat is on the bed does not change the cat being on the bed.

1 Other testimony suggested that clinicians at San Quentin are  
2 reluctant to transfer condemned inmates to the APP and do so only  
3 in very limited circumstances.

4 Pursuant to a policy implemented on August 15, 2012,  
5 condemned inmates transferred to the APP are housed in a  
6 specified housing unit, Q3, and subject to the following  
7 restrictions: (1) A condemned inmate-patient's housing cell must  
8 be between two grill gates; (2) No condemned inmate-patient shall  
9 come into contact with any other inmate-patient; "[h]e shall be  
10 separated from other patients by a locked door or grill gate at  
11 all times;" (3) Any time a condemned inmate-patient is out of  
12 his cell, all other inmate-patients "must be locked in their  
13 cells or separated from the condemned patient by a locked grill  
14 gate or door;" (5) condemned inmate-patients must eat in their  
15 cells; (6) all condemned inmate-patients receive individual  
16 therapy only and are not permitted to participate in group  
17 therapy or activities; (7) a minimum of two correctional officers  
18 or one correctional officer and one "academy trained" medical  
19 technical assistant (MTA) must be present whenever a condemned  
20 inmate-patient's cell door is opened, and the condemned inmate-  
21 patient must be escorted in waist restraints and belly chains;  
22 escort must be provided by at least one correctional officer and  
23 one MTA. Pls. Ex. 1140.<sup>17</sup>

24 Dr. Bennie Carter, a staff psychiatrist working in the APP  
25 testified that when condemned inmate-patients leave their cells,

26 \_\_\_\_\_  
27 <sup>17</sup> Condemned inmates are "entitled to appropriate nursing care, medications,  
28 and clinical services provided by the attending physician, and may be  
involuntarily medicated under the guidelines of the [Penal Code] 2602  
process." Id.

1 at least three correctional officers accompany them and grill  
2 gates are opened and closed around them to "contain" them within  
3 a specific area and away from other inmates. RT at 1000:23-  
4 1001:14. These security restrictions impact both condemned  
5 inmate-patients and non-condemned inmate patients housed in the  
6 Q3 unit.<sup>18</sup> Ellen Bachman, the Executive Director of the Vacaville  
7 Psychiatric Program, averred that

8 treating even one condemned patient on the  
9 acute unit has a significant impact on the  
10 provision of care to the other 29 patients on  
11 the unit. Because the unit has one day room  
12 that is used for groups, individual sessions,  
13 and treatment team meetings, it is very  
14 difficult to provide treatment to a condemned  
15 patient within the specifications described  
16 above without reducing group or individual  
treatment for the other patients. In  
addition, when the condemned inmate is out of  
his cell or his cell door is open, the other  
patients must be locked in their cells or  
separated from the condemned inmate by a  
locked grill gate or door.

17 Bachman Decl. (ECF No. 4598) at ¶ 24. See also Duffy Decl. (ECF  
18 No. 4599), *passim*.

19 Treatment options for condemned inmates transferred to the  
20 APP are extremely limited. Non-condemned inmates in the APP  
21 progress through a series of steps in a treatment program,  
22 starting with individual programming "which means they come out  
23 using - they're handcuffed when they come out to watch TV in the  
24 dayroom." RT at 1003:18-20. Their behavior while out of cell is  
25 assessed and "after, on average, two to three periods of watching  
26 TV or watching a video, then they come out without handcuffs for

---

27  
28 <sup>18</sup> The Q3 unit houses both condemned and non-condemned inmate-patients. See  
RT at 1001:17-22.



1 another two to three times." RT at 1003:21-24." Thereafter,  
2 "[i]f that is successful" non-condemned inmates progress to small  
3 group programs and then to large group programs. RT at 1003:25-  
4 1004:18. Condemned inmates "stay on the first level. They come  
5 into the dayroom handcuffed. Every place they go, if they go to  
6 the showers, they go handcuffed. If they go to an EKG, they are  
7 physically restrained with handcuffs." RT at 1004:15-18.<sup>19</sup>

8 Since the start of the SCCP, admissions of condemned inmates  
9 to the APP "have substantially decreased." Bachman Decl. at ¶  
10 22; see also RT at 1236:17-25 (Testimony of Monthei). Dr. Carter  
11 testified that the six condemned inmates treated at APP in the  
12 preceding year had "psychiatric conditions that . . . would be  
13 considered more mild and not the chronically debilitated  
14 individuals that one would typically see in a long-standing  
15 mental health system." RT at 1008:22-25. He also testified that  
16 since the SCCP opened San Quentin sends condemned inmate-patients  
17 "who have more the behavioral acting out situations." RT at  
18 1010:3-4. Dr. Monthei testified that a "spike" in referrals made  
19 to the APP early in 2013 "were for patients who had very little  
20 or no mental illness" but were referred "in part because of the  
21 drug-induced psychosis" caused by a "bad batch of meth" on the  
22 condemned unit at San Quentin and "the homicidal and suicidality  
23 that they exhibited during the course of intoxication." RT at  
24 1236:20-1238:8. In addition, the suicide of an inmate at San  
25 Quentin shortly after his primary clinician went on vacation led

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28 <sup>19</sup> Given these custody provisions, it is hardly surprising that the  
psychiatrists at San Quentin are reluctant to refer patients to the APP.

1 to a "degree of hypervigilance" among clinicians at San Quentin.  
2 RT at 1237:21-24; 1239:16-1240:10.

3 Dr. Burton testified that there is "no stimulation" in "the  
4 DHS acute environment . . . . There's not a lot of activity for  
5 the condemned. There's not a lot of groups, not a lot of yards.  
6 They still get medication and therapy, but there's a lot of quiet  
7 time." RT at 1424:16-20. He suggested that the APP program  
8 might be helpful for patients "who have not a primary psychiatric  
9 disorder, but perhaps a personality disorder. . . ." RT at  
10 1424:22-25. Among other considerations, the fact that it is a  
11 "low stimulation environment" without a lot of group or treatment  
12 options influences the referral decisions of clinicians at San  
13 Quentin. See, e.g., RT at 1447:16-1448:8.

14 II. Analysis

15 The motion at bar implicates the adequacy of provisions of  
16 the Program Guide governing access to inpatient hospital care to  
17 seriously mentally ill inmates on California's death row as well  
18 as the adequacy of defendants' interpretation and implementation  
19 of those provisions.<sup>20</sup> Those provisions require that "[c]ondemned  
20 male inmate-patients who experience decompensation in the form of  
21 a crisis shall be referred to the DMH Inpatient Program at CMF  
22 for a MHCB level of care or DMH inpatient level of care."  
23 Program Guide at 12-4-19, 20.

24 The evidence establishes an identified need in the condemned  
25 inmate population for long-term inpatient mental health care  
26 equivalent to that provided by the ICF programs described in the

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28 <sup>20</sup> The provisions at issue were approved by this court by order filed March 3,  
2006 (ECF No. 1773).

1 Program Guide. At present, defendants limit inpatient referrals  
2 for condemned male inmate-patients to the acute level of care, a  
3 short-term program where treatment options are severely limited  
4 due to substantial custodial restrictions. Defendants assert  
5 that this limitation is grounded in California Penal Code § 3600  
6 which, as discussed above, requires condemned inmates to be  
7 housed at San Quentin except in limited circumstances.

8 It seems clear that defendants construe the statute too  
9 narrowly with respect to access to intermediate hospital care for  
10 condemned inmate-patients, at least with respect to providing  
11 access to inpatient care that is longer-term than acute care.  
12 The statute authorizes transfer of condemned inmate-patients for  
13 inpatient mental health care where their mental health needs "are  
14 so critical as to endanger the inmate or others." Cal. Pen. Code  
15 § 3600(b)(4). Where that criterion is met, nothing in the  
16 statute limits the time an inmate-patient may be treated in an  
17 outside facility; the criteria for return is "adequate treatment  
18 of the condition or remission." Id. Thus, condemned inmate-  
19 patients who meet the statutory criteria could, without running  
20 afoul of the statute, be transferred to an ICF facility if  
21 "adequate treatment" of their condition required a longer length  
22 of stay than available in an acute hospital program.

23 It is also arguable that most, if not all, of the criteria  
24 for inpatient hospital care described in the Program Guide could  
25 be encompassed under a broad construction of Penal Code §3600.4's  
26 criterion of "mental health needs . . . so critical as to  
27 endanger the inmate or others." Cal. Pen. Code § 3600(b)(4).  
28 Given the substantial evidence before the court of sequelae to

1 deteriorating mental illness, the determination that an inmate-  
2 patient has decompensated to the point where he needs a higher  
3 level of care than available in the Enhanced Outpatient Program  
4 would in most instances support a determination that the inmate-  
5 patient has "mental health needs . . . so critical as to  
6 endanger" himself and possibly others. As noted, defendants have  
7 not, however, so construed the statute.

8 While the court finds that transfers to existing ICF units  
9 could be accomplished consistent with California Penal Code  
10 §3600(b)(4), the evidence suggests significant impediments to  
11 adequate care by such transfers. As discussed above, testimony  
12 concerning the severe custodial restrictions placed on condemned  
13 inmate-patients in the APP raises grave concerns about the  
14 adequacy of treatment available to condemned inmate-patients were  
15 defendants to transfer them to existing ICF units under such  
16 restrictions.<sup>21</sup> The custodial restrictions have a significant and  
17 substantial negative impact on treatment options in the acute  
18 hospital setting, which is a short-term placement. That negative  
19 impact and the attendant anti-therapeutic consequences would be  
20 magnified in the longer placements that are the hallmark of  
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22 <sup>21</sup> This concern extends to non-condemned inmate-patients as well. According to  
23 the Executive Director of the Vacaville Psychiatric Program, applying these  
24 security protocols to the ICF programs at Vacaville "would reduce access to  
25 care for the other patients living on the designed treatment unit. Given that  
26 intermediate treatment is long term, with lengths of stay 180 to 240 days or  
27 more, inclusion of even one or more condemned inmates in the intermediate care  
28 facility milieu would have a profound impact. In our 64-bed high custody  
Intermediate Treatment Center, providing individual treatment for a condemned  
inmate would require having all 63 other patients behind a locked door or gate  
(in a cell, group room, or yard) before escorting the condemned patient out to  
a treatment area. This process would need to be repeated to return the  
condemned inmate to his cell. The overall treatment milieu would slow down  
significantly during these escort periods." Bachman Decl. (ECF No. 4598) at ¶  
25.

1 intermediate hospital care. The court received credible evidence  
2 that called into question whether all of these restrictions are  
3 necessary, whether custodial restrictions can be considered on an  
4 individual basis, and whether creation of a separate unit housing  
5 only condemned inmate-patients might obviate the need for some or  
6 all of the restrictions. All of those matters can and should be  
7 considered by defendants moving forward, under the guidance of  
8 the Special Master.

9 The court also heard substantial testimony about factors  
10 unique to the condemned population in California which suggest  
11 that providing necessary care at San Quentin is not only  
12 consistent with California Penal Code § 3600 but in fact a sound  
13 policy decision for providing adequate mental health care to this  
14 population.

15 The SCCP is defendants' response to the identified need for  
16 ICF care in the condemned inmate population. See Pls. Ex. 1043;  
17 see also RT at 1214:5-15 (Testimony of Monthei describing  
18 spectrum of mental health services available within "the  
19 overarching treatment program we refer to as the condemned  
20 treatment program", starting with inmates in the general  
21 population and including correctional clinical case management  
22 system (CCCMS), enhanced outpatient program (EOP), Specialized  
23 Care for the Condemned Program (SCCP), mental health crisis beds  
24 (MHCB), and DHS acute hospital care (APP)). It is intended to  
25 provide long-term care for condemned inmate-patients in need of a  
26 higher level of care than EOP care. It is not, however, a  
27 licensed inpatient hospital program. Furthermore, even assuming  
28 arguendo that defendants might be able to meet this identified

1 need in an outpatient housing unit, rather than a licensed  
2 inpatient facility, defendants do not presently have sufficient  
3 beds to meet the identified need.

4 The SCCP is in some respects a program that brings  
5 defendants closer to meeting their Eighth Amendment obligations  
6 to these members of the plaintiff class than does the acute  
7 psychiatric program at CMF. As discussed above, even assuming a  
8 legitimate penological purpose for all of the custodial  
9 restrictions imposed on condemned inmate-patients transferred to  
10 the APP, the restrictions are so severe that they preclude all  
11 but the most basic mental health treatment. Moreover, in and of  
12 themselves the restrictions appear significantly anti-  
13 therapeutic.<sup>22</sup>

14 In addition, the planned length of stay for the OHU beds is  
15 six to twenty-four months, well beyond the duration of an acute  
16 hospital stay. The SCCP is a real step forward, in that the APP  
17 is simply not an adequate alternative for condemned inmate-  
18 patients in need of long-term hospital care. Moreover, the  
19 dedication and qualifications of the clinical staff at San  
20 Quentin who testified before this court is impressive, as is the  
21 apparent evolution of a working and appropriate balanced  
22 partnership between clinical and custodial staff at that  
23 institution.

24 Notwithstanding the foregoing, as currently designed and  
25 implemented, the SCCP is also insufficient in a number of

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27 <sup>22</sup> As discussed above, the evidence shows that once the SCCP became available,  
28 referrals to APP declined significantly. While there may be several reasons  
for the decline, it is plain to this court that the restrictive and limited  
therapeutic environment of the APP is one of those reasons.

1 important respects to meet the identified need in the condemned  
2 inmate-population and defendants' Eighth Amendment obligation to  
3 provide these inmates with access to adequate mental health care.

4 Most importantly, there are not enough beds available for  
5 the need that has been identified. At the time of the  
6 evidentiary hearing defendants had identified twenty-three  
7 inmates as needing an SCCP level of care. By defendants'  
8 criteria, all twenty-three of these inmates have active symptoms  
9 of serious mental illness that make them unable to function in  
10 the condemned population and in need of a higher level of mental  
11 health care than the Enhanced Outpatient Program. Yet only one  
12 of these inmates was in an actual hospital bed, an MHCB, ten were  
13 in the OHU, and twelve remained housed in East Block. The  
14 evidence before this court demonstrates that the conditions of  
15 confinement in East Block are inadequate for seriously mentally  
16 ill inmates in need of inpatient hospital care or its equivalent.  
17 Defendants plan to "rotate" SCCP inmate-patients through the ten  
18 available OHU beds, with those identified as most critically ill  
19 being given priority to those beds and others waiting six to  
20 twenty-four months until a bed becomes available. There is an  
21 identified need for more than the ten OHU beds presently  
22 available and defendants are not presently providing sufficient  
23 adequate beds to meet their constitutional obligations to these  
24 members of the plaintiff class.<sup>23</sup>

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25 <sup>23</sup> While the new Stockton facility would provide additional beds, the court has  
26 not received any information as to what custodial standards would apply to  
27 condemned inmates. Moreover, the court has been informed that transfers to  
28 that facility have been stayed because of staffing difficulties.  
In addition, space may be available at CMF for an inpatient unit for condemned  
inmates only, but similar questions are presented concerning, at least, what  
custodial restrictions would apply in such a unit and how such restrictions

1           Second, it is far from clear that the ten OHU beds are  
2 permanently available for mental health care for condemned  
3 inmate-patients. The beds are in a unit originally intended for  
4 medical care and the transfer of those beds to mental health care  
5 has, in the opinion of court experts in the Plata action,  
6 jeopardized the sufficiency of medical beds for the condemned  
7 inmate population at San Quentin. See Pls. Ex. 1011 at 31-32.  
8 Dr. Monthei acknowledged uncertainty as to whether the ten OHU  
9 beds will remain available for mental health care, and there is  
10 no evidence that any CDCR officials except Dr. Monthei and his  
11 local team have even begun to discuss alternatives should the OHU  
12 beds be returned to medical care.

13           Third, the ten OHU beds in use as part of the SCCP are  
14 outpatient beds. The beds were licensed as correctional  
15 treatment center beds but for reasons not explained at the  
16 hearing the license for those beds is not presently active.  
17 Thus, while some inpatient services such as twenty-four hour  
18 nursing services are apparently available if prescribed, the ten  
19 OHU beds are not inpatient hospital beds.

20           For all of the foregoing reasons, defendants are not yet in  
21 compliance with their Eighth Amendment obligation to provide  
22 condemned inmate-patients with access to necessary inpatient  
23 hospital care. The solution is not, however, clear from the  
24 record before the court. Instead, the record demonstrates that  
25 each remedy in its present form is insufficient and that it is  
26 defendants in the first instance who must make the decisions  
27 necessary to a complete remedy. For that reason, defendants will  
28 would affect the adequacy of care.



1 be directed to resume working with the Special Master to  
2 establish a durable remedy that provides access to necessary  
3 inpatient mental health care for seriously mentally ill inmates  
4 on California's death row.<sup>24</sup>

5 Plaintiffs also request a "sweep" of the condemned  
6 population at San Quentin to conduct an assessment of need for  
7 inpatient care. The record in this action establishes that an  
8 insufficient number of necessary hospital beds is directly  
9 correlated with underidentification of need. See, e.g., Order  
10 filed March 31, 2010 (ECF No. 3831) at 2-3 (discussing two  
11 separate unidentified needs assessments conducted in this action  
12 to identify unmet need for inpatient care). As discussed above,  
13 the evidence before the court demonstrates that there are not  
14 presently a sufficient number of beds to meet the identified need  
15 for access to an ICF level of mental health care in the condemned  
16 inmate population. Defendants' evidence concerning the general  
17 "sweeps" that they have conducted periodically at San Quentin is  
18 insufficient to outweigh the countervailing concerns presented by  
19 the demonstrated shortfall in the number of available beds.  
20 Accordingly, defendants will be directed to conduct an assessment  
21 of need for inpatient care under the guidance and supervision of  
22 the Special Master.

23  
24  
25 <sup>24</sup> The record before the court shows that cooperative efforts by the parties,  
26 under the supervision of the Special Master, to resolve this issue were  
27 interrupted by the filing of defendants' termination motion and the litigation  
28 that has ensued. The present contours of the SCCP suggest that defendants  
have moved forward with this alternative incorporating at least some of the  
guidance provided by the Special Master and his experts following their  
December 2012 visit. The court is hopeful that process can resume and be  
completed expeditiously.

1 Finally, at the hearing plaintiffs raised a number of issues  
2 concerning adequacy of care provided to condemned inmates at the  
3 EOP and CCCMS levels of care. In particular, plaintiffs seek  
4 orders requiring defendants to "regularly screen all individuals  
5 on death row for mental health needs and assess suicide risk  
6 using formal, validated screening tools," and to develop  
7 "adequate reporting mechanisms regarding mental health care for  
8 the condemned, as well as an order directing the Special Master  
9 to conduct a full evaluation of the EOP and CCCMS programs for  
10 condemned inmates at San Quentin Pls. Post-Trial Brf. (ECF No.  
11 4935) at 32-36.<sup>25</sup>

12 The court will not issue any additional orders at this time.  
13 First, the Special Master is already tasked with monitoring the  
14 delivery of mental health care at San Quentin and no further  
15 orders are necessary to direct him to fulfill that obligation.  
16 Second, the court anticipates that the assessment required by  
17 this order will provide substantial additional information as to  
18 whether there are additional unmet mental health needs in the  
19 condemned inmate population. Should those be demonstrated, the  
20 court will take such further action as may be required at that  
21 time.

#### 22 IV. Standards for Injunctive Relief

23 The court does, by this order, direct specific action by  
24 defendants. In this court's view, the orders contained herein  
25 are in aid of the remedy required by this court's 1995 order. To  
26 the extent that the requirements of 18 U.S.C. § 3626(a)(1) may  
27 apply, this court finds that the orders contained herein are

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28 <sup>25</sup> The page citations are to the ECF page number in this document.

1 narrowly drawn, extend no further than necessary to correct the  
2 Eighth Amendment violation in the delivery of mental health care  
3 to members of the plaintiff class, and are the least intrusive  
4 means to that end. See 18 U.S.C. § 3626(a)(1)(A).

5 In accordance with the above, IT IS HEREBY ORDERED that:

6 1. Plaintiffs' April 11, 2013 motion to enforce judgment and  
7 for affirmative relief related to inpatient treatment for  
8 class members in California's condemned inmate population  
9 is granted in part.

10 2. Defendants shall forthwith, under the guidance and  
11 supervision of the Special Master, conduct an assessment  
12 of unmet need for inpatient care in the condemned inmate  
13 population at San Quentin.

14 3. Defendants shall forthwith resume working under the  
15 guidance of the Special Master to establish a durable  
16 remedy that provides adequate access to necessary  
17 inpatient mental health care or its equivalent<sup>26</sup> for  
18 seriously mentally ill inmates on California's death row.

19 4. In meeting their obligations under paragraph 3 of this  
20 order, consideration shall be given to all possible  
21 remedies, including, but not limited to, creation of a  
22 hospital unit for condemned inmates only at CMF, San

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23 <sup>26</sup> The parties disagree as to whether the required care can be provided in an  
24 unlicensed outpatient housing unit or whether an inpatient licensed facility  
25 is required. At the present time no request has been made to waive any  
26 provision of state law governing the delivery of mental health care in a  
27 prison or hospital setting. While this court is precluded from ordering  
28 defendants to comply with state law, see Pennhurst State School & Hospital v. Halderman, 465 U.S. 89 (1984), a durable remedy to the Eighth Amendment violations in this action must not include programs whose continued existence are jeopardized by noncompliance with state law. The dispute over whether the proper remedy requires a licensed facility should be resolved as part of the establishment of a durable remedy required by this order.

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Quentin, Stockton or other appropriate facility.


5. Within six months the Special Master shall report to the court on the remedy elected and the time frame for its complete implementation.

6. Except as expressly granted herein, plaintiffs' motion to enforce judgment and for additional orders is denied without prejudice.

7. This order further demonstrates that defendants' motion to terminate should not have been granted.

IT IS SO ORDERED.

DATED: December 10, 2013.

  
LAWRENCE K. KARLTON  
SENIOR JUDGE  
UNITED STATES DISTRICT COURT