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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

DARRYL DUNSMORE, ANDREE ANDRADE, ERNEST ARCHULETA, JAMES CLARK, ANTHONY EDWARDS, REANNA LEVY, JOSUE LOPEZ, CHRISTOPHER NORWOOD, JESSE OLIVARES, GUSTAVO SEPULVEDA, MICHAEL TAYLOR, and LAURA ZOERNER, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

SAN DIEGO COUNTY SHERIFF'S DEPARTMENT, COUNTY OF SAN DIEGO, SAN DIEGO COUNTY PROBATION DEPARTMENT, and DOES 1 to 20, inclusive,

Defendants.

Case No. 3:20-cv-00406-AJB-DDL

DECLARATION OF PABLO STEWART IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION TO LIMIT ADMINISTRATIVE SEPARATION FOR CLASS MEMBERS WITH SERIOUS MENTAL ILLNESS

Judge: Hon. Anthony J. Battaglia

Date: November 20, 2025
Time: 2:00 p.m.
Crtrm.: 4A

Redacted

I, Pablo Stewart, M.D., declare:

1. I am a board-certified Psychiatrist and Clinical Professor at the University of Hawaii, John A. Burns School of Medicine, and have extensive background and experience in the provision of mental health care in detention settings. My curriculum vitae is attached hereto as **Exhibit A**. I have more than 35 years of experience in correctional mental health care, including serving as the court's expert in class action cases challenging the provision of mental health care to incarcerated people. I have served as amicus curiae for the First Circuit on the issue of solitary confinement in *Cintron v. Bibeault*, No. 22-1716 (May 10, 2023). I make this declaration in support of Plaintiffs' Motion for Preliminary Injunction to Limit Administrative Separation for Class Members with Serious Mental Illness.

2. I have been asked to provide my opinion regarding the policies and practices of the County of San Diego, the San Diego County Sheriff's Office ("SDSO"), and their agents as they relate to the provision of mental health care to incarcerated people in the San Diego County Jail (the "Jail"). To that end, I inspected three of San Diego's jail facilities in February 2024: San Diego Central Jail ("Central"), George Bailey Detention Facility ("George Bailey"), and Las Colinas Detention and Reentry Facility ("Las Colinas"). During my inspections, I spoke to numerous individuals with serious mental illness in the Administrative Separation units at the three facilities. The Administrative Separation units at Vista Detention Facility ("Vista") appear to follow a similar practice to the other three jails I inspected, at least as described in the declarations I received.

3. I also reviewed numerous documents regarding the provision of mental health care in the San Diego jails, including SDSO policies and procedures and medical records of *Dunsmore* class members. I then prepared a Rule 26(a) report that I am informed and believe was served on August 21, 2024 as well as a rebuttal report that I am informed and believe was served on October 31, 2024. These reports have been previously filed in connection with Plaintiffs' Opposition to

Defendants' Motion for Partial Summary Judgment and can be found at Dkt. No. 937-5, Ex. 1 and 937-5, Ex. 2. I incorporate them here by reference. I also submitted a declaration in support of Plaintiffs' Motion for Preliminary Injunction, dated April 30, 2022, Dkt. 119-7, which I incorporate here by reference. I was deposed by Defendants' counsel on November 20, 2024. On August 29, 2025, I am informed and believe that Plaintiffs served a supplemental report describing new medical records and information provided to me. A true and correct copy of that report, which I incorporate by reference, is attached hereto as **Exhibit B**.

4. Most recently, I was provided with documentation related to two horrific in-custody deaths of individuals with mental illness housed in solitary confinement, euphemistically referred to by the Sheriff as Administrative Separation. These documents included 649 pages of medical records provided by the San Diego Sheriff's Office to the family of Corey Dean, three declarations regarding the July 13, 2025 death of Corey Dean by incarcerated witnesses, and psychiatric records from Corey Dean's time in the San Diego community dated 2014 to 2020. I also received five declarations from incarcerated witnesses regarding the July 28, 2025 death of Karim Talib at Central Jail. I have requested medical records for Mr. Talib. I would also like to review the autopsy reports and any incident reports or logs related to the deaths of these two men.

5. I was also provided declarations from 14 individuals currently or recently housed in Administrative Separation units at the Jail, as follows:

- Christopher Hawkins 25710758 – Administrative Separation at Central (Unit 6/E) since approximately March 2025 **(approximately 6 months)**
- David Thomas 25702881 – Administrative Separation at Central (Unit 4/E) from approximately late February to early May 2025 **(over 2 months)**; Outpatient Step Down Unit at George Bailey (Unit 4/B) from approximately early May to mid-September 2025
- Ismael Betancourt 20944974 – Administrative Separation at George Bailey (Units 5/A, 5/B, and 6/A), Central (Units 4/E, 5/E, and 7D), and Vista (Unit E/3) since approximately July 2021 **(over 4 years and 2 months)**

- Jaelin Kearse 25709948 – Administrative Separation at Las Colinas (Unit 5/A) since approximately early June 2025 **(over 3 months)**
- Julio Serrano 25701924 – Administrative Separation at Vista (Unit E/3) from approximately mid-January to early August 2025; Administrative Separation at George Bailey (Unit 6/C) since approximately early August 2025 **(over 8 months)**
- Keith Sekerke 25731708 – Administrative Separation at Vista (Unit E/2) since approximately August 16, 2025 **(over 1 month)**
- Keona Smith 25730064 – Administrative Separation at Las Colinas (Unit 5/A) since approximately mid-July 2025 **(over 2 months)**
- Larry Millete 21140844 – Administrative Separation at Vista (Unit E/3, "the hole") from early July to late December 2023 **(over 5 months)**; Administrative Separation at George Bailey (Units 4/A and 4/C) starting late October 2024 **(for approximately 7 months)**
- Miguel Altamirano 25706406 – Administrative Separation at Vista (Unit E/4) from approximately mid-February to mid-August 2025 **(approximately 6 months**)
- Owerrie Bacon, Jr. 25724908 – Administrative Separation at George Bailey (Units 5/A, 5/B, and 5/C) in 2023 **(approximately 1 year)**; state hospital in 2024; Administrative Separation at Central (Unit 7/E) from approximately June to mid-September 2025; Administrative Separation at George Bailey (Unit 5/A) since approximately mid-September 2025 **(over 3 months)**
- Patrick Kelley 24746771 – state hospital or medical unit for most of 2023 and 2024; restricted housing at Central (Unit 7/D) from approximately November 2024 to mid-August 2025; Administrative Separation at Central (Units 4/E and 5/E) since approximately mid-August 2025 **(over 1 month)**
- Raymond Molina 25726269 – Administrative Separation at Vista ("the hole" and Unit E/4) from approximately late June to mid-August 2025 **(over 1 month)**
- William Sterling 24719410 – Administrative Separation at George Bailey (Units 5/A and 5/B) from approximately May to September 2024; Administrative Separation at Vista (Units E/2 and E/3) from approximately September 2024 to March 2025; Administrative Separation at George Bailey (Unit 6/A) from approximately March to May 2025; Administrative Separation at Vista (Unit E/2) from approximately May to July 2025; Administrative Separation at George Bailey (Unit 6/C) from approximately July to September 2025 **(approximately 1 year and 4 months)**
- Yolanda Marodi 25712651 – Administrative Separation at Las Colinas (Unit 5/A) since approximately early August 2025 **(over 1 month)**.

6. I was also provided the following jail policies and procedures:

- SDSO Detention Services Bureau Policy J.3 (Separation: Definition and Use)
- SDSO Detention Services Bureau Policy I.64 (Safety Checks: Housing and Holding Areas of Incarcerated Persons)
- SDSO Detention Services Bureau Policy T.11 (Exercise and Recreation)
- SDSO Medical Services Division Operations Manual Policy G.2.1 (Segregated Inmates)

Summary of My Opinions

7. As I explained in my Rule 26 report, I am deeply troubled by San Diego County's widespread and extreme use of solitary confinement-type housing for incarcerated persons with serious mental illness, with conditions that are extraordinarily restrictive, harsh, and damaging to a person's mental health—particularly for someone with preexisting, serious mental illness. As discussed in my reports and prior declaration, the County's practice of housing individuals with serious mental illness in solitary confinement is counter therapeutic and inconsistent with current correctional standards and scientific research. San Diego County's jail system does not come close to complying with the guidance set forth by the United States Department of Justice, the United Nations, the National Commission on Correctional Health Care ("NCCHC") and respected medical groups, or with recommendations that have been made repeatedly by parties inside and outside of the County. My inspection of the jail system's solitary confinement-type units, my interactions with incarcerated persons with serious mental illness in those units, and my review of records, declarations, and documents all point to the conclusion that the San Diego County Jail's system of Administrative Separation has caused, and currently is causing, serious and unjustified harm on a broad scale, up to and including death.

8. In fact, the conditions in San Diego's Administrative Separation units constitute some of the harshest, most restrictive forms of solitary confinement I have ever witnessed in a jail system. This is confirmed by the horrific deaths that have

occurred in Administrative Separation since January 1, 2021, including Lonnie Rupard who wasted away in Administrative Separation Unit, and whose death was labeled a homicide by San Diego's medical examiner, as well as three other individuals with serious mental illness who died by suicide in the Administrative Separation Units in May 2021 (Lester Marroquin), August 2022 (Matthew Settles), and July 2023 (Jonathan McDowell), as discussed in my prior reports and below. The testimony of individuals currently incarcerated in Administrative Separation show that the conditions continue to violate the standard of care, making it inevitable that additional individuals will die in these units, as occurred in July of this year. It is my opinion that San Diego should immediately stop the practice of placing individuals with serious mental illness in Administrative Separation units, absent exigent circumstances, and then only for a period not to exceed 72 hours and with significant safeguards in place.

San Diego County Jail's Administrative Separation Units are Solitary Confinement and are Regularly Used to House Individuals with Serious Mental Illness

9. As explained in my August 21, 2024 report, conditions in the San Diego County Jail's Administrative Separation units are among the harshest and most restrictive forms of solitary confinement I have seen in over 35 years of practice. See Dkt. 937-5 at ECF pp. 73-84. The Jail has only a few relevant policies, SDSO Detention Services Bureau Policy J.3 (Separation: Definition and Use) and SDSO Medical Services Division Operations Manual Policy G.2.1 (Segregated Inmates), which are wholly inadequate to protect individuals with serious mental illness from the harms of solitary confinement. *See* Dkt. 119-7 at ECF pp. 15-17.

10. By policy, incarcerated people in San Diego County Jail, including in the Administrative Separation units, are afforded 10 hours of out-of-cell time distributed over a period of seven days. *See* SDSO Detention Services Bureau Policy T.11 (Exercise and Recreation). My understanding is that, in practice, people in Administrative Separation are locked down much more than that; they are often

not permitted to leave their cells for over 23 hours per day and sometimes even 24 hours per day. Often, they are let out after daylight hours, including in the middle of night, such that they are unable to contact outside individuals by phone. This is even more restrictive than units deemed solitary confinement in other carceral systems, where individuals generally spend 22-23 hours each day in their cell, as explained in a 2023 amicus brief which I joined.[1]

11. The Administrative Separation cells that I inspected at George Bailey and Central ranged from approximately 70 to 75 square feet in size. This is typical of solitary confinement units in other carceral settings I have observed. I am informed that the Administrative Separation cells at Vista are similar in size. As is common generally with cells designed for solitary confinement, the Administration Separation cells at the facilities I inspected were generally constructed of concrete and lacked access to or a view of natural surroundings or natural light.

12. As is typical in solitary confinement, incarcerated people in San Diego County Jail Administrative Separation units are deprived of mental stimulation or any means of distracting themselves and passing the time. To my knowledge, the County fails to provide structured out-of-cell programming, such as group therapy, to individuals in Administrative Separation. They are also denied the kind of in-cell stimulation that would be provided by books, workbooks, radios, or tablets. In some San Diego County Jail Administrative Separation units, incarcerated people spend their brief out of cell time alone in a caged area in the dayroom. This does not provide opportunities for meaningful human contact.

13. Like other people in the Jails, individuals in Administrative Separation are rarely allowed contact visits with outside individuals. When in-person visits do occur, they are generally only permitted through glass partitions and over phones.

[1] Brief for Amici Curiae Terry Kupers, Craig Haney, Pablo Stewart, and Stuart Grassian in Support of Plaintiff-Appellee and Affirmance, *Cintron v. Bibeault*, 1st Cir. No. 22-1716 (May 10, 2023).

This is consistent with the practices of solitary confinement units in other institutions. The declarations I reviewed also confirmed that individuals in Administrative Separation are allotted only short periods of time on the phone (i.e., when they are permitted out of their cell), and often are unable to have meaningful human contact through the phones because they are let out after daylight hours.

14. As explained in the *Cintron* amicus brief, *supra*, note 1, solitary confinement magnifies the damage from underexposure to positive stimuli by overexposing individuals to negative stimuli such as the shouting of officers and incarcerated people, banging of heavy doors, pounding on walls, and foul smells. This causes individuals to experience intensified psychiatric symptoms and suffer from frequent, or even chronic, sleeplessness. My observations from the inspections as well as the incarcerated person testimony I reviewed have made clear that individuals housed in the San Diego County Jail Administrative Separation units regularly experience these symptoms.

15. The declarations I reviewed also confirm that individuals in Administrative Separation units are often required to wear restraints such as leg shackles, wrist chains, and waist chains when they leave their living space. This is consistent with practices of solitary confinement units in other institutions and contributes to a state of hypervigilance. The practice is in fact even more extreme at San Diego County Jail, where people are put in restraints when they are moved not just outside the housing unit, but even between their cell and the caged area in the dayroom. I spoke with some individuals who chose not to leave their cell, ever; they told me that the restraints are simply too painful and/or dehumanizing.

16. As a result of mental health decompensation, many incarcerated people in Administrative Separation live in cells filled with urine, feces, and food waste. The declarations I reviewed demonstrated that staff members often do not provide assistance in cleaning the cells, and often do not provide cleaning supplies so that incarcerated people can clean their own cells.

17. Having reviewed declarations, policies, reports, and other relevant documents provided to me, and also having visited three of the four San Diego jails with Administrative Separation housing units, I can confirm that these units constitute solitary confinement-type conditions, including as has been defined by the United States Department of Justice ("U.S. DOJ"). *Report and Recommendations Concerning the Use of Restrictive Housing* at 3 (Jan. 2016), available at https://www.justice.gov/dag/file/815551/dl (restrictive housing-type segregation is characterized by (1) "Removal from the general inmate population, whether voluntary or involuntary"; (2) "Placement in a locked room or cell, whether alone or with another inmate"; and (3) "Inability to leave the room or cell for the vast majority of the day, typically 22 hours or more").[2]

18. Further compounding the harsh conditions in those units, the County fails to provide mental health treatment or supports that are urgently and clearly necessary to meet the needs of the incarcerated population with mental illness. As explained in my August 2024 report, confidential, out-of-cell clinical contacts are rare for incarcerated people in Administrative Separation. Rather, the vast majority of mental health contacts for those in Administrative Separation are quick, cell-front conversations with Sheriff's deputies present, consisting of a few cursory questions about how the person is sleeping and feeling. The recent declarations from incarcerated people provided to me confirm that the practices documented in my August 2024 report are still in effect. Such brief, non-confidential interactions do not constitute mental health care, much less adequate mental health care for this

[2] SDSO Medical Services Division Policy G.2.1 falsely claims that it does not practice solitary confinement, which it defines as "segregation where an inmate is isolated and encounters staff or other inmates fewer than three times a day." First, it is likely that many incarcerated people do not encounter staff or other incarcerated people three or four times per day based on the declarations I have reviewed. Regardless, the narrow definition espoused by policy G.2.1 is not consistent with the United States Department of Justice and other well-regarded entities defining solitary confinement, as discussed above.

vulnerable population.

19. As explained in my August 2024 report, the County fails to conduct timely and appropriate psychiatric follow-up appointments for those on psychiatric medications. This failure is particularly dangerous in the Administrative Separation units at the Jail. I have never seen such poor psychiatric care provided to people in restrictive housing units in any other correctional system.

20. The County also fails to conduct safety checks in its Administrative Separation units every 30 minutes at irregular intervals, and instead conducts them only once every 60 minutes. *See* SDSO Detention Services Bureau Policy I.64 (Safety Checks: Housing and Holding Areas of Incarcerated Persons).[3] As I have explained in my prior declaration and reports, conducting safety checks at least every 30 minutes in staggered, irregular intervals, is a basic, common-sense, and standards-based practice that can save lives in solitary confinement settings. Conducting safety checks in Administrative Separation only hourly constitutes an unacceptable failure to implement an established safeguard to address the significant danger that people, especially people with mental illness, face in those units.

21. This danger is exacerbated because, to my knowledge, the Jail fails to adequately track which individuals in the Administrative Separation units have serious mental illness and how long they have been in the units. The declarations provided to me from currently incarcerated individuals suggest that their time in Administrative Separation has been significant. Shockingly long stays in Administrative Separation is also reflected in the medical records I reviewed, such as that of Christopher Hawkins, who is discussed in my supplemental report, Ex. B at 12-13, and who I understand to be currently in Administrative Separation at Central Jail. The longer a person is subjected to these conditions, the more likely

[3] As noted in my Rule 26 report, the State Auditor and others have criticized the manner in which San Diego conducts safety checks as well. Dkt. 937-5 at ECF pp. 126-129.

they are to experience a deterioration in their mental health and the more they are at risk of substantial harm, up to and including death. Yet without any mechanism for tracking the individuals most at risk and their length of stay, the Jail is further hampered in its ability to address and potentially mitigate the effects of solitary confinement.

San Diego's Use of Solitary Confinement for Incarcerated People with Serious Mental Illness is Dangerous and Deadly

22. As I have previously stated in my declaration and reports in this case, it is now widely accepted that people with serious mental illness should not be placed in solitary confinement-type conditions. In such settings, they are exceedingly vulnerable to deterioration and decompensation of their mental health conditions, intensification of their symptoms, and at substantial risk of psychosis, self-harm, and suicide. Dkt. 937-5 at ECF pp. 70-71.

23. Serious mental illness is a subset of mental illness. The American Psychiatric Association has defined this condition as follows: "Serious mental illness is a mental, behavioral or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Examples of serious mental illness include major depressive disorder, schizophrenia and bipolar disorder." *See* https://www.psychiatry.org/patients-families/what-is-mental-illness.

24. Placing people with serious mental illness in solitary confinement can and likely will worsen their mental health symptoms, including but not limited to increased feelings of depression or anxiety, worsening psychosis, such as increasing hallucinations or paranoia, and/or catatonia. These worsening mental health conditions manifest as failing to complete activities of daily living such as bathing oneself and cleaning one's living space; decreasing caloric and fluid intake (*i.e.*, not eating or drinking); engaging in self-injurious behaviors, such as head-banging, cutting, pulling out one's hair or teeth, or drinking cleaning fluid; presenting with

other unusual behaviors that are dangerous to the individual's physical health, such as touching, "playing with," or even eating one's own feces; and engaging in suicidal behaviors.

25. These behaviors and other mental health symptoms can be seen in the medical records of people with mental illness who are placed in segregated housing that I have reviewed over the past three years and in the declarations I have received from individuals currently incarcerated at the Jail. [redacted] This is a well-known response to profound distress, trauma, anxiety, and mental health deterioration. [redacted]. The evidence strongly suggests that the Administrative Separation setting worsens the mental illness of Mr. Hawkins and others like him.

26. The declarations of other individuals currently incarcerated at the Jail demonstrate psychiatric deterioration while housed in Administrative Separation units. These individuals describe feeling "so suicidal that I told my attorney that I wanted a lethal injection at court," "enter[ing] into a fugue state," "experiencing auditory and visual hallucinations," "attempt[ing] suicide … by overdosing on Tylenol pills," "hav[ing] uncontrollable meltdowns," and "constantly th[inking] about dying." These individuals also describe symptoms of psychiatric deterioration by other incarcerated people housed in Administrative Separation such as people "screaming and talking to themselves," "banging on the desk[s] and doors" "refus[ing] to shower or eat," "cut[ting their] wrist[s]," "defecat[ing] in the shower areas," and "regularly flood[ing] their cell with feces."

27. These behaviors, all of which are recognized symptoms of serious mental illness, can lead to death, for example, through suicide or due to the consequences of a self-injurious behavior. In addition, acutely psychotic individuals who have stopped eating or drinking may starve to death.

28. For example, as described in my Rule 26 Report, Lonnie Rupard, a 46-year-old man with serious mental illness housed in the Administrative Separation unit at Central Jail, died on March 17, 2022 from pneumonia, malnutrition and dehydration in the context of neglected schizophrenia. Notably, the manner of his death is listed by the County's own medical examiner as a "homicide" due to the extensive neglect Mr. Rupard encountered in Administrative Separation. Mr. Rupard was placed in solitary confinement despite clear clinical contraindications and a need for a higher level of care; he was then neglected in that setting until he starved to death. *See* Dkt. 937-5 at ECF pp. 103-106.

29. There have been other horrific deaths in Administrative Separation. Lester Marroquin, a 35-year-old man with schizophrenia, was housed in the Administrative Separation unit at Central Jail, where he drowned himself in the toilet after three months or more of solitary confinement and neglect. *See id.* at ECF pp. 106-109. The deaths by suicide of Matthew Settles in the Administrative Separation unit at Central Jail on August 16, 2022 and of Jonathan McDowell in an Administrative Separation unit at George Bailey on July 19, 2023 are additional examples of how the isolation and inadequate mental health care present in San Diego County Jail's Administrative Separation units cause substantial risk of serious harm, up to and including death. *See id.* at ECF pp. 98-103.

30. These symptoms and behaviors described in paragraphs 23-25 above can also have long-term negative effects on one's health, even short of death. It is well-established that the longer psychosis goes untreated in a patient, the more difficult it is for that patient to return to their baseline level of mental health. This deterioration can have a significant and lasting impact on the individual's ability to

re-integrate into society and avoid recidivism.

San Diego County's Use of Solitary Confinement for Incarcerated People with Serious Mental Illness is Contrary to All Established Guidelines

31. In recognition of the serious risks posed by solitary confinement, the U.S. Department of Justice and the National Commission on Correctional Health Care recommend—and other well-functioning detention systems that I have observed require—that incarcerated people with serious mental illness **not** be placed in solitary confinement except in rare circumstances. *See* Dkt. 937-5 at ECF pp. 71-72.

32. According to the United States Department of Justice, "[g]enerally, inmates with serious mental illness (SMI) should not be placed in restrictive housing." U.S. Department of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing* at 99 (Jan. 2016). My review of San Diego County Jail's policies, procedures, and practices indicates that the Jail fails to follow this federal guidance.

33. The U.S. DOJ also provides detailed guidance as to the rare circumstances under which a person with serious mental illness may be placed in segregation-type housing:

- An inmate with SMI should not be placed in restrictive housing, unless:
  - The inmate presents such an immediate and serious danger that there is no reasonable alternative; or
  - A qualified mental health practitioner determines:
    - That such placement is not contraindicated;
    - That the inmate is not a suicide risk;
    - That the inmate does not have active psychotic symptoms; and
    - In disciplinary circumstances, that lack of responsibility for the misconduct due to mental illness or mitigating factors related to the mental illness do not contraindicate disciplinary segregation.

- Inmates with SMI who are diverted from restrictive housing should be placed in a clinically appropriate alternative form of housing, such as a secure mental health unit or other residential psychology treatment program. *Id.* at 99-100.

34. The NCCHC has issued a Position Statement on Solitary Confinement and Isolation, stating: "mentally ill individuals … should be excluded from solitary confinement of any duration." As discussed in my Rule 26 report, the NCCHC Standards for Mental Health Services in Correctional Facilities' Standard MH-E-07 (Segregated Inmates) also requires that for a patient being placed in segregation, it is necessary that "mental health staff reviews the inmate's mental health record to determine whether existing mental health needs contraindicate the placement [in segregation] or require accommodation." *See* Dkt. 937-5 at ECF p. 85.

35. The American Psychiatric Association has issued a Position Statement on Segregation of Prisoners with Mental Illness, stating: "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates."[4]

36. The American Public Health Association has issued a similar statement: "Prisoners with serious mental illnesses should be excluded from placement in solitary confinement. … Prisoners should be closely monitored and removed from solitary confinement if continued placement becomes clinically contraindicated, if their physical or mental health deteriorates because of continued placement in solitary confinement, or if necessary medical or mental health services cannot be provided."[5]

[4] American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (Dec. 2012), available at http://nrcat.org/storage/documents/apa-statement-on-segregation-of-prisoners-with-mental-illness.pdf.

[5] American Public Health Association, *Solitary Confinement as a Public Health Issue* (Nov. 2013), available at https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue#:~:text=APHA%20calls%20upon%20federal%2C%20state,mental%20illnesses%20and%20chronic%20illnesses.

37. The American Medical Association passed a resolution in 2018 that supported "limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities." In addition, the resolution calls for health professionals to regularly monitor individuals placed in solitary confinement and stakeholders to implement alternatives to solitary confinement for all incarcerated persons.[6]

38. The U.N. Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has stated that "solitary confinement often results in severe exacerbation of a previously existing mental condition" and that "its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment."[7]

39. The harmful effects of solitary confinement have been established in numerous observations and empirical studies that date back to the nineteenth century, conducted in many different countries by researchers with diverse disciplinary backgrounds.[8] Psychologists have long established that social contact is fundamental to establishing and maintaining emotional health and well-being. Prolonged social deprivation is destabilizing because it denies individuals a fundamental aspect of their humanity, prevents them from having a sense of "affiliation," and deprives them of the opportunity to ground their thoughts and

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[6] American Medical Association, *Report of the Reference Committee on Amendments to Constitution and Bylaws*, "Resolution 412 – Reducing the Use of Restrictive Housing in Prisoners with Mental Illness" at 641 (June 2018), available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/a18-reference-committee-reports.pdf.

[7] Méndez, J. *Torture and other cruel, inhuman or degrading treatment or punishment.* Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment at 21 (Aug. 2011), available at https://ccrjustice.org/sites/default/files/assets/UN-Special-Rapporteur-Report-on-Solitary.pdf.

[8] Craig Haney, *The Science of Solitary: Expanding the Harmfulness Narrative*, 115 Nw. U.L. Rev. 211 (2020).

emotions in a social context, including knowing what they feel and whether those feelings are appropriate. The deprivation of this fundamental need for social interaction predictably produces a wide range of negative effects.

40. For example, leading scientific studies demonstrate that social isolation alters the brain's neurochemistry, structure, and function. Researchers have observed that even one week in solitary confinement can lead to significant changes in electrical activity in the brain, slowing brain activity and negatively impacting individuals' performance on intellectual and perceptual-motor tests. Solitary confinement can lead to a reduction in the size of the hippocampus, a brain structure crucial to learning, memory, and emotional and stress control. In addition, it can lead to increased activity in the amygdala, the structure responsible for managing fear and anxiety symptoms. Studies performed on non-human animals demonstrate that solitary confinement negatively affects the cellular mechanism of aging, leading to a shorter life span based on changes to brain chemistry.

41. Furthermore, solitary confinement leads to and exacerbates a wide host of adverse psychological reactions, including heightened levels of anxiety and panic, paranoia, hallucinations, hypersensitivity to stimuli, depression, increased suicidality and self-harm. PTSD, depression, emotional numbing, anxiety, and hypervigilance may occur as much as ten times more often among individuals in solitary confinement than in the general population, where mental health issues are already more prevalent than in the population as a whole. Social isolation also increases an individual's salivary cortisol levels and blood flow to brain regions associated with physical pain, leading to aggression and antisocial behavior often known as "action-oriented coping." Likewise, lack of human touch is an established risk factor for neurodevelopmental disorders, depression, suicidality, and other self-destructive behavior.

42. These impacts may last long after an individual is released from solitary confinement, regardless of whether the individual overtly exhibits

symptoms of serious mental illness while in solitary confinement. Solitary confinement can have a long-term and negative impact on an individual's thinking, emotions, conduct, and personality—leaving them permanently diminished, and at greater risk of death, even after being released from solitary confinement. For example, a study conducted in the North Carolina prison system between January 2000 and December 2016 demonstrated that individuals in solitary confinement were 24% more likely to die and 78% more likely to die from suicide than individuals in the general population in the first year after their release.[9] These individuals were also 127% more likely to die of an opioid overdose in the first two weeks after being released from custody, and were more likely to return to custody. These findings controlled for other factors such as prior incarcerations, drug-related convictions, violence-related convictions, mental health treatment, and length of sentence.

43. Solitary confinement can also lead to devastating effects on an individual's *physical* health. Solitary isolation adversely impacts the functioning of the immune system, undermines health outcomes, and increases mortality. For example, one recent study found that individuals held in solitary confinement units experienced a 31 percent higher risk of hypertension, and higher risk of cardiovascular disease, than individuals in the general prison population.[10] The study estimated that for a population of only 25,000 individuals, the increase in hypertension **alone** would result in $155 million in future anticipated healthcare costs and a loss of 5,673 quality-adjusted life years. The study did not focus on other possible conditions worsened by solitary confinement, so these numbers likely underestimate solitary confinement's overall impact on healthcare related costs.

[9] Lauren Brinkley-Rubinstein, et al., *Association of Restrictive Housing During Incarceration with Mortality After Release*, JAMA Network Open (Oct. 2019).

[10] Brie A. Williams, et al., *The Cardiovascular Health Burdens of Solitary Confinement*, J. Gen. Internal Med. 34(10): 1977-80 (Oct. 2019).

The growing awareness of the health and fiscal risks of solitary confinement has led organizations such as the American Medical Association to call for the elimination of solitary confinement for individuals with serious mental illness, as discussed in paragraph 37 above.

44. Consistent with this widely accepted guidance and research, other California counties have banned the use of solitary for seriously mentally ill individuals. For example, nearby San Bernardino County's Policy No. 12.2515.05 states that "[i]nmates who are confirmed to be pregnant or who have serious mental illness or a developmental or intellectual disability shall not be placed in non-disciplinary administrative housing." Similarly, Orange County does "not place people" with "[s]erious [m]ental [i]llness or who have an [i]ntellectual or [d]evelopmental [d]isability" in its special management restrictive housing unit. San Mateo County excludes individuals diagnosed with serious mental illnesses, individuals with developmental or cognitive disabilities, individuals with dementia or delirium, and individuals with a history of seizures or traumatic brain injuries from administrative housing, except for a brief period of no more than 72 hours in cases of imminent violence or serious danger.

45. Consistent with these counties' practices and guidance from respected organizations and researchers, the best practice is to prohibit the placement of people with serious mental illness in solitary confinement. San Diego does not follow this guidance, and in fact appears to place individuals with serious mental illness in solitary confinement *because* of their mental illness.

46. Given San Diego's widespread use of solitary confinement for people with serious mentally illness, and the lack of precautions, such as sufficiently frequent safety checks, confidential mental healthcare, out-of-cell structured and unstructured time, and tablets or books, it is inevitable that people with serious mentally illness will worsen and even die in these units. I have discussed the Administrative Separation deaths of Messrs. Rupard, Marroquin, McDowell and

Settles at length in my previous report. *See* Dkt. 937-5 at ECF pp. 98-109. The tragic July 2025 deaths discussed below were likewise the foreseeable consequence of San Diego County's solitary confinement practices.

The Death of Corey Dean (July 13, 2025) in Vista Administrative Separation Illustrates the Dangers of San Diego County's Administrative Separation Units

47. Corey Dean, a 43-year-old patient with a known history of psychotic disorders and mood disorders, died on July 13, 2025 in an Administrative Separation unit at the Vista Detention Facility. Mr. Dean's medical records indicate that, throughout his 28-day incarceration, he was increasingly psychotic and unable to conduct meaningful self-care activities. Although deputies and medical and mental health staff at the Jail were aware that he was in distress and knew that he required a higher level of care, he was seen just once by psychiatric staff, even as that staff noted that he needed to be seen more often given his mental health condition. As indicated below, Mr. Dean should have been seen by a psychiatrist within a week of being prescribed a psychiatric medication. Once it was clear that the prescribed medication was not working, Mr. Dean should have received additional care, and certainly should have been removed from the Administrative Separation unit. Mr. Dean's death represents an egregious case of neglect.

48. Mr. Dean was booked on June 15, 2025. This was not Mr. Dean's first incarceration at the Jail, though it is not clear if his prior Jail mental health records were reviewed by staff. During Receiving Screening, a nurse noted that he had a history of mood disorders and psychotic disorders and therefore referred Mr. Dean to psychiatric sick call. [Dean Medical Records pp. 430, 440]. Mr. Dean was not evaluated by a psychiatric practitioner (in this case, a psychiatric nurse practitioner) until June 22, 2025—one week later. [*Id.* p. 539]. During that cell-side (*i.e.*, non-confidential) evaluation, the nurse practitioner noted that Mr. Dean was "disheveled … with strong urine [smell] coming from cell, towels on floor outside of cell," as well as "visib[ly] dirty and malodorous." [*Id.* p. 540]. The nurse practitioner note

further states that Mr. Dean "reports taking Depakote and Cogentin"—psychotropic medications—"in the past," and that he had stated that he would take "Zyprexa or Haldol if you have it." [*Id.*] The nurse practitioner assessed Mr. Dean as having an unspecified psychotic disorder, prescribed 5 mg of Zyprexa to be taken twice per day, and scheduled a follow-up psych appointment "in 2 weeks unless sooner visit is warranted." [*Id.* pp. 551-52.] Zyprexa is an antipsychotic medication. Mr. Dean was then placed in Cell 12 of Vista Unit E/4, an Administrative Separation unit, on June 28, 2025, where he remained until his death on July 13, 2025.

49. Despite the nurse practitioner's June 22, 2025 instruction that a follow-up appointment should happen, **no further psychiatric appointments or notes appear in Mr. Dean's medical records**. The Jail's failure to conduct a clinically indicated and clinically ordered follow-up appointment is extremely concerning and falls below the standard of care. In general, after prescribing a new psychiatric medication or a new dosage of an existing psychiatric medication, a practitioner should follow up with the patient after one week. *See* Dkt. 937-5 at ECF pp. 38-41, 101. Failing to conduct a psychiatric follow-up appointment with Mr. Dean **at all** after prescribing new medication violates the standard of care.

50. The failure to conduct a psychiatric follow-up appointment is even more concerning in this case given the obvious indications that Mr. Dean was not improving on the prescribed dose of Zyprexa. Mr. Dean's medical records indicate that he was relatively medication compliant, with a compliance rate of 76%. Yet, there are multiple notes stating that Mr. Dean's condition was not improving, with alarming symptoms that indicated serious mental health and medical concerns:

- A June 26, 2025 Progress Note states: "reports of severe mental illness w/ bizarre [behaviors] (e.g., yelling, urinating on the door, and unkept cell), etc." [Dean Medical Records p. 443].
- Another June 26, 2025 QMHP Progress Note states: "Per collateral, I/P urinating on himself to stay warm. Psychosis, disorganization, unkempt, urinating inappropriately. … Highly malodorous outside of cell. Flies. Thick bundle of blankets outside of cell to seep up urine. Pool of urine inside of cell in between toilet and door. … I/P presented

w/ disorganization, nonlinear TP [thought process], irrelevant responses, delusional TC [thought content]." [*Id.* at p. 451-52].

- On July 3, 2025, a mental health clinician noted a wet blanket outside Mr. Dean's cell door and "additional liquid outside of his cell. Per housing deputy, the liquid was most likely a combination of urine and water." [*Id.* at p. 459]. The clinician further noted that Mr. Dean exhibited psychotic symptoms, including delusions, *e.g.*, Mr. Dean, who was 43 years old at the time of his death, reported that he served in the military from 1932-1940—nearly a century ago. [*Id.* at pp. 460, 465].
- Also on July 3, 2025, a different mental health clinician noted that Mr. Dean was "[d]isheveled/unkempt"; his cell was "[u]nkempt/foul smell," with a history of "toilet being flo[o]ded and having feces on cell"; and that he experienced delusions. [*Id.* at pp. 471-72].
- On July 10, 2025, a mental health clinician noted that Mr. Dean was disheveled and his cell had a foul smell, with a blanket "soaked in water and urine," despite a report that deputies "had just cleaned his cell the day before." The clinician also noted that Mr. Dean did "not appear to be appropriately aware of his surroundings." [*Id.* at pp. 490-91].
- Also on July 10, 2025, a different mental health clinician noted that Mr. Dean had "been yelling random numbers" and that he "responded illogically and nonsensically" to questions, including answering a question about the day's date with "USSR," and that he "was not able to engage in much of a linear conversation." The clinician also noted that Mr. Dean "had what appeared to be a towel on his head" and that his "toilet appeared to be overflowing." The Progress Note also indicates that, about 5 days prior, there had been an incident in which water had been seen dripping down the wall of Mr. Dean's cell, and Mr. Dean had confirmed when asked by a deputy that he had been "placing water into the cell intercom or into the vent," resulting in a "strong odor of burning metal" in his cell. [*Id.* at 482-83, 485].

51. These observations show that Mr. Dean remained psychotic over an extended period—a condition that was also observed by the incarcerated people in his unit who reported that he spent days constantly yelling, complaining that he did not feel well, regularly flooding his cell with water from his toilet, and covering himself in his own feces and urine.

52. This behavior should have indicated that Mr. Dean required augmented psychiatric treatment, *i.e.*, a change or increase in his medication regimen and/or transfer to a higher level of care, yet he was never again seen by a psychiatric practitioner who could have made that medication adjustment or ordered the transfer

to a more therapeutic environment or the Emergency Department of a hospital. The County's failure to follow up in the face of obvious symptoms of psychosis is a shocking departure from the standard of care.

53. According to court records I have been provided, on June 30, 2025, the Superior Court for the County of San Diego suspended criminal proceedings against Mr. Dean pursuant to Penal Code section 1368 and instead ordered a forensic evaluation of his competence to stand trial—one more indication that Mr. Dean should not have been in Administrative Separation.

54. I have also reviewed Mr. Dean's medical records from treatment he previously received in the community between 2014 and 2020. Those records show that Mr. Dean experienced long periods of stability on antipsychotic medication. In other words, Mr. Dean's psychosis likely could have been managed with medication and appropriate psychiatric follow-up in a setting other than Administrative Separation. He simply was not given the treatment that he needed while incarcerated in the Jail.

55. It is striking that Mr. Dean was referred for placement in a mental health unit three weeks before he died, when a Qualified Mental Health Professional referred him to the Jail's Outpatient Stepdown Unit ("OPSD"). [*Id.* at p. 451]. While my previous report is critical of the Jail's OPSD, *see* Dkt. 937-5 at ECF p. 138, as well as its overall mental health staffing, psychiatric follow-up, and safety checks, *id.* at ECF pp. 26-70, 136-49, 208-210, an OPSD placement would have been an improvement over Administrative Separation.

56. Based on the information I have been provided, Mr. Dean needed intensive and immediate medical and psychiatric care, along with other mental health interventions and placement in a more therapeutic environment, where he could receive out-of-cell time and increased access to family members (by phone or otherwise). None of this occurred. Mr. Dean was never actually transferred to OPSD or any other mental health unit and instead remained in Administrative

Separation for 17 days after that referral, until his death. Such denial of clinically indicated care and the continued isolation of the Administrative Separation placement were clearly dangerous for this patient. To my knowledge, the Jail has no system for tracking how long individuals are waiting for placement in OPSD or the higher level of care, the Jail's Psychiatric Safety Unit ("PSU").

57. Mr. Dean's medical records contain evidence that he was likely experiencing protein-calorie malnutrition and dehydration, *i.e.*, that he was starving. Lab tests received by the Jail on July 1, 2025 (from a blood draw on June 30, 2025) show "out of range" results for Urea Nitrogen (BUN), Creatinine, and BUN/Creatinine Ratio. [*Id.* at p. 562]. Those labs suggest that Mr. Dean was likely dehydrated and that his muscles were breaking down. The results should have—at minimum—raised the concern of Jail health staff that Mr. Dean was not eating or drinking enough. That concern should have been further heightened by the multiple notations in Mr. Dean's medical records suggesting that he was not eating, specifically:

- On June 19, 2025, a clinical counselor noted that Mr. Dean's toilet was "clogged with food wrappers." [*Id.* at p. 557].
- On June 22, 2025, a psychiatric NP wrote that Mr. Dean stated: "I am hungry, they don't feed me." [*Id.* at p. 540].
- Another mental health clinician noted on June 22, 2025 that Mr. Dean "stated he has not been given any meals" and that there "appeared to be scraps on the floor, possibly from food." [*Id.* at pp. 445-46].
- On July 3, 2025, an LVN noted that the toilet in Mr. Dean's cell was "clogged by food trays." [*Id.* at p. 443].

58. These notations are consistent with the testimony of the incarcerated witnesses, who reported that Mr. Dean spent days "constantly yelling," "regularly flood[ing] his cell with water from his toilet," and "cover[ing] himself in his own feces and urine," including "rub[bing] feces on his face and into his beard." According to these declarants, Mr. Dean was left in his cell in this state for "several days" before "custody staff brought him out to shower once," at which point

incarcerated workers removed "a flood of brown water mixed with food and trash" out of his cell. The declarations also confirm that staff did not remove Mr. Dean from Administrative Separation, but rather returned him to his cell where he "continued to cry and ask for help" until he gradually went quiet and was found dead.

59. As explained above, it is not uncommon for psychotic patients in extreme, harsh, and isolation settings, like the restrictive conditions of solitary confinement, to become so disorganized that they do not eat or simply cannot eat, even when hungry. Each of the above observations—including Mr. Dean's reports of hunger and the appearance of food scraps, packaging, and debris on the cell floor and in the toilet—suggest that is what was happening in Mr. Dean's case: his untreated mental illness in a solitary confinement setting may have predictably resulted in him not eating and in fact wasting away, as Mr. Rupard did in 2022.

60. Not eating can be a sign of other serious medical conditions. Whatever the cause, protein calorie malnutrition is a potentially life-threatening condition, as it may result in multiple organ failure and death. Medical staff should have investigated that possibility and intervened in Mr. Dean's case, given the multiple indicators that Mr. Dean was suffering and not eating. In fact, it would have been reasonable to send Mr. Dean to the hospital emergency department on July 1, 2025, when his alarming lab results came back, in pursuit of further testing and treatment. This did not occur.

61. Instead, there are multiple indications in his medical records that Mr. Dean was prevented from obtaining medical care because custody staff viewed him as an alleged "security risk." On both July 1 and July 2, 2025, nurses noted that they "[a]ttempted" to bring Mr. Dean to clinic for an electrocardiogram ("EKG"), but were unable to because "per dep[uty]" Mr. Dean was a "safety concern" or "[s]ecurity concern." [*Id.* at p. 443].

62. Notably, Mr. Dean's records suggest that custody staff viewed some of

the clear symptoms of his mental illness described above, *e.g.*, his lack of hygiene and pattern of flooding his cell with urine, as a "safety concern." [*Id.*]. One mental health clinician, in documenting Mr. Dean's medical history, noted the following:

> Per JIMS ISR dated 06.28.25, at VDF, a deputy noticed a foul odor coming from IP's cell. There were multiple blankets rolled up at the base of the cell door and the blankets were saturated in urine. IP had trash and clothing clogging his toilet. A mixture of urine and water formed a pool on the cell floor. IP's cell was cleaned. IP appeared to be unbothered by his unkempt cell and living conditions. IP has consistently shown that he cannot conform the minimum jail standards. **For IP's safety and the safety of other incarcerated persons and staff**, IP will be placed into Ad-Sep.

[*Id.* at p. 459 (emphasis added)].

63. I see ***no*** indication of so-called "safety" concerns in Mr. Dean's medical records other than references to his unkempt living behaviors and a vague reference to "disruptive" behavior "during the night which disturbed other [incarcerated persons'] sleep." [*See id.*]. This may have been the yelling referred to by the incarcerated witnesses. Neither yelling nor malodorous urine are threats to the safety of others; they are unpleasant but call for treatment, not further isolation. Yet it appears from Mr. Dean's medical records that he was placed in Administrative Separation, and not taken to the clinic to receive medical care, *because of* his untreated psychotic disorder.

64. In summary, Mr. Dean was visibly decompensating throughout his incarceration in the Jail, especially once he was placed in Administrative Separation. Mental health and custody staff repeatedly noted that Mr. Dean was presenting as psychotic and failing to engage in basic activities of self-care. Jail staff referred him to a mental health placement in the OPSD unit. Rather than effectuate that mental health placement, or provide him with psychiatric follow-up that was clinically indicated and ordered, or take him to the medical clinic for appointments, or send him to the hospital, the Jail left him to decompensate in Administrative Separation, where he died.

The Death of Karim Talib (July 28, 2025) is Likely Related to His Placement in Administrative Separation

65. Karim Talib was an 82-year-old man who died in the Administrative Separation unit of the San Diego Central Jail on July 28, 2025. According to records from the Sheriff's Office, he was awaiting a mental competency proceeding. This fact strongly suggests that Mr. Talib had a mental illness.

66. Mr. Talib was arrested and booked into Central Jail on May 27, 2025. It appears that he was placed in a Medical Observation Unit, suggesting he was seriously ill, until approximately a week before his death. The declarations I reviewed from other *Dunsmore* class members about Mr. Talib's behavior when incarcerated in the Administrative Separation unit state that he used a wheelchair and wore a diaper, which he required assistance from medical staff to change. Those declarations also indicate that both Mr. Talib himself and his cell regularly smelled of feces, and that Mr. Talib often failed to respond when asked questions by staff and other incarcerated people. One incarcerated person reportedly asked Mr. Talib a question from outside his cell, but Mr. Talib "just stared back at [him] without saying anything." Based on this information, Mr. Talib was likely catatonic. According to the declarations, Mr. Talib only left his cell once during the time he was in Administrative Separation. At the time of his death, uneaten trays of food were observed in his cell.

67. I would like to see Mr. Talib's medical records. Without them, I do not have the full picture of what happened to him. However, based on the information I do have, it seems highly likely that housing Mr. Talib in Administrative Separation was dangerous, as he could not, and did not, receive the care he needed there. Conditions like those in Administrative Separation are extremely dangerous for those with serious mental health conditions, particularly for an elderly man with other health conditions and disabilities like incontinence.

San Diego County Must Stop Placing Incarcerated People with Serious Mental Illness in Administrative Separation

68. To prevent future deaths of this nature and reduce the deleterious effects of solitary confinement, the Jail needs to make changes as described in my prior declaration and reports. Most importantly, the Jail should follow other California counties like San Bernardino, Orange, and San Mateo in adopting a prohibition on the use of solitary confinement for individuals with serious mental illness. As discussed above, extensive scientific literature, good correctional practice and accepted standards have shown that individuals with serious mental illness cannot receive the care they need in solitary confinement, and that such a setting affirmatively harms them.

69. My inspections of San Diego County Jail facilities confirm that it is virtually impossible to provide therapeutic out-of-cell time, dayroom, and confidential mental healthcare in the Administrative Separation units because of their configuration and staffing. Without these protections, as well as devices like tablets for communication and programming, and without 30-minute safety checks, these units are simply too dangerous for incarcerated people with serious mental illness.

70. If solitary confinement is used (as when there is an immediate threat to physical safety), it must be limited to short periods of time such as 72 hours, similar to the limit placed in San Mateo County, and must be subject to multiple protections not present in San Diego County Jail. These include but are not limited to careful psychiatric follow-up and monitoring, including with respect to psychiatric medication, confidential mental health consultations, significant therapeutic out of cell programming, significant unstructured out of cell time, staggered and irregular safety checks, a level of care mental health system with meaningful therapeutic programming, tracking individuals with serious mental illness, and providing access to in-cell stimulation and communication devices such as tablets.

71. The Jail currently has several mental health units including one called OPSD. It also has Medical Observation Units at each of the jails that have Administrative Separation units. At least in Medical Observation and in the PSU, San Diego County's policy requires safety checks every 30 minutes, *see* SDSO Detention Service Bureau Policy I.64 at 1. My prior reports have been critical of the mental healthcare provided in PSU and OPSD. Still, these units are more therapeutic, and safer, than the Administrative Separation units. I strongly urge San Diego County to follow the standard of care and prohibit the placement of people with serious mental illness in Administrative Separation, and to instead house those individuals in the OPSD, the PSU, or Medical Observation units, while working to improve mental health programming to meet the needs of the population.

72. These changes would not only lead to improved mental and physical health outcomes for incarcerated individuals but would also have a positive impact on SDSO and San Diego County as a whole. As discussed above, the fiscal savings resulting from improved health among individuals diverted from solitary confinement are substantial.

73. Moreover, as demonstrated by a recent case study performed in Oregon, eliminating solitary confinement conditions for individuals with serious mental illness would lead to improved conditions for the Jail's deputies and mental health staff.[11] As discussed in the Oregon study, correctional staff often experience physical and psychological injury and vicarious trauma due the harmful effects of solitary confinement. This leads to poor job satisfaction, lower life expectancy and increased risk of alcoholism, depression, and suicide. As a result of eliminating solitary confinement conditions for individuals with serious mental illness, the unit in the Oregon study saw an 85.7% decrease in use of force incidents, a 55.7%

[11] David H. Cloud, et al., *The Resource Team: A Case Study of a Solitary Confinement Reform in Oregon*, PLoS ONE 18(7) (July 2023).

decrease in disciplinary infractions, and a 73.9% decrease in assaults (including zero staff assaults). Staff members reported dramatically reduced work-related stress, conflict, and violence, increased job satisfaction, and an increased sense of occupational purpose. Jail operations also benefited as a whole, as the study found a 23% reduction in use of sick leave for participating staff members.

74. I urge San Diego County to adopt a ban on solitary confinement for people with serious mental illness and to improve and expand its OPSD and PSU units. The need for change is urgent before more individuals tragically die.

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75. The information and opinions contained in this declaration are based on the evidence and documentation available to me and on my professional knowledge and my experiences working in correctional settings. I reserve the right to modify or expand these opinions should additional information become available to me, including but not limited to the medical records of Karim Talib and the autopsy reports for Messrs. Dean and Talib.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge, and that this declaration is executed at Honolulu, Hawaii this 30th day of September, 2025.

Pablo Stewart, M.D.

EXHIBIT A

CURRICULUM VITAE

PABLO STEWART, M.D.

[redacted]

e-mail: [redacted]

(Updated June 2024)

Personal Statement: As evidenced in my CV, my psychiatric career is based on several guiding principles. These include, but are not limited to, a commitment to diversity at all levels of medical education, including medical students, residents and faculty members. Also, I have always believed that health care is a right and not a privilege. I have demonstrated this fact by my passion for social justice and health equity for everyone.

Language Competency: Fluent in both Spanish and English.

EDUCATION:

University of California, San Francisco, Teaching Certificate in General Medical Education, 2017

University of California, San Francisco, School of Medicine, Department of Psychiatry, Psychiatric Residency Program, 1986

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

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

LICENSURE:

California Medical License #GO50899
Hawai'i Medical License #MD-11784
Federal Drug Enforcement Administration #BS0546981
Hawaii Controlled Substances Certificate of Registration #E14341
Diplomate in Psychiatry, American Board of Psychiatry and Neurology, Certificate #32564

ACADEMIC APPOINTMENTS:

September 1, 2021-Present: Academic Appointment: Clinical Professor/Psychiatrist, Queens University Medical Group (QUMG), University of Hawaii, John A. Burns School of Medicine.

July 1, 2019-August 31, 2021: Academic Appointment: Clinical Professor/Psychiatrist, University Health Partners (UHP), University of Hawaii, John A. Burns School of Medicine.

February 22, 2018- June 30, 2019	Academic Appointment: Clinical Professor, Department of Psychiatry, University of Hawaii, John A. Burns School of Medicine.
September 2006- Present	Academic Appointment: Clinical Professor, Department of Psychiatry, University of California, San Francisco. School of Medicine.
July 1995 - August 2006	Academic Appointment: Associate Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1989 - June 1995	Academic Appointment: Assistant Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1986 - July 1989	Academic Appointment: Clinical Instructor, Department of Psychiatry, University of California, San Francisco, School of Medicine.

EMPLOYMENT:

July 2019- Present	Attending Psychiatrist John A. Burns School of Medicine, Department of Psychiatry, University of Hawaii. Current duties include supervising psychiatric residents in their provision of acute and chronic care to the mentally ill inmate population housed at the Oahu Community Correctional Center. In this capacity I was also involved with local agencies in formulating the jail's response to Covid-19. I present a lecture series to the psychiatric residents regarding Forensic Psychiatry. I also serve as an Attending Psychiatrist in the Emergency Department, the Psychiatric Inpatient Unit and the Medical and Surgical Units at the Queens Medical Center.
December 1996- Present	Psychiatric Consultant Provide consultation to governmental and private agencies on a variety of psychiatric, forensic, substance abuse and organizational issues; extensive experience in all phases of capital litigation and correctional psychiatry.
January 1997- September 1998	Director of Clinical Services, San Francisco Target Cities Project. Overall responsibility for ensuring the quality of the clinical services provided by the various departments of the project including the Central Intake Unit, the ACCESS Project and the San Francisco Drug Court Also responsible for providing clinical in-service trainings for the staff of the Project and community agencies that requested technical assistance.
February 1996 - November 1996	Medical Director, Comprehensive Homeless Center, Department of Veterans Affairs Medical Center, San Francisco. Overall responsibility for the medical and psychiatric services at the Homeless Center.

March 1995 - January 1996	Chief, Intensive Psychiatric Community Care Program, (IPCC) Department of Veterans Affairs Medical Center, San Francisco. Overall clinical/administrative responsibility for the IPCC, a community-based case management program. Duties also include medical/psychiatric consultation to Veteran Comprehensive Homeless Center. This is a social work managed program that provides comprehensive social services to homeless veterans.
April 1991 - February 1995	Chief, Substance Abuse Inpatient Unit, (SAIU), Department of Veterans Affairs Medical Center, San Francisco. Overall clinical/administrative responsibility for SAIU.
September 1990 - March 1991	Psychiatrist, Substance Abuse Inpatient Unit, Veterans Affairs Medical Center, San Francisco. Clinical responsibility for patients admitted to SAIU. Provide consultation to the Medical/Surgical Units regarding patients with substance abuse issues.
August 1988 - December 1989	Director, Forensic Psychiatric Services, City and County of San Francisco. Administrative and clinical responsibility for psychiatric services provided to the inmate population of San Francisco. Duties included direct clinical and administrative responsibility for the Jail Psychiatric Services and the Forensic Unit at San Francisco General Hospital.
July 1986 - August 1990	Senior Attending Psychiatrist, Forensic Unit, University of California, San Francisco General Hospital. Administrative and clinical responsibility for a 12-bed, maximum-security psychiatric ward. Clinical supervision for psychiatric residents, postdoctoral psychology fellows and medical students assigned to the ward. Liaison with Jail Psychiatric Services, City and County of San Francisco. Advise San Francisco City Attorney on issues pertaining to forensic psychiatry.
July 1985 June 1986	Chief Resident, Department of Psychiatry, University of California San Francisco General Hospital. Team leader of the Latino-focus inpatient treatment team (involving 10-12 patients with bicultural/bilingual issues); direct clinical supervision of 7 psychiatric residents and 3-6 medical students; organized weekly departmental Grand Rounds; administered and supervised departmental residents' call schedule; psychiatric consultant to hospital general medical clinic; assistant coordinator of medical student education; group seminar leader for introduction to clinical psychiatry course for UCSF second-year medical students.
July 1984 - March 1987	Physician Specialist, Westside Crisis Center, San Francisco, CA. Responsibility for Crisis Center operations during assigned shifts, admitting privileges at Mount Zion Hospital. Provided psychiatric consultation for the patients admitted to Mount Zion Hospital when requested.
April 1984 -	Psychiatric Consultant, Marin Alternative Treatment, (ACT).

July 1985	Provided medical and psychiatric evaluation and treatment of residential drug and alcohol clients; consultant to staff concerning medical/psychiatric issues.
August 1983 - November 1984	Physician Specialist, Mission Mental Health Crisis Center, San Francisco, CA. Clinical responsibility for Crisis Center clients; consultant to staff concerning medical/psychiatric issues.
July 1982- July 1985	Psychiatric Resident, University of California, San Francisco. Primary Therapist and Medical Consultant for the adult inpatient units at San Francisco General Hospital and San Francisco Veterans Affairs Medical Center; Medical Coordinator/Primary Therapist - Alcohol Inpatient Unit and Substance Abuse Clinic at San Francisco Veterans Affairs Medical Center; Outpatient Adult/Child Psychotherapist; Psychiatric Consultant - Adult Day Treatment Center - San Francisco Veterans Affairs Medical Center; Primary Therapist and Medial Consultant - San Francisco General Hospital Psychiatric Emergency Services; Psychiatric Consultant, Inpatient Medical/Surgical Units - San Francisco General Hospital.
June 1973 - July 1978	Infantry Officer - United States Marine Corps. Rifle Platoon Commander; Anti-tank Platoon Commander; 81mm Mortar Platoon Commander; Rifle Company Executive Officer; Rifle Company Commander; Assistant Battalion Operations Officer; Embarkation Officer; Recruitment Officer; Drug, Alcohol and Human Relations Counselor; Parachutist and Scuba Diver; Officer in Charge of a Vietnamese Refugee Camp. Received an Honorable Discharge. Highest rank attained was Captain.

HONORS AND AWARDS:

June 2024	Recognized by the Department of Psychiatry, John A. Burns School of Medicine, University of Hawaii as the recipient of the 2023-2024 Excellence in Teaching Award-Psychiatry.
June 2020	Recognized by the Department of Psychiatry, John A. Burns School of Medicine, University of Hawaii as the recipient of the 2019-2020 Excellence in Teaching Award-Psychiatry.
June 2015	Recognized by the Psychiatry Residents Association of the University of California, San Francisco, School of Medicine, Department of Psychiatry for “Excellence in Teaching” for the academic year 2014-2015.
June 1995	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1994/1995.
June 1993	Selected by the class of 1996, University of California, San Francisco, School of Medicine as outstanding lecturer, academic year 1992/1993.

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

MEMBERSHIPS:

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

July 1992 - June 1995	Secretary-Treasurer, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1990 - June 1992	Councilor-at-large, Alumni-Faculty Association, University of California, San Francisco, School of Medicine

PUBLIC SERVICE:

June 1992	Examiner, American Board of Psychiatry and Neurology, Inc.
November 1992 - January 1994	California Tuberculosis Elimination Task Force, Institutional Control Subcommittee.
September 2000- April 2005	Editorial Advisory Board, *Juvenile Correctional Mental Health Report.*
May 2001- September 2010	Psychiatric and Substance Abuse Consultant, San Francisco Police Officers' Association.
January 2002- June 2003	Psychiatric Consultant, San Francisco Sheriff's Department Peer Support Program.
February 2003- April 2004	Proposition "N" (Care Not Cash) Service Providers' Advisory Committee, Department of Human Services, City and County of San Francisco.
December 2003- January 2004	Member of San Francisco Mayor-Elect Gavin Newsom's Transition Team.
February 2004- June 2004	Mayor's Homeless Coalition, San Francisco, CA.
April 2004- January 2006; February 2017- October 2018	Member of Human Services Commission, City and County of San Francisco.
February 2006- January 2007; April 2013- January 2015	Vice President, Human Services Commission, City and County of San Francisco.
February 2007- March 2013; February 2015- 2017	President, Human Services Commission, City and County of San Francisco.
January 2019- present	Death Doula and Medical Aid In Dying practitioner. In these roles, I attend to dying patients to help them achieve a dignified, painless death.

UNIVERSITY SERVICE:

June 2020- Present	Member of the John A. Burns School of Medicine, University of Hawaii Scholarship Committee.
June 2020- Present	Member of the resident selection committee for the Department of Psychiatry, John A. Burns School of Medicine, University of Hawaii.
October 1999- October 2001	Lecturer, University of California, San Francisco, School of Medicine Post Baccalaureate Reapplicant Program.
July 1999- July 2001	Seminar Leader, National Youth Leadership Forum On Medicine.
November 1998- November 2001	Lecturer, University of California, San Francisco, School of Nursing, Department of Family Health Care Nursing. Lecture to the Advanced Practice Nurse Practitioner Students on Alcohol, Tobacco and Other Drug Dependencies.
January 1994 - January 2001	Preceptor/Lecturer, UCSF Homeless Clinic Project.
June 1990 - November 1996	Curriculum Advisor, University of California, San Francisco, School of Medicine.
June 1987 - June 1992	Facilitate weekly Support Groups for interns in the Department of Medicine. Also, provide crisis intervention and psychiatric referral for Department of Medicine housestaff.
January 1987 – June 1988	Student Impairment Committee, University of California San Francisco, School of Medicine. Advise the Dean of the School of Medicine on methods to identify, treat and prevent student impairment.
January 1986 – June 1996	Recruitment/Retention Subcommittee of the Admissions Committee, University of California, San Francisco, School of Medicine. Advise the Dean of the School of Medicine on methods to attract and retain minority students and faculty.
October 1986 - September 1987	Member Steering Committee for the Hispanic Medical Education Resource Committee. Plan and present educational programs to increase awareness of the special health needs of Hispanics in the United States.
September 1983 - June 1989	Admissions Committee, University of California, School of Medicine. Duties included screening applications and interviewing candidates for medical school.
October 1978 - December 1980	Co-Founder and Director of the University of California, San Francisco Running Clinic. Provided free instruction to the public on proper methods of exercise and preventative health measures.

TEACHING RESPONSIBILITIES:

July 2019-present	Present a lecture series to the psychiatric residents of the Department of Psychiatry, JABSOM, University of Hawaii on forensic psychiatry and Medical Aid In Dying. Psychotherapy supervisor and career mentor Department of Psychiatry, JABSOM, University of Hawaii.
December 2018-May 2019	Lecturer, Department of Psychiatry, JABSOM, University of Hawaii.
September 2016-June 2018	Evidence-Based Inquiry Facilitator for the *Bridges Curriculum*, University of California, San Francisco, School of Medicine.
August 2014-June 2018	Small Group Facilitator, Foundations of Patient Care, University of California, San Francisco, School of Medicine.
July 2003-June 2018	Facilitate weekly psychotherapy training group for residents in the Department of Psychiatry.
January 2002-January 2004	Course Coordinator of Elective Course University of California, San Francisco, School of Medicine, "Prisoner Health." This is a 1-unit course, which covers the unique health needs of prisoners.
September 2001-June 2003	Supervisor, San Mateo County Psychiatric Residency Program.
April 1999-April 2001	Lecturer, UCSF School of Pharmacy, Committee for Drug Awareness Community Outreach Project.
February 1998-June 2000	Lecturer, UCSF Student Enrichment Program.
January 1996 - November 1996	Supervisor, Psychiatry 110 students, Veterans Comprehensive Homeless Center.
September 1990-December 2002	Supervisor, UCSF School of Medicine, Department of Psychiatry, Substance Abuse Fellowship Program.
September 1994 - June 1999	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Drug and Alcohol Abuse." This is a 1-unit course, which covers the major aspects of drug and alcohol abuse.
August 1994 - February 2006	Supervisor, Psychiatric Continuity Clinic, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Supervise 4th Year medical students in the care of dual diagnostic patients.

February 1994 - February 2006	Consultant, Napa State Hospital Chemical Dependency Program Monthly Conference.
July 1992 - June 1994	Facilitate weekly psychiatric intern seminar, "Psychiatric Aspects of Medicine," University of California, San Francisco, School of Medicine.
July 1991- Present	Group and individual psychotherapy supervisor, Outpatient Clinic, Department of Psychiatry, University of California, San Francisco, School of Medicine.
January 1991	Lecturer, University of California, San Francisco, School of Pharmacy course, "Addictionology and Substance Abuse Prevention."
September 1990 - February 1995	Clinical supervisor, substance abuse fellows, and psychiatric residents, Substance Abuse Inpatient Unit, San Francisco Veterans Affairs Medical Center.
September 1990 - November 1996	Off ward supervisor, PGY II psychiatric residents, Psychiatric Inpatient Unit, San Francisco Veterans Affairs Medical Center.
September 1990 - June 1991	Group therapy supervisor, Psychiatric Inpatient Unit, (PIU), San Francisco Veterans Affairs Medical Center.
September 1990 - June 1994	Course coordinator, Psychiatry 110, San Francisco Veterans Affairs Medical Center.
September 1989 - November 1996	Seminar leader/lecturer, Psychiatry 100 A/B.
July 1988 - June 1992	Clinical supervisor, PGY III psychiatric residents, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project.
September 1987 - Present	Tavistock Organizational Consultant. Extensive experience as a consultant in numerous Tavistock conferences.
September 1987 - December 1993	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Alcoholism". This is a 1-unit course offered to medical students, which covers alcoholism with special emphasis on the health professional. This course is offered fall quarter each academic year.
July 1987- June 1994	Clinical supervisor/lecturer FCM 110, San Francisco General Hospital and Veterans Affairs Medical Center.
July 1986 - June 1996	Seminar leader/lecturer Psychiatry 131 A/B.
July 1986 -	Clinical supervisor, Psychology interns/fellows,

August 1990	San Francisco General Hospital.
July 1986 - August 1990	Clinical supervisor PGY I psychiatric residents, San Francisco General Hospital
July 1986 - August 1990	Coordinator of Medical Student Education, University of California, San Francisco General Hospital, Department of Psychiatry. Teach seminars and supervise clerkships to medical students including: Psychological Core of Medicine 100 A/B; Introduction to Clinical Psychiatry 131 A/B; Core Psychiatric Clerkship 110 and Advanced Clinical Clerkship in Psychiatry 141.01.
July 1985 – August 1990	Psychiatric Consultant to the General Medical Clinic, University of California, San Francisco General Hospital. Teach and supervise medical residents in interviewing and communication skills. Provide instruction to the clinic on the psychiatric aspects of ambulatory medical care.

COMMUNITY SERVICE AND PRISON CONDITIONS EXPERT WORK:

February 2019- Present	Forensic psychiatric consultant to the British Charity, Reprieve. In this role, I have conducted postconviction, capital mitigation assessments. I have done this work in Indonesia and Malawi.
May 2016- July 2022	Court-appointed monitor in *Ashoor Rasho, et al. v. Director John* R. Baldwin, et al., No.:1:07-CV-1298-MMM-JEH (District Court, Peoria, Illinois.) This case involves the provision of constitutional mental health care to the inmate population of the Illinois Department of Corrections.
June 2015- May 2017	Senior Fellow, University of California, Criminal Justice & Health Consortium.
April 2014- October 2018	Plaintiffs' expert in *Hernandez, et al. v. County of Monterey, et al.*, No.: CV 13 2354 PSG. This case involves the provision of unconstitutional mental health and medical services to the inmate population of Monterey County Jail.
January-December 2014	Federal Bureau of Prisons: Special Housing Unit Review and Assessment. This was a year-long review of the quality of mental health services in the segregated housing units of the BOP.
August 2012- December 2021	Plaintiffs' expert in *Parsons et al. v. Ryan* et al., (District Court, Phoenix, Arizona.) This case involves the provision of unconstitutional mental health and medical services to the inmate population of the Arizona Department of Corrections.
October 2007- Present	Plaintiffs' expert in 2007-2010 overcrowding litigation and in opposing current efforts by defendants to terminate the injunctive relief in *Coleman v. Brown,* United States District Court, Eastern District of California, Case No. 2:90-cv-00520-LKK-JFM.

	The litigation involves plaintiffs' claim that overcrowding is causing unconstitutional medical and mental health care in the California state prison system. Plaintiffs won an order requiring the state to reduce its population by approximately 45,000 state prisoners. My expert opinion was cited several times in the landmark United States Supreme Court decision upholding the prison population reduction order. *See Brown v. Plata,* __ U.S. ___, 131 S. Ct. 1910, 1933 n.6, 1935, 179 L.Ed.2d 969, 992 n.6, 994 (2011).
July/August 2008- July 2016	Plaintiff psychiatric expert in the case of Fred Graves, et al., plaintiffs v. Joseph Arpaio, et al., defendants (District Court, Phoenix, Arizona.) This case involved Federal oversight of the mental health treatment provided to pre-trial detainees in the Maricopa County Jails.
February 2006- December 2009	Board of Directors, Physician Foundation at California Pacific Medical Center.
June 2004- September 2012	Psychiatric Consultant, Hawaii Drug Court.
November 2003- June 2008	Organizational/Psychiatric Consultant, State of Hawaii, Department of Human Services.
June 2003- December 2004	Monitor of the psychiatric sections of the "Ayers Agreement," New Mexico Corrections Department (NMCD). This is a settlement arrived at between plaintiffs and the NMCD regarding the provision of constitutionally mandated psychiatric services for inmates placed within the Department's "Supermax" unit.
October 2002- August 2006	Juvenile Mental Health and Medical Consultant, United States Department of Justice, Civil Rights Division, Special Litigation Section.
July 1998- June 2000	Psychiatric Consultant to the Pacific Research and Training Alliance's Alcohol and Drug Disability Technical Assistance Project. This Project aids programs and communities that will have long lasting impact and permanently improve the quality of alcohol and other drug services available to individuals with disabilities.
July 1998- February 2004	Psychiatric Consultant to the National Council on Crime and Delinquency (NCCD) in its monitoring of the State of Georgia's secure juvenile detention and treatment facilities. NCCD is acting as the monitor of the agreement between the United States and Georgia to improve the quality of the juvenile justice facilities, critical mental health, medical and educational services, and treatment programs. NCCD ceased to be the monitoring agency for this project in June 1999. At that time, the Institute of Crime, Justice and Corrections at the George Washington University became the monitoring agency. The work remained unchanged.

July 1998- July 2001	Psychiatric Consultant to the San Francisco Campaign Against Drug Abuse (SF CADA).
March 1997- Present	Technical Assistance Consultant, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.
January 1996- June 2003	Psychiatric Consultant to the San Francisco Drug Court.
November 1993- June 2001	Executive Committee, Addiction Technology Transfer Center (ATTC), University of California, San Diego.
December 1992 - December 1994	Institutional Review Board, Haight Ashbury Free Clinics, Inc. Review all research protocols for the clinic per Department of Health and Human Services guidelines.
June 1991- February 2006	Chief of Psychiatric Services, Haight Ashbury Free Clinic. Overall responsibility for psychiatric services at the clinic.
December 1990 - June 1991	Medical Director, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Responsible for directing all medical and psychiatric care at the clinic.
October 1996-July 1997	Psychiatric Expert for the U.S. District Court, Northern District of California, in the case of Madrid v. Gomez, No. C90-3094-TEH. Report directly to the Special Master regarding the implementation of constitutionally mandated psychiatric care to the inmates at Pelican Bay State Prison.
April 1990 –January 2000	Psychiatric Expert for the U.S. District Court, Eastern District of California, in the case of Gates v. Deukmejian, No. C1V S-87-1636 LKK-JFM. Report directly to the court regarding implementation and monitoring of the consent decree in this case. This case involves the provision of adequate psychiatric care to the inmates at the California Medical Facility, Vacaville. A major portion of this consent decree also involved establishing a program for the identification and treatment of inmates with Mental Retardation (currently referred to as Intellectual Disability.)
January 1984 - December 1990	Chief of Psychiatric Services, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Direct medical/psychiatric management of project clients; consultant to staff on substance abuse issues. Special emphasis on dual diagnostic patients.
July 1981- December 1981	Medical/Psychiatric Consultant, Youth Services, Hospitality House, San Francisco, CA. Advised youth services staff on client management. Provided training on various topics related to adolescents. Facilitated weekly client support group.

SERVICE TO ELEMENTARY AND SECONDARY EDUCATION:

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

PRESENTATIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

161. Administrative Office of the United States Courts, Federal Death Penalty Resource Counsel Projects, 2016 Strategy Session: "Ethnocultural Competency Issues in Working with Experts;" "Understanding Drug Use and Abuse by our Clients and Strategies for

Effectively Incorporating this Information into the Mitigation Narrative." Denver, Colorado, November 17-19, 2016.

162. "Evaluating the mentally ill and substance abusing client." Idaho Association of Criminal Defense Lawyers, Sun Valley, Idaho, March 10, 2017.

163. Mental Health & Death Penalty Training, Community Legal Aid Institute (LBH Masyarakat), Jakarta, Indonesia, February 12 -16, 2019.

164. Mental Health & Death Penalty Training, Blantyre, Malawi, October 6, 2023.

PUBLICATIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16) Brief of Medical and Other Scientific and Health-Related Professionals as Amici Curiae in Support of Respondents and Affirmance: Ahmer Iqbal Abbasi, et al., Respondents v. James W. Ziglar, John D. Ashcroft, et al., and Dennis Hasty, et al. Petitioners, On Writs of Certiorari to the United States Court of Appeals for the Second Circuit, In the Supreme Court of the United States, Nos. 15-1358, 15-1359 and 15-1363.

17) Brief of Professors and Practitioners of Psychiatry, Psychology, and Medicine as Amici Curiae in Support of Plaintiff-Appellant Eric Joseph Depaola, Denis Rivera & Luis Velazquez, Plaintiffs v. Virginia Department of Corrections, et al., External Review Team, et al., Defendants. On appeal from the United States District Court for the Western District of Virginia, Case No. 7:14-cv-00692 in the United States Court of Appeals for the Fourth Circuit, No. 16-7358.

18) Brief of Professors and Practitioners of Psychiatry, Psychology, and Medicine in support of Petitioner Shawn T. Walker v. Michael A. Farnan, et al., Respondents on petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit in the Supreme Court of the United States, No. 17-53.

19) Brief of Professors and Practitioners of Psychiatry, Psychology, and Medicine in support of Plaintiff-Appellant Edgar Quintanilla v. Homer Bryson, Commissioner, State of Georgia's Department of Corrections, et al., On appeal from the United States District Court for the Southern District of Georgia, Case No. 6:17-cv-00004-JRH-RSB in the United States Court of Appeals for the Eleventh Circuit, No. 17-14141.

EXHIBIT B

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Attorneys for Plaintiffs and the Certified Class and Subclasses

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

DARRYL DUNSMORE, ANDREE ANDRADE, ERNEST ARCHULETA, JAMES CLARK, ANTHONY EDWARDS, REANNA LEVY, JOSUE LOPEZ, CHRISTOPHER NORWOOD, JESSE OLIVARES, GUSTAVO SEPULVEDA, MICHAEL TAYLOR, and LAURA ZOERNER, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

SAN DIEGO COUNTY SHERIFF'S DEPARTMENT, COUNTY OF SAN DIEGO, SAN DIEGO COUNTY PROBATION DEPARTMENT, and DOES 1 to 20, inclusive,

Defendants.

Case No. 3:20-cv-00406-AJB-DDL

SUPPLEMENTAL EXPERT REPORT OF PABLO STEWART, M.D.

Judge: Hon. Anthony J. Battaglia
Magistrate: Hon. David D. Leshner

Trial Date: None Set

1. I have been asked by Plaintiffs' counsel to write a supplemental report regarding the current matter before the court concerning the provision of mental health care in the San Diego County Jail (hereinafter, the "Jail") system. This report is a supplement to my August 19, 2024 expert report ("August 2024 Report"), and my October 31, 2024 expert rebuttal report, Stewart Rebuttal Report ("October 2024 Rebuttal Report") (filed at Dkt. 937-5, 796-5).

2. This supplemental report is based on information that was not made available to me at the time that I completed these reports, including information produced in discovery that occurred in this case in 2025.

3. For this report, I have reviewed updated mental health and medical care records, from late 2023, 2024, and through February 3, 2025, for incarcerated persons whom I reviewed and discussed in my previous reports. I have also reviewed additional incarcerated persons' mental health and medical care records from late 2023, 2024, and through February 3, 2025, which I understand were produced by Defendants through discovery that occurred in 2025.

4. The materials I reviewed in preparing my opinions and findings are listed in **Exhibit A**.

5. The opinions in my previous expert reports remain unchanged, and the findings I provide in this supplemental report serve only to further reinforce those opinions.

I. FINDING #1: THE JAIL'S FAILURES TO ADEQUATELY IDENTIFY AND TRACK PATIENTS' MENTAL HEALTH NEEDS PERSIST.

6. In my previous report, I identified multiple systemic deficiencies with respect to the intake screening process, such that the system did not timely, effectively, or adequately identify and meet the mental health needs of incarcerated people when admitted at the Jail. August 2024 Report ¶¶ 24-52. Based on my supplemental review, my opinions as to the systemic deficiencies regarding

identification and tracking of people with mental health needs remain the same. These systemic deficiencies continue to place people with mental illness at substantial risk of serious harm. For example:

[redacted]

13. This is a patient who requires an individualized plan for meaningful and robust mental health treatment, yet there is no indication of such an individualized plan or that any such treatment is being provided to him.

14. In my previous report, I noted several ways that the system of identifying incarcerated people's mental health needs was inadequate, including that even the identification of a person's elevated suicide risk would not lead to clinically indicated treatment planning or meaningful treatment services. These same systemic deficiencies show up in the updated records I received, with [redacted] case an illustrative example.

II. FINDING #2: DANGEROUS SYSTEMIC DEFICIENCIES IN THE PROVISION OF ESSENTIAL MEDICATIONS AND PSYCHIATRIC CARE CONTINUE TO PUT PATIENTS AT GREAT RISK OF HARM.

15. In my previous reports, I described my extreme concern about systemic deficiencies in the provision of essential medications to people with mental health

treatment needs in the San Diego County Jail. I outlined how the resulting failures and delays in the provision of medications and psychiatric care put patients in this Jail system at substantial risk of serious harm. August 2024 Report ¶¶ 53-95.

16. Having now reviewed updated and additional records, the level of my concern remains extreme. My findings and opinions are unchanged. I provide below some illustrative examples of patients who continue to be placed at enormous risk, and who have in fact been harmed by the persistence of these systemic psychiatric care deficiencies.

[redacted]

[redacted]. His psychiatric care did not meet the standard of care, and highlights serious deficiencies with the psychiatric care system at this Jail.

[redacted]

[redacted] Such delays in psychiatric follow-up in this Jail system are pervasive, and they are dangerous.

[redacted] The failure to monitor for such medication side effects, and to address them as warranted, signals a dangerous systemic deficiency in the Jail's psychiatric care system.

[redacted]

[redacted]

30. The standard of care for prescribing practices caution against abruptly restarting high doses of these sorts of medications after a period of nonadherence; doing so can lead to dangerous side effects such as oversedation, gastrointestinal issues, and sudden dangerous drops in blood pressure. [redacted]

[redacted]

32. This patient demonstrates the unsafe prescribing practices, the insufficient monitoring and follow-up protocols, and the failure to adhere to the standard of care for psychiatry, systemic deficiencies that expose [redacted] and other patients to unnecessary and preventable harm.

[redacted]

[redacted]

III. FINDING #3: THERE IS STILL NO LEVEL OF CARE SYSTEM, AND THE JAIL SYSTEM CONTINUES TO DENY PEOPLE THE MENTAL HEALTH TREATMENT THAT THEY NEED.

36. In my previous report, I discuss in detail my finding that the San Deigo County Jail system lacks an adequate levels of care system and fails to provide minimally adequate treatment to people with mental health needs, causing unnecessary suffering and putting people at substantial risk of harm. August 2024 Report ¶¶ 96-181.

37. Based on my review of updated and additional records, I can discern no indication that the San Deigo County Jail system has, since that time, implemented

an adequate level of care system or is providing treatment programming that comes close to meeting the needs of the patient population. Instead, I found that patients continue to be denied clinically indicated treatment programming, *including* in units that are ostensibly designated for a "mental health population." For example:

[redacted]

40. In any minimally adequate Jail mental health system, one would expect to see meaningful effort to provide this sort of patient structured treatment activities, with proactive clinical and custodial efforts to bring him into a group setting. Here, the records reflect what I observed in multiple patients' record review and during my site visit – that is, patients are left isolated and undertreated because they are deemed "too unstable," without sufficient clinical interventions, *even* in the acute care unit.

[redacted]

[redacted]

46. In all, this patient did not receive anything close to minimally adequate treatment – not with respect to clinical contacts, nor psychiatric care, nor protection from the well-known risks of decompensation in Administrative Separation. The deficiencies I found in my previous reports show up, in the same substantive ways, in this patient's records into early 2025.

IV. FINDING #4: THE JAIL'S USE OF SOLITARY CONFINEMENT REMAINS EXTREME WITH RESPECT TO HARMFUL CONDITIONS AND LACK OF TREATMENT

47. I remain gravely concerned about the Jail's use of solitary confinement, and the lack of adequate treatment provided to people with mental health needs in such conditions. The current use of solitary confinement in this system puts people at unnecessary and serious risk of harm.

48. I have provided extensive discussion about the widely accepted reality that solitary confinement conditions can cause healthy people to develop mental illness and place people with existing mental illness at enormous risk of deterioration, decompensation, and substantial risk of psychosis, self-harm, and suicide. May 2, 2022 Stewart Decl., Dkt. 119-7, ¶¶ 24-33.

49. I have also provided my detailed findings about how the San Diego County Jail use of solitary confinement has caused, and continues to cause, serious and unjustified harm on a broad scale. August 2024 Report ¶¶ 182-283. As I have noted, this Jail's isolation units (called "Administrative Separation") constitute some of the harshest, most restrictive forms of solitary confinement I have ever witnessed

in any jail system.

50. Having reviewed additional and updated records of incarcerated people with serious mental health treatment needs who have been held in these solitary confinement units more recently, I see clear evidence in records from late 2023 through early 2025 that they continue to suffer and to face substantial risk of serious harm. The systemic deficiencies I have identified remain unremedied. For example:

[redacted]

[redacted] The conditions and lack of treatment, and the continued placement of people with mental illness in highly restrictive settings, place people at grave and unacceptable danger. [redacted]

[redacted]

In my experience, even a minimally effective quality assurance program would have identified and addressed this sort of dangerous failure in the provision of psychiatric care.

[redacted]

64. This case illustrates several aspects of the dangerous conditions and lack of adequate care that persist in this Jail system, especially in the Administrative Separation units.

V. FINDING #5: THE GRAVE DEFICIENCIES IN SUICIDE PREVENTION PRACTICES AT THE JAIL PERSIST.

65. Given the long history and considerable public attention of suicides in the San Diego County Jail system, my work in this case has included substantial consideration of the suicide prevention policies and practices in this system. I describe several deficiencies on this topic in my previous findings. August 2024 Report ¶¶ 284-350.

66. While I am relieved to hear that the number of suicides has reportedly decreased more recently, my review of the updated and additional records makes plain that major deficiencies with respect to suicide prevention policies and procedures remain essentially unchanged since the review I conducted for my previous reports. For example:

[redacted]

[redacted]

70. [redacted] recent treatment has been deficient in ways that are entirely consistent with the systemic deficiencies related to suicide prevention and mental health treatment that I identified in my previous findings.

[redacted]

[redacted]

Based on my experience and expertise, it is my strong opinion that this very serious suicide attempt was preventable with appropriate provision of mental health care and, in particular, the appropriate

involvement and intervention of psychiatry (which did not occur).

VI. FINDING #6: UPDATED RECORDS EVIDENCE CONTINUED DEFICITS IN STAFFING THAT PREVENT THE PROVISION OF CLINICALLY NECESSARY MENTAL HEALTH CARE.

76. In my previous reports, I explained in detail how the San Diego County Jail lacks sufficient mental health staffing resources to meet the treatment needs of the Jail population, and that the Jail's extremely unusual staffing structure is dysfunctional and ineffective in ways that impede necessary systemic improvements to the Jail mental health care system. August 2024 Report ¶¶ 351-388.

77. Based on my review of updated and additional records, I can easily discern that these systemic deficiencies have continued. The staffing structure that includes (a) county-employed mental health clinicians (inappropriately supervised and directed by the Sheriff's Office leadership), and (b) private contractor-employed psychologists, psychiatrists, and psychiatric nurse practitioners (who seem to operate independent of county policies and procedures, and with no clear supervision or effective accountability structure), is unchanged.

78. The continued lack of adequate staffing is a primary contributor to the (a) untimely provision of mental health treatment (including with respect to psychiatry), (b) the grossly inadequate mental health treatment programming, (c) the lack of an adequate level of care system, and (d) the pervasive failure to provide confidential mental health contacts (with a staggering reliance on non-confidential cell-front contacts). I found each of these systemic deficiencies in my previous reports, and have found them again as part of this updated supplemental review. In short, my opinions as to the systemic deficiencies with respect to staffing as it impacts the Jail mental health care system are unchanged.

VII. FINDING #7: THE JAIL'S DENIAL OF CONFIDENTIALITY IN THE PROVISION OF MENTAL HEALTH CARE HAS NOT CHANGED, AND STAFF CONTINUE TO MISUNDERSTAND AND MISREPRESENT WHETHER CLINICAL CONTACTS ARE CONFIDENTIAL.

79. In my previous reports, I describe in detail how and why confidential mental health contacts are the standard of care, both in the community and in detention settings. The failure to provide confidential treatment in San Diego County Jail puts people at substantial risk of serious harm by hindering their ability to share information and to receive adequate treatment. August 2024 Report ¶¶ 389-401.

80. As described in several of the individual patient reviews in this supplemental report, the San Diego County Jail still fails to provide necessary confidentiality in the provision of mental health treatment. The vast, overwhelming majority of mental health encounters are not confidential in this Jail system. This critical systemic deficiency has not been addressed.

81. Staff continue to misunderstand confidentiality requirements and, in turn, misrepresent which clinical contacts are confidential. [redacted]

82. And just as alarming, clinicians still frequently mark the cell-front contact as "confidential," *even* where they document that *custody staff was present* (Based on my experience, the necessity of custody staff's presence "for safety" in such a scenario is hard to believe, given that the patient is behind a locked cell door).

VIII. FINDING #8: JAIL CUSTODY STAFF CONTINUE TO EXERT IMPROPER AND DANGEROUS CONTROL OVER CLINICAL MENTAL HEALTH CARE DECISIONS.

83. In my previous declaration, I identified practices by which San Diego

County Jail custody staff improperly control and direct the placement and treatment of people with serious mental health needs, in ways that are inconsistent with the standard of care and that put people at substantial risk of serious harm. May 2, 2022 Decl. ¶¶ 17-76; August 2024 Report ¶¶ 403-417.

84. Based on my review of the updated and additional records, I can discern *no* changes to critical systemic deficiencies I previously identified relating to custody's improper control of and interference with the provision of clinically indicated care.

85. I have observed no records indicating that mental health staff assess incarcerated people *prior* to their placement in Administrative Separation to identify clinical contraindications with such placement and to prevent any such contraindicated placement. This practice is well-established in the field of detentions and jail mental health care as necessary to prevent foreseeable and serious risk of substantial harm.

86. I have observed no records indicating that mental health staff meaningfully assess incarcerated people while they are housed in Administrative Separation to identify signs of decompensation, or that they have been given direction and authority to remove patients who are decompensating or at risk of decompensating. This practice is also well-established in the field of detentions and jail mental health care as necessary to prevent foreseeable and serious risk of substantial harm.

87. I have observed no records indicating that the San Diego County Jail system has eliminated the blanket bans on people designated by custody as "Protective Custody" or "Administrative Separation" from the Outpatient Stepdown (OPSD) units, which are currently the only Jail-operated housing locations outside of the acute care Psychiatric Services Units (PSUs) designated to house and serve people with serious mental health needs. This exclusion remains completely unacceptable and puts people at unnecessary risk.

IX. FINDING #9: THERE MUST BE FULL AND MEANINGFUL IMPLEMENTATION OF THE COURT-APPROVED REMEDIAL PLANS TO ADDRESS THE SYSTEMIC DEFICIENCIES RESULTING IN THE IMPROPER AND DANGEROUS PUNISHING OF PEOPLE WITH MENTAL HEALTH NEEDS OR AN INTELLECTUAL DISABILITY.

88. In my previous findings, I discuss my concerns with this Jail's policies and procedures that result in improper and dangerous punishments for people with serious mental illness or intellectual disability. August 2024 Report ¶¶ 418-426.

89. I am aware that, since that time, a Joint Motion and Order regarding the Americans with Disabilities Act claim in this case has been submitted and approved by the court. In that document, there are remedial provisions that I perceive as serving to address my concerns on this topic. *See, e.g.*, Dkt. 792-2, ¶¶ 125-129.

90. Full and meaningful implementation of those remedial provisions will be absolutely essential to providing a remedy to the systemic deficiencies I identified.

X. FINDING #10: THERE MUST BE FULL AND MEANINGFUL IMPLEMENTATION OF THE COURT-APPROVED REMEDIAL PLANS TO ADDRESS SYSTEMIC DISCRIMINATION AGAINST PEOPLE WITH MENTAL HEALTH AND INTELLECTUAL DISABILITIES.

91. In my previous findings, I discuss my concerns with this Jail's policies and procedures that result in harmful discrimination against people with mental health disabilities or intellectual disabilities. August 2024 Report ¶¶ 427-430.

92. Again, I am aware that the Joint Motion and Order regarding the Americans with Disabilities Act claim in this case contains remedial provisions that I perceive as serving to address my concerns on this topic, including the concerning discriminatory practices of (1) failing to place incarcerated people with mental health or intellectual disabilities in the least restrictive setting appropriate to their individual needs and circumstances; (2) placing such people in more restrictive

settings due to their disability and (3) denying such people access to services, programs, and activities that similarly situated, non-disabled individuals receive (*e.g.*, classes, recreation, job opportunities, etc.). *See, e.g.*, Dkt. 792-2, ¶¶ 76-81 ("Program Access").

93. Full and meaningful implementation of those remedial provisions will be absolutely essential to providing a remedy to the systemic deficiencies I identified.

XI. FINDING #11: DISCHARGE PLANNING REMAINS A COUNTY-WIDE, SYSTEMIC FAILURE

94. I continue to have significant concern regarding the inadequacy of discharge planning services at the Jail. As I have discussed, this is an essential component of an adequate jail mental health care system. It is absolutely necessary to ensure medication and treatment continuity, linkages to community-based service providers, and resources to prevent people with mental health needs from being subjected to a substantial risk of serious harm upon release. August 2024 Report ¶¶ 431-439.

95. I emphasize here that this is an effort that requires a *multi-agency* solution, including with the County's Behavioral Health Services Department, Public Health Services Department, Public Defender, and Probation Department.

96. Based on my supplemental review, discharge planning services at the San Diego County Jail remain inadequate and will require additional focus and resources in order to achieve a systemic remedy. For example:

[redacted]

[redacted]

100. This case illustrates persistent systemic deficiencies to provide adequate discharge planning services, and to ensure appropriate *coordination* across county agencies to facilitate continuity of care for people with mental illness upon release. While my review suggests that Jail staff are in some respects working to enhance discharge planning efforts within the Jail, it is clear that more resources and attention, including from other County agencies, are needed to meet the needs of discharging people who have ongoing mental health treatment needs.

CONCLUSION

101. As I have previously noted, in my more than 35 years evaluating and working in detention facilities, I have come across very few, if any, mental health care systems so lacking in effective systems and levels of care to meet the needs of the incarcerated population with serious mental health treatment needs, and to protect people from serious harm.

102. Based on my supplemental review of records through February 3, 2025, the systemic deficiencies I identified in my 2024 reports have persisted. It remains the case that remedial action to address these systemic deficiencies is urgently needed.

103. The information and opinions contained in this report are based on evidence, documentation, and/or observations available to me. I reserve the right to modify or expand these opinions should additional information become available to me. The information contained in this report and the accompanying exhibits are a fair and accurate representation of the subject of my anticipated testimony in this case.

DATED: August 23, 2025

Pablo Stewart, M.D.

EXHIBIT A

INDEX OF DOCUMENTS REVIEWED BY PABLO STEWART
(for Supplemental Expert Report)

[redacted]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1591871-SD 1591885)

[redacted]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1592335-1592370)

[redacted]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1592009-1592044)

[redacted]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1592371-1592388) (SD 1592389-1592395) (2 files)

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CONFIDENTIAL FOR COUNSEL ONLY (SD 1620795-1623535)

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CONFIDENTIAL – FOR COUNSEL ONLY (SD 1591886-1592008)

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CONFIDENTIAL FOR COUNSEL ONLY (SD 1626279-1627013)

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CONFIDENTIAL FOR COUNSEL ONLY (SD 1609861-1611496)

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CONFIDENTIAL – FOR COUNSEL ONLY (SD 1592334)

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CONFIDENTIAL – FOR COUNSEL ONLY (SD 1592045) (SD 1592046-SD 1592210) (SD 1592211-SD_1592333) (3 files)