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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	2:90-cv-00520 KJM-DB (PC) DEFENDANTS' EXPEDITED MOTION TO CONTINUE AUGUST 31, 2020 BRIEFING DEADLINE AND SEPTEMBER 10, 2020 HEARING, OR IN THE ALTERNATIVE, FOR RECONSIDERATION OF JULY 30, 2020 ORDER

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INTRODUCTION

Psychiatrist staffing is one of Defendants' highest priorities, which is why staffing continues to be a significant focus even as the California Department of Corrections and Rehabilitation (CDCR) and the Department of State Hospitals (DSH), along with the rest of the world, grapple with the impacts of the COVID-19 pandemic. But after delaying a hearing on staffing due to intervening events, including the COVID-19 pandemic, the Court now directs the parties to provide significant briefing concerning issues never previously raised by the Court, and to do it all in just thirty days and then conduct a hearing twelve days later. Defendants understand the Court's interest in a staffing hearing, but these unreasonably short deadlines (amidst a pandemic that has severely curtailed movement and the flow of information within and between institutions) do not allow Defendants to prepare a comprehensive response and obtain assistance from their recently retained expert consultants to assess the order's weighty issues and make a full record to inform the Court.

In addition, the July 30, 2020 order's timeframes do not allow the parties to evaluate population management measures instituted in response to the pandemic that have substantially reduced the number of mentally ill inmates and those measures' attendant impact on the prison mental health system. Since the Court issued its October 10, 2017 order mandating that CDCR come into compliance with staffing ratios in Defendants' 2009 staffing plan, CDCR's total mental health population has fallen by 8,000 inmates, with the majority of that reduction occurring in the last five months. The effects of this palpable reduction of the mentally ill inmate population should be examined by Defendants, Plaintiffs, and the Special Master before the contours of a prisoner release order should even be considered.

Furthermore, the order does not permit Defendants to work with the stakeholders to collaboratively discuss and emplace a new staffing plan currently under development. Nor does the order allow Defendants to assess benchmarks concerning constitutional compliance that the Court recently announced it would confirm at the July 2020 status conference, but has yet to issue. Those benchmarks will inform the staffing discussion and provide necessary metrics to

further evaluate whether the current staffing plan remains appropriate. Compounding these impairments, the tight timeframes do not allow Defendants to receive information from the Special Master's data expert concerning various CDCR data metrics that are key to evaluating their staffing model and compliance, and thus they cannot prepare an adequate response to the July 30 order.

Given these considerations, and so that Defendants can present their defense on the new issues raised in the July 30 order regarding population reduction, Defendants request that the Court stay the August 31 briefing deadline and September 10 hearing and direct the parties to provide briefing in January 2021 concerning resetting these deadlines.[1] In the interim, Defendants will continue to work with the Special Master and Plaintiffs on staffing. In the alternative, Defendants request that the Court reconsider the July 30 order, stay its timelines, and direct the parties to provide briefing in January 2021.

FACTUAL AND PROCEDURAL BACKGROUND

The Court's July 30 order is the product of past orders setting and then continuing status conferences on Defendants' compliance with the Court's October 10, 2017 order. (ECF No. 5711.) The Court's October 10, 2017 order directed Defendants to come into complete compliance with the staffing ratios set forth in the 2009 Staffing Plan, including a maximum ten percent psychiatry staffing vacancy rate required by the Court's June 13, 2002 order. (ECF No. 5711 at 30.) As part of this order, the Court set a "further status conference" for October 11, 2018, to address issues pertaining to enforcement of the order, as well as an evaluation of the durability of the staffing remedy. (*Id.* at 31.)

In response to the Court's October 2017 order, CDCR developed a comprehensive set of proposals to remedy staffing vacancies and correct false assumptions underlying the 2009 staffing plan. CDCR's efforts were interrupted in October 2018, when a psychiatrist issued a report calling into question CDCR's data. (ECF No. 6705 at 2.) On December 23, 2019, following a

[1] The Court at several status conferences over the past few months has indicated its willingness to address motions on an expedited basis or on shortened time. Defendants request that accommodation on this motion. If the Court would like to hear argument, Defendants can be available at the Court's earliest convenience.

year of investigation and reporting on CDCR's data management and reporting practices, including briefing and an evidentiary hearing, the Court issued an order directed at correcting deficiencies in CDCR's data management and reporting. (ECF No. 6435.) The Court directed the Special Master to hire his own data expert. (*Id.*) The Special Master's data expert was appointed on April 29, 2020 (ECF No. 6466), and on June 8, 2020, the Special Master filed a report documenting the scope and status of the data expert's work, and requested leave to file to file his expert's report within ninety days, on or before September 8, 2020. (ECF No. 6705.) The investigation into CDCR's data further delayed the hearing on Defendants' compliance with the October 10, 2017 order.

On January 7, 2020, the Court reset "the deferred questions of Defendants' compliance with the October 2018 deadline set in the court's October 10, 2017 order . . . and enforcement of that order" for hearing on April 23, 2020. (ECF No. 6441 at 5.) After the onset of the COVID-19 pandemic, the Court vacated the hearing. (ECF No. 6600 at 4.) During the July 2020 quarterly status conference, the Court raised the idea of resetting the hearing in September, for the first time describing it as a "fully adversarial proceeding" to brief the remedies available for "Defendants' ongoing noncompliance." (July 17, 2020 Tr. at 21-23, ECF No. 6781.)

The Court's July 30 order subsequently set a hearing for September 10 to discuss whether "targeted reduction of the mentally ill prison population might be the only path remaining for Defendants to achieve constitutional compliance in this case," among other topics. (ECF No. 6794 at 7.) The July 30 order, which appears to be based upon the assumption that population reduction is the only way to solve Defendants' staffing issues, further directed the parties to file briefs within thirty days detailing the size of such a population reduction and the "general contours" of a plan to achieve that population reduction within one year, and directed briefing on additional subjects. (*Id.* at 8.) Defendants seek relief from the July 30 order's timeframes.

ARGUMENT

I. THE COURT SHOULD CONTINUE THE BRIEFING AND HEARING DIRECTED BY THE JULY 30 ORDER TO ALLOW FOR A PROPER DEFENSE.

While the Court has previously expressed its desire to conduct a staffing hearing, the subject of the September 10 hearing is substantially different from the Court's earlier orders. Defendants are now ordered to consider a potential prisoner release order—an entirely different question that requires different analysis and expertise. Any assessment of CDCR's current population and staffing needs requires detailed consultation and examination, which cannot occur during the COVID-19 pandemic or in the time allotted before the September 10 hearing. Therefore, the briefing and hearing directed by the Court must be continued so that Defendants can adequately prepare for these significant litigation events.

Immediately after the July 30 order was issued, Defendants commenced a search to identify subject matter experts in the area of correctional mental health services and staffing to assist in their defense. (*See* Declaration of R. Silberfeld Supp. Defs.' Mot. (Silberfeld Decl.) ¶ 2.) Between July 31 and August 13, Defendants identified a number of qualified individuals who could serve as consultants or experts concerning these topics and other issues to assist in responding to the Court's briefing and hearing requirements. (*Id.*) However, in light of logistical considerations, conflicts of interest, or other issues, Defendants were not able to retain experts during that period. (*Id.*)

Between August 14 and 18, Defendants communicated with an expert group, assessed that group's ability to provide consultation, and if needed, expert testimony, regarding the novel issues presented by the Court's order. (Silberfeld Decl. ¶ 3.) Defendants recently retained this expert group, but conversations with this expert group about the scope of work and tasks to be accomplished make clear that neither this group, nor any group, can adequately prepare for the briefing due on August 31 or the hearing on September 10 in such a short timeframe, and particularly under current pandemic conditions. (*Id.*) Defendants' retained expert group anticipates two work streams involving site inspections and staff interviews, but neither work stream can be accomplished during the COVID-19 pandemic due to travel restrictions and prison

operational constraints. (*Id.*) And some of these site inspections will involve joint tours with the Plaintiffs, which will require further coordination. As a result, the nature of this virus and the necessary precautions taken across the nation and throughout CDCR preclude Defendants' and the group's ability to perform the necessary review of systems, programs, practices and policies necessary to mount a defense to the Court's order. (*Id.*) Furthermore, the briefing and hearing timeframes do not allow adequate time for any necessary expert depositions by the parties or any pre-trial motions practice. Accordingly, the Court should continue both the briefing and the hearing on the issues raised in the July 30 order so that Defendants can prepare a proper defense utilizing witnesses and their retained expert group. (*Id.*)

Moreover, the sheer scale of the issues contemplated by the July 30 order necessitates a continuance so that Defendants and their expert group can analyze and obtain or provide consultation regarding topics unique to this decades-long civil rights action involving the nation's largest prison system. (Silberfeld Decl. ¶ 4.) As stated above, Defendants expeditiously reviewed the order, in which for the first time this Court seems to assume that a prisoner release order is the *only* means to come into compliance with a prior staffing order. (*Id.* ¶¶ 2, 4.) But the various actions needed to prepare for, brief, and conduct the hearing contemplated by the July 30 order cannot be conducted during an unprecedented pandemic within the extremely constricted schedule set by the Court. (*Id.* ¶¶ 4, 5.)

Finally, the State's ability to present a defense to the serious issues raised in the July 30 order using data and metrics is significantly hampered by the lack of a completed review of CDCR's data systems by the Special Master and his data expert. These systems were called into question during the October 2019 evidentiary hearing, but until the Special Master's data expert independently validates CDCR's mental health data systems, Plaintiffs will object to relevant staffing and mental health program data, impairing Defendants' ability to defend themselves.

Indeed, any position on the relationship between the mental health population and compliance with CDCR's 2009 Staffing Plan necessarily requires data from the mental health performance reports showing the level of care and treatment. For example, the 2009 Staffing Plan outlines how the ratios are informed by the level of treatment provided during

Interdisciplinary Treatment Teams and individual contacts. (ECF No. 3693 at 11-2 and 16-17.) The data showing treatment for *Coleman* class members over the past several years will need to be analyzed to provide a comprehensive understanding of staffing levels. That evidence necessarily includes data that the expert is still analyzing and that will be the subject of his anticipated report and testimony. (*See* ECF No. 6705 at 18 (the expert is reviewing "mental health business intelligence, mental health on demand reports, and update/change policies around mental health quality management and fixed benchmarks," and "data and policies regarding the Coleman class members and CDCR's population generally and with respect to COVID-19, including analysis of its risk factors").)

Without this report, presently due September 8—ten days *after* briefing in response to the July 30 order is due and only two days before the hearing—there is no way for Defendants to present data the basic validity of which the parties will not dispute. Given this severe handicap, Defendants are unfairly disadvantaged and unable to present a defense consistent with their due process rights, let alone one that is effective.

Forcing Defendants to defend against mandatory population reduction and other enforcement remedies (ECF No. 6794 at 8) within the extraordinary confines of the present schedule risks irreparable harm to Defendants' due process rights. The Court should continue the dates contemplated by the July 30 order, and direct the parties to provide briefing in January 2021 regarding rescheduling the briefing and hearing dates. *See Little v. Kern Cty. Superior Ct.*, 294 F.3d 1075, 1080-81 (9th Cir. 2002) (citations omitted) (a contemnor must be afforded "'reasonable notice of the specific charges and an opportunity to be heard,' and such notice of the contempt charge "must be explicit in order to conform to the requirements of due process").

II. GIVEN RECENT AND ONGOING POPULATION REDUCTION MEASURES AND FURTHER ANTICIPATED COVID-19 REMEDIAL EFFORTS, THE COURT SHOULD RECONSIDER THE JULY 30 ORDER AND STAY BRIEFING AND THE HEARING.

A district court has the inherent power to reconsider and modify its interlocutory orders prior to the entry of judgment. *Smith v. Massachusetts*, 543 U.S. 462, 475 (2005). Reconsideration is appropriate if the district court (1) is presented with newly discovered

evidence, (2) committed clear error or the initial decision was manifestly unjust, or (3) if there is an intervening change in controlling law. *Sch. Dist. No. 1J, Multnomah Cty., Or. v. ACandS, Inc.*, 5 F.3d 1255, 1263 (9th Cir. 1993).

Here, various intervening events over the past few months present new evidence or render the Court's order manifestly unjust, and thus worthy of reconsideration.

III. CDCR'S MENTAL HEALTH POPULATION IS SIGNIFICANTLY LOWER THAN IN PREVIOUS YEARS.

To promote physical distancing and protect the inmate population from risks associated with the COVID-19 pandemic, CDCR has voluntarily accelerated the release of thousands of inmates. As a result, since March 18, 2020, CDCR's total in custody population has been reduced from 117,394 inmates to 98,183 inmates as of August 19, 2020. (*Compare* https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/03/Tpop1d200318.pdf and https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/08/Tpop1d200819.pdf.) To date, these releases have helped reduce the number of inmates in CDCR's Mental Health Services Delivery System from 35,834 patients on March 18, 2020, to 30,816 patients on August 19, 2002, a reduction of over 5,000 *Coleman* class members. (Decl. of J. Powell Supp. Defs.' Mot. (Powell Decl.) ¶ 4.) This represents a 14% reduction in the size of the *Coleman* class over just the past five months. The effect of this significant reduction of mentally ill inmates on CDCR's mental health program operations or staff capabilities in such a compressed timeframe has not yet been examined by Defendants, Plaintiffs, or the Special Master, but constitutes a substantially changed condition that did not exist when the Court issued the October 2017 staffing order. In fact, there are presently 8,120 fewer inmates in CDCR's mental health delivery system than on October 9, 2017, when the population stood at 38,936 patients. (Powell Decl. ¶ 5.) That represents a dramatic 21% decrease in the population requiring regular psychiatric care since the time that the Court issued its October 2017 order. And these reductions will continue as individuals are expedited to parole due to the rolling implementation of population reduction measures taken in response to the pandemic.

Indeed, this evidence calls into question the Court's underlying assumption in the October 2017 order that CDCR's current mental health staffing levels are insufficient to meet constitutional obligations. (*See* ECF No. 5711 at 28.) Because the size of CDCR's mentally ill population has *not* at all "remain[ed] at current levels or continue[d] to grow" since the October 2017 order was issued, it is manifestly unjust to require briefing and a hearing on population reduction issues when the conditions for that reduction likely no longer exist, particularly in light of this new evidence concerning CDCR's current population. (*Id.*; ECF No. 6794 at 7.) In light of the significant reductions of the size of the Plaintiff class in response to the COVID-19 pandemic, any analysis of an even *further* population reduction is premature at this time. The effect of recent population changes has not been evaluated yet. With fewer mentally ill inmates, and new modes for the delivery of mental health care, the parties should be allowed to examine whether Defendants' staffing needs have evolved such that they are now closer to staffing compliance. However, it is physically impossible for such an evaluation to occur in the brief time allotted Defendants to prepare the directed briefing and for the September 10 hearing. (Silberfeld Decl. ¶¶ 3, 4.) Given this new evidence, the Court should reconsider the July 30 order and stay its timeframes concerning briefing and a hearing.

IV. CDCR IS PREPARING A NEW STAFFING PLAN.

As the Court acknowledges, Defendants are "actively engaged in producing [a] new staffing proposal" and related "things [are] being discussed with the Special Master." (ECF 6794 at 2 (July 17, 2020 Tr. at 24, ECF No. 6781).) Indeed, Defendants have consistently worked on staffing plans since 2015, and have resumed these efforts following the evidentiary hearing concerning CDCR data practices. At the recent status conference, the Special Master confirmed that he has "been working with DSH on their staffing plan" and that the recent DSH staffing process "has been a very positive experience" that requires further work and comments from the Plaintiffs. (July 17, 2020 Tr. at 25, ECF No. 6781.) Recognizing that positive work, the Court essentially excluded DSH and its staffing plan from the July 30 briefing and hearing, even though DSH and its staffing are considered integral to the delivery of constitutional care to CDCR patients. (*See* ECF No. 6794.) CDCR should not be held to a staffing hearing at this time,

particularly where Defendants informed the Court that CDCR is working on a staffing plan. (*Id.* at 27.) A component of this work concerns developing a standardized staffing plan for the Psychiatric Inpatient Programs, a program which utilizes a significant number of resources. CDCR has been developing this plan with the input of the Special Master but it will not be finalized by the September 10 hearing date. With Defendants taking active steps to develop staffing plans and work with stakeholders concerning this important issue, an adversarial hearing and further litigation are unwarranted and contrary to the Court's professed desire to avoid counterproductive litigation.

V. NEITHER THE COURT NOR THE SPECIAL MASTER HAS YET TO CLARIFY BENCHMARKS FOR CONSTITUTIONAL COMPLIANCE.

At the recent status conference, in response to Defendants' concern that "twenty-five years into the remedial phase of this litigation, neither the Court nor the Special Master have established benchmarks for 'full and durable' constitutional compliance at *any* population level" (ECF No. 6769 at 15 (emphasis added)), and two years after the Court itself expressly called upon the Special Master to define benchmarks for constitutional compliance (ECF No. 5852 at 3), the Court indicated that it would clarify and confirm benchmarks concerning constitutional compliance.

At the hearing, the Court stated:

> The Court has addressed benchmarks in a couple of areas with respect to transfers and clarified the benchmark there with respect to staffing; at least I'm holding out a benchmark in staffing. We need to resolve staffing sooner rather than later now, and we'll get to that. My tentative plan subject to hearing from you this morning would be to clearly put out there the benchmark the special master has been using reflected in his reports to the Court for quite some time now and ask why these should not be confirmed as the benchmarks. (*Id.* at 11.)

After hearing from the parties, the Court stated that it saw "no reason not to put the special master's benchmarks out there for clarification, for transparency, and I think it can drive the process most efficiently." (*Id.* at 16.) The Court has not yet provided the benchmarks. Indeed,

rather than clarify any benchmarks that would help guide the parties' work toward achieving constitutional compliance, the Court found that Defendants had not complied with the October 2017 staffing order and directed the parties to a hearing on a population reduction order and related items. (ECF No. 6794 at 8.) Defendants are entitled to these benchmarks for constitutional compliance to accurately assess the entire operation of CDCR's Mental Health Services Delivery System, including its present staffing needs and staffing model given present conditions, technologies, and clinical thinking, so that Defendants can determine what systemic modifications are required to achieve overall constitutional compliance at any population level. Mental health staffing is inextricably tied to other areas for which the Court will confirm benchmarks, including medical records, and suicide prevention, among others, and having these benchmarks will allow Defendants to appropriately evaluate the topics addressed by the July 30 order.

Because there is new evidence bearing upon the July 30 order, and the order is manifestly unjust, the Court should continue briefing and the hearing.

CONCLUSION

The briefing and hearing contemplated by the July 30 order address novel issues in this case and require sufficient time to evaluate and prepare an adequate response. The hearing should be continued so that Defendants can adequately prepare for these significant litigation events. As demonstrated by the offer of proof submitted in counsel's supporting declaration, Defendants expeditiously retained an expert group, but the order's unreasonably compacted schedule and the operational limitations caused by the global pandemic prevent their ability to work with their experts to formulate a defense. Defendants are further hampered by the lack of the Special Master's data expert's report, which will provide a common understanding and verity concerning CDCR's mental health data.

In the alternative, given the changed circumstances in California's prisons, including new evidence concerning significantly fewer mentally ill inmates, and other information demonstrating that the July 30 order's briefing and hearing timeframe is manifestly unjust, the order should be stayed. The order prematurely directs the parties to consider a prisoner release to

remedy mental health staffing vacancies, despite Defendants' anticipated production of a revised staffing plan and the Court's confirmation of benchmarks defining constitutionally compliant staffing practices.

For these reasons, the Court should continue the timeframes contained in the July 30 order, and direct the parties to provide briefing in January 2021 regarding rescheduling the briefing and hearing dates.

CERTIFICATION

Defendants' counsel certifies that he reviewed the following orders relevant to this filing: ECF Nos. 1382, 5711, 5852, 6435, 6441, 6466, 6600 and 6794.

Dated: August 21, 2020

Respectfully Submitted,

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	2:90-cv-00520 KJM-DB (PC) **DECLARATION J. POWELL IN SUPPORT OF DEFENDANTS' EXPEDITED MOTION TO CONTINUE AUGUST 31, 2020 BRIEFING DEADLINE AND SEPTEMBER 10, 2020 HEARING, OR IN THE ALTERNATIVE, FOR RECONSIDERATION OF JULY 30, 2020 ORDER** Judge: The Hon. Kimberly J. Mueller

I, Jay Powell, declare:

1. I am the Correctional Administrator for the Health Care Placement Oversight Program (HCPOP), Corrections Services division of the California Correctional Health Care Services. I make this declaration in support of Defendants' Motion to Continue August 31, 2020 Briefing Deadline and September 10, 2020 Hearing, or, in the Alternative, for Reconsideration of

July 30, 2020 Order. I have personal knowledge of the statements in this declaration and could testify to them if called to do so.

2. I was appointed as the Correctional Administrator of the HCPOP on May 1, 2018. I am familiar with the numerous and complex policies and procedures that govern the movement of patients within the mental health care delivery system and I supervise and direct HCPOP's activities. HCPOP is the program area responsible for managing and tracking the statewide movement of patients into and out of designated health care beds.

3. Attached as Exhibits A, B, and C, are true copies of the California Department of Corrections & Rehabilitation's Management Information Summary (MIS) report and the Summary of Population by Institution and Level of Care report (also referred to as H1 report) as of October 10, 2017, March 18, 2020, and August 20, 2020, respectively. HCPOP staff prepare the MIS and the H1 reports. As the footnotes on each report note, the source of the MIS in October of 2017 was Datamart for Correctional Clinical Case Management System (CCCMS), Enhanced Outpatient Program (EOP); HCPOP Endorsements and Referrals Tracking (HEART) for Mental Health Crisis Bed (MHCB); Referrals to Inpatient Programs Application (RIPA) reports for Intermediate Care Facility (ICF), Acute Psychiatric Program (APP), and Psychiatric Inpatient Program (PIP) programs; and Department of State Hospital reports for Parolee programs. The source of the H1 report is the Health Care Offender Data Store (HCODS). The reports provide information for a specific date and time (H1 only) noted by the report's time stamp. The H1 report shows the operational capacity, design capacity, population number, occupied percentage, and the vacant number of beds at each mental health level of care. The definitions for operational capacity, population, percent occupied, and vacancy rate are all provided on the H1 report.

4. Based on the data in Exhibit A, there were 38,936 patients in CDCR's Mental Health Services Delivery System on October 9, 2017. According to Exhibit B, on March 18, 2020, there were 35,834 patients in CDCR's Mental Health Services Delivery System. On August 19, 2020, the data from Exhibit C indicates there were 30,816 patients in CDCR's Mental Health Services Delivery System.

5. Comparing the MIS and the H1 reports attached as Exhibits A and C, there were 8,120 fewer patients in CDCR's Mental Health Delivery System on August 19, 2020, than were there on October 9, 2017.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed in Elk Grove, California on August 21, 2020.

Jay Powell
Correctional Administrator
Health Care Placement Oversight Program
(original signature retained by attorney)

Exhibit A

10/9/2017

Level of Care	MALES			FEMALES		
	Capacity	Census[1]	Awaiting Placement[2]	Capacity	Census[1]	Awaiting Placement[2]
Correctional Clinical Case Management System (CCCMS)	**27,450**	**26,940**		**2,100**	**2,291**	
CCCMS - General Population (GP)		23,590			1,989	
CCCMS - Reception Center (RC)		2,410			165	
CCCMS - Administrative Segregation Unit (ASU)		139			0	
CCCMS - Security Housing Unit (SHU)		0			38	
CCCMS - Restricted Housing Long-Term (LTRH)		91				
CCCMS - Restricted Housing Short-Term (STRH)+STRH-RC		710			99	
CCCMS - Non Disciplinary Segregation (NDS)		0				
Enhanced Outpatient Program (EOP)[4]	**7,707**	**7,719**		**235**	**239**	
EOP - GP	6,886	6,618		195	214	
Sensitive Needs Yard (SNY)	*3,636*	*3,364*				
EOP - RC		265			0	
EOP - ASU[5]	585	636	45	20	17	0
EOP - PSU[5]	236	200	19	20	8	0
EOP - NDS		0				
Mental Health Crisis Bed (MHCB)	**427**	**392**	**34**	**22**	**18**	**7**
Psychiatric Inpatient Programs: Intermediate Care Facility (ICF)	**1130**	**874**	**74**			
Low Custody	390	339	36			
Atascadero State Hospital (ASH)	256	218	27			
Coalinga State Hospital (CSH)	50	48	2			
California Medical Facility (CMF)	84	73	7			
High Custody	740	535	38			
California Health Care Facility (CHCF)	330	183	6			
CMF Single Cells	94	74	11			
CMF Multi Cells	70	58	11			
SVPP Single Cells	202	187	2			
Salinas Valley Psychiatric Program (SVPP) Multi Cells	44	33	8			
Acute Psychiatric Program (APP)	**402**	**380**	**47**			
ASH	0	0	0			
CHCF	184	166	28			
CMF	218	214	19			
Psychiatric Inpatient Program (PIP)	**40**	**33**	**0**	**75**	**50**	**5**
California Institution for Women (CIW)				45	39	3
Patton State Hospital (PSH)				30	11	2
San Quentin (SQ)	40	33	0			
Penal Code 2974s (Parolees)		**3**				
Metro State Hospital (MSH)		0				
Napa State Hospital (NSH)		3				
Patton State Hospital (PSH)		0				
TOTALS (excluding Parolees)	**37,156**	**36,338**	**219**	**2,432**	**2,598**	**12**

	Total Capacity	Total Census[1]	Total Awaiting Placement[2]	Total Over Timeframes[3]	CENSUS PERCENTAGES	
					% MHSDS	% CDCR[6]
CCCMS	29,550	29,231			**75.07%**	**22.23%**
EOP	7,081	7,097			**18.23%**	**5.40%**
EOP-ASU	605	653	45	5	**1.68%**	**0.50%**
PSU	256	208	19	0	**0.53%**	**0.16%**
MHCB	449	410	41	11	**1.05%**	**0.31%**
PSYCHIATRIC INPATIENT	1,647	1,337	126	10	**3.43%**	**1.02%**
GRAND TOTAL	**39,588**	**38,936**	**231**	**26**	**100.00%**	**29.61%**

[1] Census sources: Datamart for CCCMS, EOP; HEART for MHCB; RIPA reports for ICF, APP, and PIP programs; and DSH reports for Parolee programs.

[2] Awaiting Placement = The sum of inmates waiting to be placed in a bed at a specific level of care. Those awaiting placement to ICF, APP, and PIP include referrals that have been custodially reviewed by HCPOP and are awaiting bed availability, inpatient program acceptance, or transfer to the inpatient program as of the reporting date (based on the Referrals to Inpatient Programs Application (RIPA)).

[3] Total Over Timeframes = The number of referrals that are beyond Mental Health Program Guide transfer timeframes: EOP-ASU includes cases in non-hubs waiting > 30 days, PSU includes cases with an original CSR endorsement date > 60 days, MHCB includes referrals > 24 hours, Psychiatric Inpatient includes Intermediate referrals > 30 days and Acute referrals > 10 days.

[4] EOP, EOP-ASU, & PSU may not reflect actual program vacancies because beds can be held vacant for inmate-patients temporarily housed in MHCB and

[5] The numbers for Awaiting Placement and Total Over Timeframes in EOP-ASU, PSU, and Pyschiatric Inpatient may include inmates who cannot transfer due to the following reasons: out-to-court, medical holds, safekeeper status.

[6] CDCR pop as of 10/04/17 (OISB). Based on Total In-State Institution Population and Out of State (COCF).

Exhibit B

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE (H1)

CONFIDENTIAL

Data Refreshed: 3/18/20 6:10 AM

Mental Health Summary by Level of Care

Institution	Correctional Clinical Case Management System (CCCMS)				Enhanced Outpatient Program (EOP)						Mental Health Crisis Bed (MHCB)				Intermediate Care Facility (ICF)				Acute Psychiatric Program (APP)				Total Mental Health Population
	Operational Capacity	Population	% Occupied	Vacant Beds	EOP Operational Capacities: General Population (GP)	EOP Operational Capacities: Administrative Segregation Unit (ASU)	EOP Operational Capacities: Psychiatric Services Unit (PSU)	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	
ASP	1,100	1,074	98 %	26																			1,074
CAL																							
CCC		3		-3																			3
CCI	1,850	1,476	80 %	374				5		-5													1,481
CEN																							
CHCF	550	638	116 %	-88	375	50		574	135 %	-149	78	62	79 %	16	315	342	109 %	-27	219	178	81 %	41	1,794
CIM	1,050	1,131	108 %	-81				35		-35	34	25	74 %	9		4		-4		1		-1	1,196
CMC	750	714	95 %	36	552	100		571	88 %	81	50	28	56 %	22		13		-13		13		-13	1,339
CMF	600	499	83 %	101	391	58		513	114 %	-64	50	27	54 %	23	248	234	94 %	14	218	183	84 %	35	1,456
COR	1,000	931	93 %	69	366	100		273	59 %	193	24	14	58 %	10		4		-4		5		-5	1,227
CRC	1,150	1,519	132 %	-369				2		-2													1,521
CTF	1,500	1,444	96 %	56				2		-2													1,446
CVSP		5		-5																			5
DVI	500	422	84 %	78				5		-5													427
FOL	500	425	85 %	75				1		-1		1		-1									427
HDSP	1,050	1,003	96 %	47				5		-5	10	7	70 %	3									1,015
ISP	0	1		-1																			1
KVSP	900	948	105 %	-48	96			100	104 %	-4	12	7	58 %	5						5		-5	1,060
LAC	1,000	813	81 %	187	600	100		577	82 %	123	12	8	67 %	4		11		-11		6		-6	1,415
MCSP	1,350	1,396	103 %	-46	774	50		720	87 %	104	8	9	113 %	-1		4		-4		1		-1	2,130
NKSP	1,000	895	90 %	105				50		-50	10	6	60 %	4		1		-1		2		-2	954
PBSP	300	282	94 %	18				1		-1	10	1	10 %	9									284
PVSP	700	463	66 %	237				7		-7	6			6									470
RJD	1,500	1,293	86 %	207	894	63		835	87 %	122	14	10	71 %	4		6		-6		1		-1	2,145
SAC	500	526	105 %	-26	642	64	172	769	88 %	109	44	9	20 %	35		10		-10		4		-4	1,318
SATF	2,000	1,911	96 %	89	660			575	87 %	85	20	9	45 %	11		4		-4		6		-6	2,505
SCC	400	522	131 %	-122																			522
SOL	1,000	692	69 %	308				2		-2	9	5	56 %	4									699
SQ	1,250	994	80 %	256	200			291	146 %	-91	0	4		-4	30	27	90 %	3	10	2	20 %	8	1,318
SVSP	850	865	102 %	-15	396			304	77 %	92	10	2	20 %	8	246	243	99 %	3		2		-2	1,416
VSP	1,350	1,078	80 %	272	372			332	89 %	40										1		-1	1,411
WSP	1,300	1,071	82 %	229				60		-60	6	5	83 %	1						1		-1	1,137
DSH-ASH		1		-1				3		-3					256	236	92 %	20		4		-4	244
DSH-CSH															50	47	94 %	3		1		-1	48
Male Subtotal	**27,000**	**25,035**	**93%**	**1,965**	**6,318**	**585**	**172**	**6,612**	**93%**	**463**	**407**	**239**	**59%**	**168**	**1,145**	**1,186**	**104%**	**-41**	**447**	**416**	**93%**	**31**	**33,488**
CCWF	1,350	1,261	93 %	89	120	10		125	96 %	5	12	8	67 %	4						1		-1	1,395
CIW	750	679	91 %	71	75	10	10	64	67 %	31	31	7	23 %	24	43	34	79 %	9		2		-2	786
FWF	150	145	97 %	5				1		-1													146
DSH-PSH		1		-1				2		-2					30	16	53 %	14					19
Female Subtotal	**2,250**	**2,086**	**93%**	**164**	**195**	**20**	**10**	**192**	**85%**	**33**	**43**	**15**	**35%**	**28**	**73**	**50**	**68%**	**23**	**0**	**3**		**-3**	**2,346**
Grand Total	**29,250**	**27,121**	**93%**	**2,129**	**6,513**	**605**	**182**	**6,804**	**93%**	**496**	**450**	**254**	**56%**	**196**	**1,218**	**1,236**	**101%**	**-18**	**447**	**419**	**94%**	**28**	**35,834**

NOTES:

1. This report provides operational capacities, population, and vacant beds detail by mental health level of care and institution. Level of care is based on Current Mental Health level of care code in SOMS. For each level of care, a summary of patients by SOMS housing program and institution is provided. Data Source is HCODS, as of the "Data Refreshed" time stamp.
2. Definitions:
   - Operational Capacity = indicates the number of beds available in the program based on factors such as treatment space and staffing, as determined by CCHCS headquarters.
   - Design Capacity = indicates the total number of beds available in the program Determined by Facility Planning, Construction, & Management.
   - Population = total census per SOMS as of the "Data Refreshed" time stamp shown on the report.
   - % Occupied = ([Population] / [Operational Capacity]) x 100.
   - Vacant Beds = the number of beds available after subtracting the Population from the Operational Capacity.
   - The "PIP" column in the "Psychiatry Inpatient Program (PIP) Housing" refers to programs that have the ability to provide multiple levels of care.
3. PIP capacities:
   - SQ PIP is for male condemned patients only, and has a total capacity of 40 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF, APP, and MHCB level of care.
   - CIW PIP has a total capacity of 45 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
   - DSH-PSH has a total capacity of 30 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
4. Housing Groups:

*GP Housing Group census includes patients in the following housing programs: Camp Program Beds, Debrief Processing Unit, Family Visiting, Fire House, General Population, Institution Hearing Program, Minimum Security Facility, Non-Designated Program Facility, Protective Housing Unit, Restricted Custody General Population, Sensitive Needs Yard, SNY Fire House, SNY MSF, Transitional Housing Unit, Unkown, Varied Use and Work Crew.

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 3/18/20 6:10 AM

Correctional Clinical Case Management System (CCCMS) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total CCCMS Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		1,069								5								1,074
CAL																		
CCC		3																3
CCI		1,447									29							1,476
CEN																		
CHCF		222	7					158		249	2							638
CIM	86	1,003		3						11	28							1,131
CMC		700		1				4			9							714
CMF		450						13	6	17	13							499
COR		630	2					14		3			191				91	931
CRC		1,517								2								1,519
CTF		1,425								10	9							1,444
CVSP		2									3							5
DVI	252	127								9	34							422
FOL		422									3							425
HDSP		935						8									60	1,003
ISP		1																1
KVSP		851						4									93	948
LAC		689	23					2			2						97	813
MCSP		1,365	14								17							1,396
NKSP	708	169		1				1			16							895
PBSP		211						2									69	282
PVSP		445															18	463
RJD		1,264	4					4			21							1,293
SAC		354	33					1			1		42		6		89	526
SATF		1,797	12					5									97	1,911
SCC		515								1	6							522
SOL		680						1			11							692
SQ	213	641						2			6	132						994
SVSP		774	7					3									81	865
VSP		1,059								11	8							1,078
WSP	926	131						3			11							1,071
DSH-ASH		1																1
DSH-CSH																		
Male Subtotal	**2,185**	**20,899**	**102**	**5**	**0**	**0**	**0**	**225**	**6**	**318**	**229**	**132**	**233**	**0**	**6**	**0**	**695**	**25,035**
CCWF	259	910						12			64	16						1,261
CIW		645						2		6	2					24		679
FWF		145																145
DSH-PSH		1																1
Female Subtotal	**259**	**1,701**	**0**	**0**	**0**	**0**	**0**	**14**	**0**	**6**	**66**	**16**	**0**	**0**	**0**	**24**	**0**	**2,086**
Grand Total	**2,444**	**22,600**	**102**	**5**	**0**	**0**	**0**	**239**	**6**	**324**	**295**	**148**	**233**	**0**	**6**	**24**	**695**	**27,121**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 3/18/20 6:10 AM

Enhanced Outpatient Program (EOP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total EOP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI		4									1							5
CEN																		
CHCF			420			2		43		75	34							574
CIM	29	1		1							4							35
CMC		1	519	2				2			47							571
CMF			442	5	4	4		11		10	37							513
COR			213	2				16		5	37							273
CRC		2																2
CTF		2																2
CVSP																		
DVI	3										2							5
FOL		1																1
HDSP		2															3	5
ISP																		
KVSP			87					1									12	100
LAC			502								75							577
MCSP		1	677					1			41							720
NKSP	48										2							50
PBSP																	1	1
PVSP		6															1	7
RJD			796					7			32							835
SAC		1	568					1			64				135			769
SATF		7	554	2				8									4	575
SCC																		
SOL				2														2
SQ	24	19	184					1			3	60						291
SVSP		23	268			1											12	304
VSP		5	323							1	3							332
WSP	58										2							60
DSH-ASH			1			2												3
DSH-CSH																		
Male Subtotal	**162**	**75**	**5,554**	**14**	**4**	**9**	**0**	**91**	**0**	**91**	**384**	**60**	**0**	**0**	**135**	**0**	**33**	**6,612**
CCWF	1	44	65	1				3			11							125
CIW			58				1								5			64
FWF		1																1
DSH-PSH		2																2
Female Subtotal	**1**	**47**	**123**	**1**	**0**	**0**	**1**	**3**	**0**	**0**	**11**	**0**	**0**	**0**	**5**	**0**	**0**	**192**
Grand Total	**163**	**122**	**5,677**	**15**	**4**	**9**	**1**	**94**	**0**	**91**	**395**	**60**	**0**	**0**	**140**	**0**	**33**	**6,804**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 3/18/20 6:10 AM

Mental Health Crisis Bed (MHCB) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total MHCB Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF			1	60						1								62
CIM		1		24														25
CMC				28														28
CMF			2	24							1							27
COR				13				1										14
CRC																		
CTF																		
CVSP																		
DVI																		
FOL											1							1
HDSP				7														7
ISP																		
KVSP				7														7
LAC			1	5							1						1	8
MCSP			2	7														9
NKSP				6														6
PBSP				1														1
PVSP																		
RJD				9							1							10
SAC				7										2				9
SATF				9														9
SCC																		
SOL				5														5
SQ	1		1		2													4
SVSP		2																2
VSP																		
WSP	1			4														5
DSH-ASH																		
DSH-CSH																		
Male Subtotal	**2**	**3**	**7**	**216**	**2**	**0**	**0**	**1**	**0**	**1**	**4**	**0**	**0**	**2**	**0**	**0**	**1**	**239**
CCWF	1	1		6														8
CIW				6				1										7
FWF																		
DSH-PSH																		
Female Subtotal	**1**	**1**	**0**	**12**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**
Grand Total	**3**	**4**	**7**	**228**	**2**	**0**	**0**	**2**	**0**	**1**	**4**	**0**	**0**	**2**	**0**	**0**	**1**	**254**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 3/18/20 6:10 AM

Acute Psychiatric Program (APP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total APP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF				8	167	2		1										178
CIM				1														1
CMC				13														13
CMF				9	169	4		1										183
COR				4				1										5
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP																		
ISP																		
KVSP				5														5
LAC				6														6
MCSP								1										1
NKSP				2														2
PBSP																		
PVSP																		
RJD				1														1
SAC				4														4
SATF				6														6
SCC																		
SOL																		
SQ					2													2
SVSP						2												2
VSP			1															1
WSP				1														1
DSH-ASH					2	2												4
DSH-CSH					1													1
Male Subtotal	0	0	1	60	341	10	0	4	0	0	0	0	0	0	0	0	0	416
CCWF				1														1
CIW				1			1											2
FWF																		
DSH-PSH																		
Female Subtotal	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	3
Grand Total	0	0	1	62	341	10	1	4	0	0	0	0	0	0	0	0	0	419

Exhibit C

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE (H1)

CONFIDENTIAL

Data Refreshed: 8/19/20 6:08 AM

Mental Health Summary by Level of Care

Institution	Correctional Clinical Case Management System (CCCMS)				Enhanced Outpatient Program (EOP)						Mental Health Crisis Bed (MHCB)				Intermediate Care Facility (ICF)				Acute Psychiatric Program (APP)				Total Mental Health Population
	Operational Capacity	Population	% Occupied	Vacant Beds	EOP Operational Capacities: General Population (GP)	Administrative Segregation Unit (ASU)	Psychiatric Services Unit (PSU)	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	
ASP	1,100	859	78 %	241				8		-8		3		-3									870
CAL		23		-23				1		-1		2		-2									26
CCC																							
CCI	1,850	1,167	63 %	683				13		-13		1		-1									1,181
CEN		29		-29																			29
CHCF	550	615	112 %	-65	375	50		557	131 %	-132	98	7	7 %	91	356	356	100 %	0	158	67	42 %	91	1,602
CIM	1,050	742	71 %	308				34		-34	34	8	24 %	26		17		-17		4		-4	805
CMC	750	637	85 %	113	552	100		555	85 %	97	50	21	42 %	29		18		-18		9		-9	1,240
CMF	600	431	72 %	169	391	58		483	108 %	-34	50	16	32 %	34	257	235	91 %	22	207	142	69 %	65	1,307
COR	1,000	1,010	101 %	-10	366	100		265	57 %	201	24	7	29 %	17		11		-11		14		-14	1,307
CRC	1,150	863	75 %	287				2		-2		1		-1									866
CTF	1,500	1,100	73 %	400				8		-8		1		-1									1,109
CVSP		3		-3																			3
DVI	500	293	59 %	207				1		-1													294
FOL	500	434	87 %	66				6		-6													440
HDSP	1,050	1,013	96 %	37				18		-18	10	1	10 %	9									1,032
ISP	0	28		-28								2		-2									30
KVSP	900	1,000	111 %	-100	96			126	131 %	-30	12	3	25 %	9		10		-10		1		-1	1,140
LAC	1,000	756	76 %	244	600	100		531	76 %	169	12	5	42 %	7		33		-33		6		-6	1,331
MCSP	1,350	1,446	107 %	-96	774	50		637	77 %	187	8	8	100 %	0		7		-7		3		-3	2,101
NKSP	1,000	341	34 %	659				21		-21	10			10		4		-4					366
PBSP	300	254	85 %	46				4		-4	10	1	10 %	9									259
PVSP	700	474	68 %	226				8		-8	6	1	17 %	5									483
RJD	1,500	1,296	86 %	204	894	63		790	83 %	167	14	4	29 %	10		11		-11		6		-6	2,107
SAC	500	455	91 %	45	642	64	172	725	83 %	153	44	15	34 %	29		33		-33		21		-21	1,249
SATF	2,000	1,691	85 %	309	660			461	70 %	199	20	4	20 %	16		18		-18		3		-3	2,177
SCC	400	474	119 %	-74				1		-1													475
SOL	1,000	599	60 %	401				4		-4	9	2	22 %	7									605
SQ	1,250	807	65 %	443	200			233	117 %	-33	0	5		-5	31	27	87 %	4	9	8	89 %	1	1,080
SVSP	850	807	95 %	43	396			360	91 %	36	10	7	70 %	3	246	182	74 %	64		1		-1	1,357
VSP	1,350	998	74 %	352	372			277	74 %	95		2		-2		1		-1		1		-1	1,279
WSP	1,300	582	45 %	718				26		-26	6	1	17 %	5		5		-5		1		-1	615
DSH-ASH		1		-1				3		-3		1		-1	256	187	73 %	69		2		-2	194
DSH-CSH															50	41	82 %	9					41
Male Subtotal	**27,000**	**21,228**	**79%**	**5,772**	**6,318**	**585**	**172**	**6,158**	**87%**	**917**	**427**	**129**	**30%**	**298**	**1,196**	**1,196**	**100%**	**0**	**374**	**289**	**77%**	**85**	**29,000**
CCWF	1,350	990	73 %	360	120	10		91	70 %	39	12	2	17 %	10		2		-2		1		-1	1,086
CIW	750	558	74 %	192	75	10	10	51	54 %	44	29	3	10 %	26	45	26	58 %	19		4		-4	642
FWF	150	77	51 %	73																			77
DSH-PSH		1		-1				2		-2					30	8	27 %	22					11
Female Subtotal	**2,250**	**1,626**	**72%**	**624**	**195**	**20**	**10**	**144**	**64%**	**81**	**41**	**5**	**12%**	**36**	**75**	**36**	**48%**	**39**	**0**	**5**		**-5**	**1,816**
Grand Total	**29,250**	**22,854**	**78%**	**6,396**	**6,513**	**605**	**182**	**6,302**	**86%**	**998**	**468**	**134**	**29%**	**334**	**1,271**	**1,232**	**97%**	**39**	**374**	**294**	**79%**	**80**	**30,816**

NOTES:

1. This report provides operational capacities, population, and vacant beds detail by mental health level of care and institution. Level of care is based on Current Mental Health level of care code in SOMS. For each level of care, a summary of patients by SOMS housing program and institution is provided. Data Source is HCODS, as of the "Data Refreshed" time stamp.
2. Definitions:
   - Operational Capacity = indicates the number of beds available in the program based on factors such as treatment space and staffing, as determined by CCHCS headquarters.
   - Design Capacity = indicates the total number of beds available in the program Determined by Facility Planning, Construction, & Management.
   - Population = total census per SOMS as of the "Data Refreshed" time stamp shown on the report.
   - % Occupied = ([Population] / [Operational Capacity]) x 100.
   - Vacant Beds = the number of beds available after subtracting the Population from the Operational Capacity.
   - The "PIP" column in the "Psychiatry Inpatient Program (PIP) Housing" refers to programs that have the ability to provide multiple levels of care.
3. PIP capacities:
   - SQ PIP is for male condemned patients only, and has a total capacity of 30 beds reflected under ICF capacity. It is noted that these are flex beds that can accommodate ICF, APP, and MHCB level of care.
   - CIW PIP has a total capacity of 45 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
   - DSH-PSH has a total capacity of 30 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
4. Housing Groups:

*GP Housing Group census includes patients in the following housing programs: Camp Program Beds, Debrief Processing Unit, Family Visiting, Fire House, General Population, Institution Hearing Program, Minimum Security Facility, Non-Designated Program Facility, Protective Housing Unit, Restricted Custody General Population, Sensitive Needs Yard, SNY Fire House, SNY, MSF, Transitional Housing Unit, Unkown, Varied Use and Work Crew.

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 8/19/20 6:08 AM

Correctional Clinical Case Management System (CCCMS) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total CCCMS Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		853								6								859
CAL		14									9							23
CCC																		
CCI		1,105									52			10				1,167
CEN		18									11							29
CHCF		197	14	3				150		244	7							615
CIM	33	645		1						14	49							742
CMC		613	1					3			20							637
CMF		390	2	1				12	3	16	7							431
COR		778	24					12		6			87				103	1,010
CRC		860								3								863
CTF		1,079								6	15							1,100
CVSP		2									1							3
DVI	73	190								11	19							293
FOL		421									13							434
HDSP		955						6									52	1,013
ISP		28																28
KVSP		910	1					3									86	1,000
LAC		624	22								3						107	756
MCSP		1,408	14								24							1,446
NKSP	162	160						3			16							341
PBSP		207						1									46	254
PVSP		466															8	474
RJD		1,228	13					4			51							1,296
SAC		327	28					1			6		36	2	7		48	455
SATF		1,638	1					7									45	1,691
SCC		456									18							474
SOL		574						2			23							599
SQ	95	553						5			25	129						807
SVSP		716	7			1		6			11						66	807
VSP		970								10	18							998
WSP	438	119						3			22							582
DSH-ASH		1																1
DSH-CSH																		
Male Subtotal	**801**	**18,505**	**127**	**5**	**0**	**1**	**0**	**218**	**3**	**316**	**420**	**129**	**123**	**12**	**7**	**0**	**561**	**21,228**
CCWF	75	826						18			57	14						990
CIW		527						2		7	12					10		558
FWF		77																77
DSH-PSH		1																1
Female Subtotal	**75**	**1,431**	**0**	**0**	**0**	**0**	**0**	**20**	**0**	**7**	**69**	**14**	**0**	**0**	**0**	**10**	**0**	**1,626**
Grand Total	**876**	**19,936**	**127**	**5**	**0**	**1**	**0**	**238**	**3**	**323**	**489**	**143**	**123**	**12**	**7**	**10**	**561**	**22,854**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 8/19/20 6:08 AM

Enhanced Outpatient Program (EOP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total EOP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		6								2								8
CAL		1																1
CCC																		
CCI		12									1							13
CEN																		
CHCF			372	6	1	29		42		86	21							557
CIM	6	24									4							34
CMC		10	489					2			54							555
CMF			411	7	8	6		11	2	5	33							483
COR		6	187					17		3	52							265
CRC		2																2
CTF		8																8
CVSP																		
DVI	1																	1
FOL		5									1							6
HDSP		8															10	18
ISP																		
KVSP		10	90					1									25	126
LAC		5	460								66							531
MCSP		9	576					1			51							637
NKSP	17										4							21
PBSP		3															1	4
PVSP		7															1	8
RJD		2	743					7			38							790
SAC		4	531								55		14		121			725
SATF		15	418					7									21	461
SCC											1							1
SOL		1									3							4
SQ	12	41	106					1			12	61						233
SVSP		28	291			6					1						34	360
VSP		15	258							1	3							277
WSP	21										5							26
DSH-ASH			1			2												3
DSH-CSH																		
Male Subtotal	**57**	**222**	**4,933**	**13**	**9**	**43**	**0**	**89**	**2**	**97**	**405**	**61**	**14**	**0**	**121**	**0**	**92**	**6,158**
CCWF	1	32	54								4							91
CIW			49												2			51
FWF																		
DSH-PSH		2																2
Female Subtotal	**1**	**34**	**103**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**	**0**	**0**	**2**	**0**	**0**	**144**
Grand Total	**58**	**256**	**5,036**	**13**	**9**	**43**	**0**	**89**	**2**	**97**	**409**	**61**	**14**	**0**	**123**	**0**	**92**	**6,302**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 8/19/20 6:08 AM

Mental Health Crisis Bed (MHCB) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total MHCB Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP										3								3
CAL										2								2
CCC																		
CCI		1																1
CEN																		
CHCF				7														7
CIM				8														8
CMC				21														21
CMF				16														16
COR				7														7
CRC										1								1
CTF											1							1
CVSP																		
DVI																		
FOL																		
HDSP				1														1
ISP										2								2
KVSP				3														3
LAC				5														5
MCSP			1	6							1							8
NKSP																		
PBSP																	1	1
PVSP		1																1
RJD			2	2														4
SAC				15														15
SATF			1	3														4
SCC																		
SOL				2														2
SQ			1		2		2											5
SVSP				7														7
VSP		2																2
WSP				1														1
DSH-ASH				1														1
DSH-CSH																		
Male Subtotal	**0**	**4**	**5**	**105**	**2**	**0**	**2**	**0**	**0**	**8**	**2**	**0**	**0**	**0**	**0**	**0**	**1**	**129**
CCWF				2														2
CIW				3														3
FWF																		
DSH-PSH																		
Female Subtotal	**0**	**0**	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**
Grand Total	**0**	**4**	**5**	**110**	**2**	**0**	**2**	**0**	**0**	**8**	**2**	**0**	**0**	**0**	**0**	**0**	**1**	**134**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 8/19/20 6:08 AM

Intermediate Care Facility (ICF) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total ICF Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF					45	309		1		1								356
CIM				17														17
CMC		2	6	7							3							18
CMF			1	7	27	198		1			1							235
COR			7								4							11
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP																		
ISP																		
KVSP			6	3													1	10
LAC			18	1							14							33
MCSP			5								2							7
NKSP	2			2														4
PBSP																		
PVSP																		
RJD			3	6							2							11
SAC			15	1							5				12			33
SATF		2	10	5													1	18
SCC																		
SOL																		
SQ					5		22											27
SVSP			2			180												182
VSP			1															1
WSP	3										2							5
DSH-ASH		1	38	28	72	46		1		1								187
DSH-CSH		1	13	7	15	5												41
Male Subtotal	**5**	**6**	**125**	**84**	**164**	**738**	**22**	**3**	**0**	**2**	**33**	**0**	**0**	**0**	**12**	**0**	**2**	**1,196**
CCWF											2							2
CIW							26											26
FWF																		
DSH-PSH		4	1				3											8
Female Subtotal	**0**	**4**	**1**	**0**	**0**	**0**	**29**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
Grand Total	**5**	**10**	**126**	**84**	**164**	**738**	**51**	**3**	**0**	**2**	**35**	**0**	**0**	**0**	**12**	**0**	**2**	**1,232**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 8/19/20 6:08 AM

Acute Psychiatric Program (APP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total APP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF				3	60	4												67
CIM				4														4
CMC				9														9
CMF			1	3	136	1		1										142
COR				14														14
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP																		
ISP																		
KVSP				1														1
LAC				6														6
MCSP			1	2														3
NKSP																		
PBSP																		
PVSP																		
RJD				6														6
SAC				20				1										21
SATF				3														3
SCC																		
SOL																		
SQ					2	1	5											8
SVSP						1												1
VSP																		1
WSP				1														1
DSH-ASH					2													2
DSH-CSH																		
Male Subtotal	0	0	2	72	200	7	5	2	0	0	0	0	0	0	0	0	0	289
CCWF				1														1
CIW							4											4
FWF																		
DSH-PSH																		
Female Subtotal	0	0	0	1	0	0	4	0	0	0	0	0	0	0	0	0	0	5
Grand Total	0	0	2	73	200	7	9	2	0	0	0	0	0	0	0	0	0	294

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IN THE UNITED STATES DISTRICT COURT

FOR EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 2:90-cv-00520 KJM-DB (PC)

DECLARATION OF ROMAN M. SILBERFELD

Judge: The Hon. Kimberly J. Mueller

I, Roman M. Silberfeld, declare as follows:

1. I am special counsel to the defendants in this matter. I am familiar with the Court's recent orders and, in particular, the Court's July 30, 2020 order setting a briefing and hearing schedule regarding staffing and compliance with prior court orders that pertain to staffing levels. When I became aware of the Court's July 30, 2020 order, and specifically the reference in that order to a possible population reduction, I began to consider the extent to which the preparation of evidence for the September 10, 2020 hearing would involve the use of expert testimony.

2. I conducted an immediate search of the relevant scientific, social and medical literature pertaining to the provision of mental health services to an inmate population. I also considered the recent literature about the effects of the pandemic on the provision of both mental and medical care to an inmate population. I also reviewed the relevant literature pertaining to the provision of mental health care through the use of telepsychiatry methods. I conducted these reviews for the purpose of trying to identify individuals and firms with deep knowledge of these issues who might act as experts on behalf of the defendants in this matter. Over the course of the last two weeks, I identified a number of qualified individuals who could act as experts. Some of my contacts were logistically unavailable such as a group of researchers in the United Kingdom. Other experts that I contacted had conflict of interest issues involving prior work on this matter that could not be overcome. Others had time restrictions and project commitments that prevented their participation on behalf of the defendants in a timely manner.

3. Between August 14 and 18, I held a series of conference calls and emails with an expert group that, in my opinion, can adequately address all of the issue raised by the Court's July 30. 2020 order. I have retained this group to act as expert consultants, and perhaps expert witnesses, on behalf of the defendants in this matter. My conversations with this expert group about the scope of work and the tasks to be accomplished makes clear that neither this group, nor any group, can adequately prepare for the briefing due on August 31, 2020 or the hearing on September 10, 2020. The inability to prepare is not merely a function of the fact that the Court provided only 32 days' notice of the briefing and 42 days' notice of the hearing. While these compressed time frames alone are a sufficient reason to not require briefing or hold a hearing at this time, there are equally compelling reasons that are not date or time dependent which compel the conclusion that the briefing and hearing contemplated by the Court's July 30, 2020 order should not take place until such time as the pandemic effects are sufficiently ameliorated so that the defendants, and its experts, can conduct an adequate review of systems, programs, practices and policies to present the defense perspective respecting the Court's order. More specifically, I'm informed that the preparation by our experts will necessarily involve three work streams that simply cannot be conducted within a 30-day time period. The first is data gathering through

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document requests; second is staff and all stakeholder interviews and third, are tours of facilities to observe programs, operations, processes, and evaluate the physical plant status of various state institutions. Given the physical access restrictions imposed by CDCR and DSH, it is simply impossible to conduct tours of certain locations. Similarly, because of individual health issues and concerns, our experts are unable to travel to visit locations, even if those locations were open and available to them. For these reasons, the Court should grant the relief sought in this motion and defer both the briefing and hearing until such time as the pandemic effects are sufficiently abated to allow normal operations to resume which, in turn, will allow the defendants to prepare a proper defense presentation through their own witnesses and experts to address the concerns expressed in the Court's July 30, 2020 order.

4. The scale and scope of the expert consultation contemplated by the Court's July 30, 2020 order also provides an ample reason to put the briefing and hearing off for a substantial period of time. While it is true that the parties have been aware of the Court's intention to conduct a staffing hearing [such as the hearing that had been set for April 23, 2020], the first mention of population reduction as a means of potentially addressing staffing concerns occurred in the July 30, 2020 order. That reference, especially in view of the three judge court proceedings conducted earlier this year, came as a complete surprise to the defendants and we have moved expeditiously to address the Court's concerns since receiving that order. In this regard, we believe that a fair and full presentation of evidence in both the briefing responsive to the Court's questions and a hearing thereon necessarily involves the consideration of at least the following topics:

- Current and historical staffing ratios
- Current and historical efforts, methods, incentives and programs to hire additional psychiatrists
- The effect of telepsychiatry
- The effects of the pandemic
- The 10% hiring vacancy figure
- The performance of CDCR compared to other state prison systems

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- The public safety impact of a population release
- The community safety net impact of a population release
- The efficiency and efficacy of CDCR operations with its current staffing levels
- The application of national prison operations best practices
- Whether CDCR clinicians are currently and historically meeting the needs of the Coleman class population

5. These topics are weighty matters and require time and processes to be completed appropriately, none of which currently can be conducted in the pandemic environment in which the country, state and CDCR find themselves. For each and all of these reasons, the briefing and hearing schedule set forth in the Court's July 30, 2020 order should be stayed or taken off calendar until such time as the pandemic effects abate sufficiently to allow a semblance of normal operations to resume.

6. We met and conferred with Plaintiffs' counsel regarding a 60-day continuance of the dates contemplated by the Court's order. Plaintiffs' counsel refused to agree to an extension. As we retained our expert group and further analyzed the motion, we determined that a longer continuance was necessary and that a further meet and confer would be futile. This motion follows the failure of that meet and confer process.

7. The facts set forth herein are personally known to me and I could and would testify thereto if called upon to do so.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed in Los Angeles, California on August 21, 2020.

By: /s/ *Roman M. Silberfeld*
ROMAN M. SILBERFELD

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