(PC) Coleman, et al v. Brown, et al. Doc. 5583

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

EDMUND G. BROWN, JR., et al.,

Defendants.

No. 2:90-cv-0520 KJM DB P

ORDER

This matter came on for hearing on January 23, 2017 to address ongoing issues with timely access to inpatient mental health care and mental health crisis beds (MHCBs). *See* ECF Nos. 5551, 5529. Prior to the hearing, the parties filed briefs and evidence in response to the court's December 9, 2016 order, ECF No. 5529. ECF Nos. 5542, 5543, 5544, 5546. At the hearing, the court heard testimony from Pamela Ahlin, Director of the Department of State Hospitals (DSH), Dr. Katherine Warburton, Medical Director and Deputy Director for Clinical Operations for DSH, and Katherine Tebrock, Deputy Director of the California Department of Corrections and Rehabilitation's (CDCR) Mental Health Services Delivery System (MHSDS). *See* Reporter's Transcript of Proceedings (RT), ECF No. 5560; Decl. of Pam Ahlin, ECF No. 5544-1 ¶ 1; Decl. of Katherine Tebrock, ECF No. 5544-2 ¶ 1. Following the hearing, defendants filed additional evidence as directed by the court. ECF Nos. 5558, 5559.

Dockets.Justia.com

For several months the court has signaled that defendants' non-compliance with court orders and Program Guide[1] timelines for access to inpatient care must end. *See*, *e.g.*, ECF No. 5519 (ordering defendants to show cause why waitlists for inpatient care cannot be reduced to zero); RT 5:1-6:13. For the reasons explained in this order, defendants will be directed to show cause in writing why they should not be required to come into full and permanent compliance with Program Guide timelines for transfers to acute and intermediate care facility (ICF) hospital beds by May 15, 2017. In addition, the parties will be directed to brief why defendants should not be required to comply with the Program Guide requirement for transfer to MHCBs within twenty-four hours of referral by the same date, and, if so, whether the court should require full and permanent compliance with that requirement or, instead, whether 90 percent compliance should be required. Furthermore, the parties will be directed to brief (1) how any subsequent court order requiring compliance with these timelines should be enforced; (2) whether monthly data templates required by this court, *see* ECF No. 5367, with recent proposed revisions currently pending before the court, *see* ECF Nos. 5537, 5577,[2] will provide sufficient data to allow the court to enforce such an order; and (3) whether monetary sanctions are an appropriate remedy for non-compliance with such an order.

I. BACKGROUND

In 1995, the court found "substantial delays in access to mental health care for inmates housed in" CDCR in violation of the Eighth Amendment to the United States Constitution. *Coleman v. Wilson*, 912 F. Supp. 1282, 1308 (E.D. Cal. 1995). The court found delays "everywhere within the system," including access to necessary inpatient hospitalization, "and that those delays result in exacerbation of illness and patient suffering. . . ." *Id.* at 1309.

[1] The Mental Health Services System Delivery System Program Guide, 2009 Revision, is the operative remedial plan in this action. *See Coleman v. Brown*, 938 F. Supp. 2d 955, 961 (E.D. Cal. 2013). It is called, variously, the Program Guide or the Revised Program Guide. References in this order to the "Program Guide" or the "Revised Program Guide" are to this document.

[2] The court accepts the most recent monthly report in the form filed, ECF 5577, subject to hearing from the parties in response to this order regarding whether that form will achieve the goals the court now contemplates.

"To remedy the gross systemic failures in the delivery of mental health care, the court appointed a Special Master to work with defendants to develop a plan to remedy the violations and, thereafter, to monitor defendants' implementation of that remedial plan." *Coleman v. Brown*, 938 F. Supp. 2d at 959. A year and a half after ordering their development, in June 1997, the court gave provisional approval to defendants' remedial plans and directed the Special Master to begin monitoring defendants' implementation and compliance with those plans. Dkt.[3] No. 858. Defendants' remedial plan is "currently referred to as the Revised Program Guide." *Coleman v. Brown*, 938 F. Supp. 2d at 961. In March 2006, nine years after provisional approval, with limited exceptions not applicable here, the Revised Program Guide was given final approval by the court and defendants were ordered to "immediately implement" all of its provisions. ECF No. 1773. "Defendants' remedial plan, the Revised Program Guide, contains 'the time frames which'" must be met for the transfer of class members between levels of the MHSDS, including inpatient care. *Coleman v. Brown*, 938 F. Supp. 2d at 981. In relevant part, the Revised Program Guide requires:

1. Any inmate referred to an MHCB be transferred within 24 hours of referral;
2. Any inmate referred to any acute inpatient mental health hospital placement be transferred within ten days of referral, if accepted by DSH,[4] and
3. Any inmate referred to any intermediate care mental health hospital placement be transferred within 30 days of referral, if accepted by DSH.

Program Guide, 2009 Revision, at 12-1-16. These time frames "represent defendants' considered assessment of what is sufficiently 'ready access' to each level of care." *Coleman v. Brown*, 938

---

[3] Citations to the court's docket using the convention "Dkt. No." refer to filings made prior to initiation of the court's current electronic filing system. Citations to electronic filings using the convention "ECF No."

[4] Acceptance of referrals by DSH is governed by standards in an Administrative Letter dated November 2015 and offered into evidence at hearing as Plaintiffs' Exhibit A. The January 23, 2017 Status Conference Joint Exhibit List filed by the parties on January 27, 2017, as required by the court, identifies this document as Plaintiffs' Exhibit B. *See* ECF No. 5557 at 2. It was marked as Plaintiffs' Exhibit A at hearing.

F. Supp. 2d at 981. Almost twenty-two years after judgment was entered in this action, twenty years after defendants' remedial plans were provisionally approved, and more than a decade after these timelines were given formal approval and ordered "immediately implemented," the record before this court shows the timelines are regularly exceeded as class members wait to receive the highest and most urgent levels of mental health care. The court does not and has never contemplated endless entanglement with defendants as a result of this case. As discussed below, the record makes clear that defendants have had sufficient time to develop and implement the capacity and systems to comply with the timelines set forth in their remedial plan. It is time now for defendants to come into full and permanent compliance with this part of the Program Guide.

II. HISTORY

As the court discussed in its December 9, 2016 order, the history of the remedial phase of this action demonstrates clearly that "delays in access to inpatient care create backlogs at every layer of the MHSDS." ECF No. 5529 at 3; *see also Coleman v. Brown*, 938 F. Supp. 2d at 980 n.43. This has been demonstrated repeatedly over the past twenty years, most recently in the increase in waitlists for inpatient care that led to the current proceedings before this court. In its 2013 order denying defendants' motion to terminate this action, the court described the "unconscionable delays in access to inpatient care and the sequelae therefrom, including periodic substantial decline in clinical referrals to necessary hospital care" as "one of the most tragic failures in the delivery of mental health care." *Coleman v. Brown*, 938 F. Supp. 2d at 982. While noting that defendants had made "substantial improvement" in such access, the court found that the gains made by 2013 were "new and work remains." *Id.*

Three years later, in a monitoring report on inpatient mental health care for class members, the Special Master described those gains as "short-lived." ECF No. 5448 at 24.[5] The findings in that report, which are adopted in full by separate order, include a detailed summary of the history of efforts to remediate this Eighth Amendment violation, the obstacles to compliance,

[5] All references to page numbers in ECF documents are to the page number assigned by the court's Electronic Case Filing system and not necessarily to pagination within the document.

and the numerous court orders that have been directed at achieving constitutional compliance. *See id*. at 22-44. Several things are clear from this summary and the twenty years it encapsulates.

An insufficient number of inpatient beds, or delays in placement and transfer of inmates referred for inpatient care, or both, has a chilling effect on identification and referral of class members to necessary hospital care. *See*, *e.g.*, *id*. 8 & n.8. Defendants' failure to consistently fill the full complement of designated low-custody inpatient beds has

> a resounding ripple effect throughout all of the DSH inpatient programs which treat these patients, creating almost instantly a re-shuffling for other beds at other DSH programs, and at CDCR a back-up of patients awaiting DSH placement. Stays in mental health crisis beds (MHCB) at CDCR soon become overly long, as patients are waiting for admission and transfers to the inpatient programs they need.

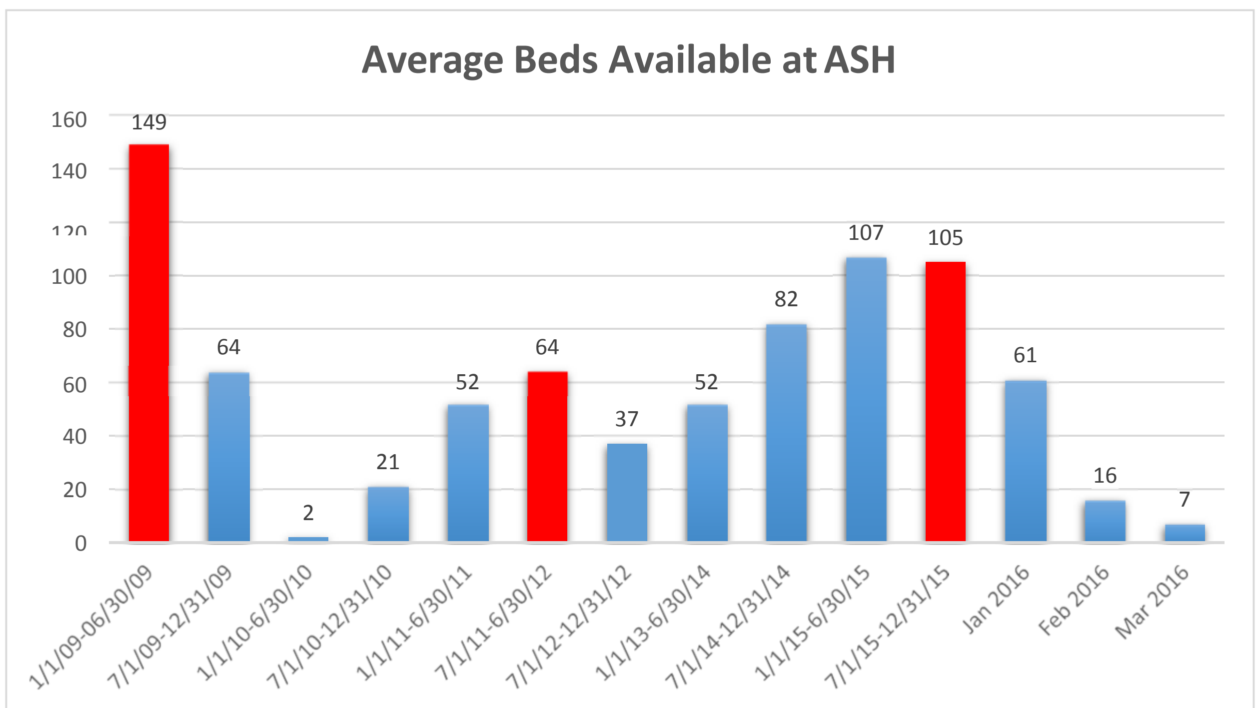
Id. at 9. Three times in the past twelve years, the Special Master has guided an assessment of unmet needs for identification and referral to inpatient care. *Id*. at 23. The first, conducted in 2005, resulted in identification of 400 inmates in need of inpatient mental health care. *Id*. at 8 n.8. The second, in 2009, found almost 1,000 inmates in need of inpatient mental health care who had not been identified or referred to an inpatient program. *Id*. at 29. The last assessment, conducted in 2011, led to planning and implementation in 2012 of a so-called "sustainable self-monitoring process ('the sustainable process') to ensure that inmates in need of inpatient care were timely identified, referred, and transferred to such care." *Id*. at 24. As the Special Master reported, however,

> the gains in access to inpatient care turned out to have been short-lived. Over time, in each instance, the number of *Coleman* class members in DSH beds diminished, referrals and transfers slowed, and waitlists grew – just as they did by July 2015. The process known as the *sustainable* process for identification, referral and transfer of CDCR inmates to inpatient care at DSH unfortunately turned out to be unsustainable.

Id.

As described in detail by the Special Master, court orders going back to 1998 reflect the myriad efforts to address ongoing problems with access to inpatient care. *See id*. at 36-39. Defendants have presented several plans to address those problems, including plans for creation of a sufficient number of beds, both through conversion and utilization of beds at DSH

hospitals and through construction of additional space at CDCR prison facilities, as well as review of custody criteria in order to increase "referrals of patients whose custody factors had previously precluded them from being placed in dorm settings or low custody beds at" Atascadero State Hospital (ASH). *Id*. at 25-35. These plans have been approved in whole or in part by the court and, where approved, ordered implemented. *Id*. at 36-39. And yet, by July 2015 the waitlists had swelled again and court intervention has once more been required. A particularly telling graph in the report shows three times in the past eight years when increases in the number of unoccupied *Coleman* beds at ASH have declined after issuance of court orders aimed at reducing or eliminating inpatient waitlists, followed after approximately three years by increases in unoccupied ASH beds and then declines again only after court intervention.



The red bars signify time periods during which court orders were issued to address the lack of patients being admitted to ASH. The blue bars indicate initial declines in bed availability at ASH after the issuance of court orders, followed by gradual increases over time resulting in the issuance of further court orders.

Id. at 39.

The latest round of court intervention on this issue began in August 2015 following the re-emergence of waitlists for inpatient care. *See* ECF No. 5333. The court held a status conference on August 19, 2015. ECF No. 5340. Following the status conference, the court

issued an order requiring, *inter alia*, defendants to report to the court within thirty days "on whether regular and consistent use of the full complement of 256 beds at Atascadero State Hospital (ASH) designated for *Coleman* class members is sufficient to permanently eliminate the ongoing waitlist for inpatient mental health care and if not, why not, and what alternate plans are in place for waitlisted class members." ECF No. 5343 at 2. The court also ordered the parties to finalize a template for defendants to use to report monthly on the census of their inpatient programs and the status of pending referrals to those programs. *See id.* at 3. On October 13, 2015, the court approved the templates proposed at that time and directed defendants to file them monthly beginning in October 2015. ECF No. 5367. Since then, defendants have been filing templates on or about the 15th of every month. The question for the court at this point is whether the most recent template proposed by defendants, and used to make their most recent monthly filing, will be "more helpful in identifying and highlighting information the court needs in order to enforce compliance with the remedial plan and other remedial orders." ECF No. 5537; *see also* ECF No. 5577.

After receiving an extension of time, ECF No. 5360, on October 30, 2015, defendants filed their report concerning full bed utilization at ASH. In the report, defendants represented that

> [t]hrough informal implementation of the Housing Review policy and existing utilization management measures, Defendants have effectively eliminated the waitlist for Intermediate inpatient care, are addressing Acute inpatient needs, and are maximizing the use of inpatient *Coleman* beds throughout the system, including at DSH-Atascadero, by ensuring that patients are moved to a less restrictive custodial setting as soon as it is clinically appropriate to do so. Defendants are confident that the measures underway and under consideration will effectively address the waitlist for Acute care.

ECF No. 5374-1 at 8. Less than a year later, on September 28, 2016, defendants filed a document styled "Defendants' Update to Department of State Hospitals' Inpatient Census and Movement." ECF No. 5496. That document showed a total of 187 class members on waitlists for transfer to inpatient care and only 71 beds available. ECF No. 5496-1 at 4. Defendants indicated that they would "welcome the opportunity to further discuss the issue before the Court in a status conference." *Id.* at 3.

On October 6, 2016, the court granted plaintiffs fourteen days to file a response to defendants' update, and set the matter for status conference on November 10, 2016. ECF No. 5498. Following the status conference, defendants were ordered to show cause in writing why the waitlists for inpatient care could not be reduced to zero by November 23, 2016, at 5:00 p.m. and maintained at zero thereafter. ECF No. 5519 at 3. On November 22, 2016, defendants reported to the court they would not be able to eliminate the waitlists by the deadline set in the court's order. ECF No. 5522 at 1. Defendants also represented that "while obstacles remain, the number of patients waiting beyond *Coleman* Program Guide timelines is decreasing . . . ." *Id*. However, they did not provide a "concrete timeline for permanent elimination of these waitlists." ECF No. 5529 at 1.

At the November 10, 2016 status conference, the court set a further status conference for January 20, 2017. ECF No. 5512. On December 9, 2016 and January 19, 2017, the court issued orders directing the parties' attention to specific issues to be addressed in supplemental briefing and at the hearing, and indicated it would take testimony over the course of one day, as necessary. ECF Nos. 5529 and 5551. The hearing was continued to January 23, 2017, and held on that day.

After hearing, and review of all the briefing filed by the parties, the court finds the Special Master was correct in his May 25, 2016 assessment that it is time to break "the all too predictable cycle of court intervention" in the rise and fall of inpatient waitlists. ECF No. 5448 at 39.

III. OPTIONS FOR COMPLIANCE WITH ACUTE AND ICF TIMELINES

Taken together, the extensive history of remedial efforts in this action and the evidence and testimony presented in connection with the January 23, 2017 hearing convince the court that defendants have sufficient options available to allow them to comply now, fully and permanently, with the timeline requirements of the Program Guide for transfers to acute and ICF inpatient care.

A. BED CAPACITY AND PROJECTED NEED

1. Capacity

At present, defendants report a total capacity for male inmates of 412 acute inpatient care beds, including 40 beds at the San Quentin Psychiatric Inpatient Program (SQ PIP); 390 ICF beds; and 700 high custody ICF Beds. ECF No. 5544-2 at Ex. A. The 700 high custody ICF beds include 58 beds at Salinas Valley Psychiatric Program (SVPP), which were taken offline in October 2016 and January 2017 due to flooding at SVPP. ECF No. 5544-1 ¶ 4; RT 139:12-14. Defendants' Census, Waitlists and Trends Report for Inpatient Mental Health Care for January 2017 (January Census Report), filed February 15, 2017, shows a total of 72 ICF high custody beds, 71 at SVPP and 1 at DSH-Stockton (Stockton), that are "temporarily unavailable due to repairs." *See* ECF No. 5566 at 6-7. In order to address the loss of capacity, defendants have started housing class members in 24 isolation beds at Stockton on an emergency basis.[6] RT 139:3-19. Although it was not entirely clear, it appears repair work on the SVPP units will begin this month. *See* RT 20:12-19, 133:6-12. Until the repairs are completed, it would appear defendants actually have 652 high custody ICF beds available.[7] Finally, the acute bed capacity number includes ten beds at Stockton that defendants have no plans to use because they are isolation rooms. RT 139:20-24. Defendants also propose a permanent addition of 72 high custody ICF beds at California Medical Facility (CMF), ECF No. 5544-2 at Ex. A, and Director Ahlin testified that they plan to convert 16 isolation rooms at Stockton to ICF beds, with construction beginning at the end of this month, March 2017. RT 45:16-24.

[6] The Special Master informs the court that he asked defendants more than a year ago for a plan for conversion of some or all of those rooms so they could be used as inpatient mental health beds. To date, defendants have not provided him with a plan, and they did not advise him the rooms were in use until shortly before the January 23, 2017 hearing. Director Ahlin testified these rooms were not designed for mental health inpatient care and that safety concerns presented by their use are currently being addressed with "enhanced staffing." RT 19:10-19, 43:1-23. Director Ahlin also testified that DSH has "a plan to convert one room in each cell" to long-term care. RT 19:25-20:6, 45:16-24. Defendants are cautioned that a failure to fulfill their obligation to work with the Special Master and his team on all matters that affect remediation in this action may result in further orders to show cause from this court.

[7] 700 ICF high custody beds less 72 temporarily unavailable plus 24 emergency beds equals 652 beds.

For female inmates, defendants report a total capacity of 45 Acute/ICF beds. ECF No. 5544-2 at Ex. A. They also report a temporary capacity of 30 Acute/ICF beds at Patton State Hospital (Patton), for a net total of 75 female Acute/ICF beds. *Id*.

2. Projected Need

In 2006, the court ordered defendants to "contract with Navigant Consultants to conduct annual population reviews and updates of their projections for mental health program populations from 2007 through 2009." ECF No. 1998 at 2. By order filed July 9, 2009, defendants were directed to renew that contract "and/or execute a contract with John Misener of McManis Consulting" for a period of three additional years. ECF No. 3629 at 3. Defendants continue today to contract with John Misener for their mental health program population projections, including bed need. RT 129:16-19. On January 11, 2017, defendants published their latest Mental Health Bed Need Study based on Fall 2016 Population Projections. ECF No. 5542-1 at 103. That study forecasts inpatient bed need through the end of fiscal year 2021. *Id*. at 112.

All of the projected need is based on a 90 percent occupancy standard and therefore includes more beds than the projected average daily census for all of the inpatient programs. *Id*. at 108, 112-115, 121. The charts below show the projected bed need for 2017 through 2021 and the average daily census on which the projected need is based:

a) Male Acute Psychiatric Program

YEAR	2017	2018	2019	2020	2021
Average Daily Census (ADC)	328.2	330.5	331.8	333.5	335.1
Bed Need	365	367	369	371	372

/////

/////

/////

/////

b) Male ICF High Custody

YEAR	2017	2018	2019	2020	2021
ADC[8]	631.5	635.5	637	639.7	641.9
Bed Need[9]	702	706	708	711	713

c) Male ICF Low Custody

YEAR	2017	2018	2019	2020	2021
ADC	324.2	327	329.4	332	334.5
Bed Need	360	363	366	369	372

d) Male PIP

YEAR	2017	2018	2019	2020	2021
ADC	38.5	38.6	38.8	39	39.1
Bed Need	43	43	43	43	43

e) Female Acute/ICF

YEAR	2017	2018	2019	2020	2021
ADC	49.7	50	50	50	50
Bed Need	55	56	56	56	56

ECF No. 5542-1 at 112-115, 121.

/////

/////

/////

/////

---

[8] Includes 0.6 average pending list for "1370s". *See* ECF No. 5542-1 at 113. These are individuals found incompetent to stand trial held in DSH hospitals pending restoration of competency. *See* Cal. Penal Code § 1370.

[9] This also includes 1370s. *See* ECF No. 5542-1 at 113; note 6 *supra*.

3. Capacity Compared to Projected Need

Based on the foregoing, the following table shows defendants' current and proposed bed capacity for 2017 and the projected bed need for the next five years:

YEAR	2017	2018	2019	2020	2021
Male Acute Capacity	372				
Need	365	367	369	371	371
Male ICF HC Capacity	700				
Need	702	706	708	711	713
Male ICF LC Capacity	390				
Need	360	363	366	369	372
SQ PIP Capacity	40				
Need	43	43	43	43	43
Female Acute/ICF Capacity	75[10]				
Need	55	56	56	56	56

Using defendants' numbers, the foregoing shows that defendants currently appear to have a sufficient number of male ICF low custody beds, and a sufficient number of female acute/ICF beds unless they remove the availability of the 30 beds at Patton. Defendants' current number of SQ PIP beds is less than their projected need, and the projected need for male acute care beds is slightly above existing capacity. Finally, as discussed above the net number of currently available ICF high custody beds is currently 652, which is lower than the projected need but above the projected average daily census.

4. Planned Additional Capacity

Defendants have presented evidence that they plan to open an additional 72 male high custody ICF beds at California Medical Facility (CMF) by April of this year. *See* ECF

[10] Defendants identify 30 of these 75 beds, located at Patton, as temporary. ECF No. 5544-2 at Ex. A.

No. 5544-2 ¶ 4. These beds are located in the L-1 unit at CMF, *id*., and are presently used as Enhanced Outpatient Program (EOP) beds. RT 140:13-24. At an earlier stage in these proceedings, three units in L-Wing at CMF were used for 110 ICF beds. *See* ECF No. 4103 at 10-11; ECF No. 4120 at 2. The October 2011 plan for use of L-Wing for high custody ICF patients called for single cells. *See* ECF No. 4103 at 10. At hearing, Deputy Director Tebrock confirmed that L-1 had single cells and only 36 patients when it was operated as an "emergency ICF unit" until early 2014. RT 147:17-148:1. The plan to open these additional 72 beds at CMF is described as "preliminary" in defendants' bed plan, ECF No. 5544-2 at Ex. A. RT 148:5-12. Defendants are assessing ways to address a shortage of treatment space in the unit, primarily by escorting inmate patients to O Wing, a "fairly new and . . . big" treatment facility at CMF. RT 148:5-23.

In addition, "the 2017-18 Governor's Budget proposes to construct two 50-bed, flexible use, inpatient units" and to complete construction by summer 2021. ECF No. 5544-2 ¶ 5. One unit will be at R.J. Donovan State Prison and one will be at California Institution for Men. *Id*. Primarily intended for use as MHCBs, the beds will also be able to "be flexed for use as an Acute Psychiatric Program or Intermediate Care Facility" as needed. *Id*.

Finally, at hearing Director Ahlin testified that defendants have a plan to convert sixteen isolation rooms at Stockton to ICF beds, with construction beginning at the end of March 2017. RT 45:14-24.

The foregoing evidence suggests that, while capacity in several areas is extremely close to projected need, defendants currently have enough overall inpatient bed capacity to meet the projected need for the next four years. That evidence alone suggests defendants should be able to come into full and permanent compliance with the Program Guide timelines forthwith.

The re-emergence of waitlists raises some question about defendants' capacity to meet demand, particularly when need spikes or beds must be taken offline. Currently, defendants use a 90 percent occupancy standard for projecting bed need. *See* ECF No. 5542-1 at 108. As explained in the most recent Mental Health Bed Need Study:

> The goal of the Study is to address the adequacy of the capacities in each program so that those who are referred on the basis of a clinical judgment will not encounter barriers caused by inadequate supply. Occupancy standards were selected to ensure that, on average, capacities would not be exceeded in the future given the forecasted bed requirements. While the inpatient community standard is approximately 80 percent, the California Correctional Health Care Services decided to apply a 90 percent occupancy standard to all inpatient programs, ... The lower occupancy standard increases the probability of having an empty bed available.

Id. Defendants attribute the latest re-emergence of waitlists to "[u]nexpected spikes," which have required them "to take specific action to address shortfalls in available bed capacity. . . ." and, as discussed, flooding at SVPP this winter has required defendants to take 70 high custody beds offline. These events, together with the 2015 re-emergence of waitlists, suggest questions about whether use of a 90 percent occupancy standard for planning going forward provides sufficient excess capacity. Defendants may want to seriously consider using an 80 or 85 percent occupancy standard for bed planning purposes going forward to avoid any shortfall in capacity. That determination will be for defendants to make as part of their overall responsibility for coming into full and permanent compliance with Program Guide timelines for transfer to inpatient care.

In a declaration filed November 22, 2016, Director Ahlin averred that "forecasting is not a perfect indictor of real demand" and that "[s]ometimes demand forecasting will fall short of real-time demand." Decl. of Pam Ahlin, ECF No. 5522-1 ¶ 9. She averred this kind of shortfall is what led to the most recent recurrence of waitlists, and why defendants could not, by November 23, 2016, reduce to zero the number of inmate-patients waiting for transfer to inpatient care. *Id.* The court credits the testimony that some of the forecasting of bed need "is certainly challenging to do." RT 130:11. Ultimately, however, it is defendants' responsibility to maintain an adequate capacity of inpatient mental health beds in order to meet their "constitutional obligation to provide 'a system of *read*y access to *adequate* [mental health] care.' *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982 (emphasis added)…" *Coleman v. Brown*, 938 F. Supp. 2d at 981. This includes sufficient capacity to manage inevitable spikes in demand. The record is replete with evidence of options available to defendants, many described by defendants

in recent filings with the court, to transfer all class members in need of inpatient care to the required level of care within the timelines established for doing so.

B. LEAST RESTRICTIVE HOUSING

In August 2015, this court held what would be the first in a series of hearings to address the re-emergence of waitlists for inpatient hospital beds for class members. *See* ECF Nos. 5333, 5340. Following the hearings, the court issued an order directing the Special Master to "be actively involved in the ongoing negotiations to update the memorandum of understanding (MOU) between DSH and the California Department of Corrections and Rehabilitation (CDCR) for provision of inpatient mental health care." ECF No. 5343 at 2. The court also directed defendants to report to the court within thirty days "on whether regular and consistent use of the full complement of 256 beds at Atascadero State Hospital (ASH) designated for *Coleman* class members is sufficient to permanently eliminate the ongoing waitlist for inpatient mental health care and if not, why not and what alternate plans are in place for waitlisted class members." *Id*. Defendants subsequently sought and received an extension of time to report to the court on the use of ASH beds on the ground that finalization of the MOU would impact that report. ECF No. 5360.

In their response, filed October 30, 2015, defendants reported to the court that they were "implementing a new Housing Review policy that will safely maximize the use of Defendants' inpatient *Coleman* beds throughout the system, including at DSH-Atascadero, by ensuring that patients who are, or who become, custodially eligible for Low-Custody Intermediate care placement are moved to a Low-Custody bed as soon as it is clinically appropriate to do so." ECF No. 5374-1 at 3. This least restrictive housing (LRH) policy builds on a policy implemented by defendants in 2011 that "lowered custodial criteria for placement in Low-Custody Intermediate programs and has resulted in nearly 1,400 direct admissions to Low-Custody programs to date, including over 860 admissions to DSH-Atascadero." *Id*. These efforts are aimed at remediating a longstanding problem with access to inpatient care for inmate-patients with a high custody classification score and a recurring pattern of waitlists for high-custody inpatient beds while low custody inpatient beds, particularly at ASH, are unoccupied.

Director Ahlin testified that a patient's "clinical presentation doesn't always match their least restrictive housing . . . and it gives us an opportunity to find the best environment for what clinical presentation they are at that point in time so that they can be successful in treatment." RT 16:7-12. In such circumstances, the LRH designation serves as a kind of "step down" part of case management; patients are "reviewed upon admission and there's an assessment done at that point in time by their initial IDTT, which is the interdisciplinary treatment team, and then they are required to have a treatment team every 30 days thereafter." RT 17:2-7. She also testified that "approximately 90 per month are stepping down from our acute ICF [sic] programs into a least restrictive environment." RT 17:15-17.

Director Ahlin testified that as of January 20, 2017, 351 patients were housed in a DSH inpatient unit above their LRH classification. RT 12:17-19. At hearing, defendants offered as Exhibit 3 a Psychiatric Inpatient Programs Census Report as of 1/20/17. Defs.' Ex. 3. This exhibit shows that total as 354 patients. *See id.*[11] This represents more than half of the 685 patients in units where inmates out of LRH were housed. *Id.* At the same time, there were 46 unoccupied *Coleman* beds at ASH and 4 unoccupied *Coleman* beds at Coalinga State Hospital (Coalinga), *id.*, while 29 inmates had been waiting more than thirty days for admission to an ICF-High Custody bed. Defs.' Ex. 1.

Defendants have committed themselves to the LRH process both as part of their bed utilization management and efficiency goals and because of clinical considerations. The evidence before the court suggests that proper use of the LRH process will indeed aid defendants in making complete and efficient use of their full complement of inpatient mental health beds and in complying with Program Guide timelines.

[11] Defendants' January Census Report shows 351 patients housed out of LRH, still representing over half the 680 patients housed in units where inmates out of LRH were housed. *See* ECF No. 5566 at 6-7. This report shows 216 patients at ASH, five in an acute care program and 211 in ICF, with 12 beds on hold and 28 beds available. *Id.* There was 1 bed available at Coalinga. *Id.* at 7.

C. ADDITIONAL BED CAPACITY

1. DSH Hospitals

The option of adding increased *Coleman* inpatient bed capacity, particularly at ASH and Coalinga, has been raised over the course of the remedial phase of this action as defendants have grappled with the ongoing failure to eliminate waitlists for transfer to inpatient care. *See*, *e.g.*, ECF No. 4069 at 8 (Order resetting evidentiary hearing on why beds at Coalinga cannot be filled with high custody class members in need of inpatient care and granting defendants ninety days to "work with the special master to develop a supplemental plan to reduce or eliminate the inpatient wait list and to better serve the treatment needs of inmates on the wait list."). At the January 23, 2017 hearing, Director Ahlin testified that there are approximately 189 inpatient beds at Coalinga State Hospital (Coalinga) that are unoccupied and not already designated for *Coleman* class members, and approximately 91 such beds at ASH. RT 22:16-22. Of those, a total of 47 beds at ASH are "on two units that are not occupied at this time." RT 22:23-24. Those two units "were closed for fire life safety reasons" and are used "as swing space" when DSH does construction, repairs or modifications to other units. RT 25:9-15. The other 44 beds at ASH have been taken offline "due to aggression reduction." RT 22:25-23:4. Director Ahlin explained that these beds are found in units where the number of patients has been reduced in order to reduce patient assaults on staff and other patients. RT 22:25-23:17. Director Ahlin also testified that at some point in 2016, defendants began treating some inmates in need of acute inpatient care in an admissions unit at ASH. RT 66:20-67:1.

Dr. Warburton shed further light on this patient management issue. She testified that DSH facilities are required to treat, among other patients, individuals civilly committed as mentally disordered offenders (MDO patients) and that "[t]he MDO patients [in DSH] facilities are a much more volatile and difficult group of individuals to treat" than the *Coleman* patients admitted to DSH hospitals. RT 95:8-14. DSH is faced with "license and joint commission requirements" that prevent clinicians in DSH hospitals from managing violent behavior of MDO patients unless those patients "reach a level . . . where, essentially, the assault has to be either happening or we have objective evidence that it's about to happen." RT 95:18-96:21.

Dr. Warburton testified that those standards were developed for psychotic patients, but that MDOs and *Coleman* patients "have a whole host of violence risk factors and perpetrate different types of violence, . . . that those types of standards don't allow us to contain." RT 96:22-97:4. DSH is able to manage the violence risk of *Coleman* patients by placing high-risk individuals in one of the prison hospital programs where the violence can be contained; in contrast, in ASH or Coalinga, DSH staff "simply cannot contain that behavior" because they are "legally not allowed to. . . ." RT 97:8-11.

In light of the clarified record regarding ASH, it appears there may be some additional capacity available at ASH in the admissions unit currently being used to provide acute inpatient care, although defendants' January Census Report indicates defendants are counting these beds as part of the complement of 256 *Coleman* beds at ASH. *See* ECF No. 5566 at 6-7. Beyond the admissions unit, safety issues may preclude addition of any further bed capacity for class members at ASH. Specifically, Director Ahlin's testimony that the only two empty units at ASH have been closed "for fire life safety reasons" raises questions about why those units are used at all, even if not made available to *Coleman* class members. If additional ICF capacity is unavailable at ASH, it would appear that the full complement of 256 ASH beds designated for *Coleman* class members must be fully used at all times. The court assumes that complete and proper implementation of the LRH policy will mean that there are no unoccupied beds while class members are waiting for necessary inpatient care, particularly when such waits approach the deadlines set in the Program Guide.

Director Ahlin's testimony raises questions about the availability of additional capacity at Coalinga as well, though that is less clear. She testified that there are 189 undesignated beds available at Coalinga. RT 22:21-22. Fifty of those beds are offline because they are in two units "not designed for long-term patients, more of a pre-conditional release program . . . very much independent living" for the sexually violent predators Coalinga was originally built to house, and "not suitable for ICF or acute patients." RT 23:5-10. The remaining 139 unoccupied beds apparently are spread across a variety of the 28 long-term units that are open but operating with reduced population as part of "aggression reduction."

RT 23:11-21. Although Director Ahlin's testimony suggests that the two unused units at Coalinga are not immediately available, it is unclear whether those two unused units could, if necessary, be converted to additional inpatient space for *Coleman* class members. That too is a decision for defendants, not for this court. For purposes of this order, it is enough to note that there are two units at Coalinga that defendants might consider converting if additional inpatient mental health bed capacity is necessary to meet Program Guide timelines in the future.

2. Community Hospitals

In one of two declarations filed in connection with the recent proceedings, Deputy Director Tebrock averred that in 2012 and 2013, "CDCR attempted to secure beds in community hospitals to provide inpatient care to inmates." ECF No. 5544-2 ¶ 9. At the hearing, she testified that defendants have "recently . . . reached out again" "to try to identify any potential contractors in the community." RT 128:17-24. She was "not sure" what response they will get. RT 129:2-6. At this juncture, the record is not clear this is a viable option, though the court commends defendants for exploring all possible available resources to ensure that class members no longer wait for necessary urgent mental health care.[12]

[12] In connection with this issue, plaintiffs have submitted a Declaration of Pablo Stewart, M.D., prepared for and filed in another action in the Eastern District of California, *Hedrick v. Grant*, Case No. 2:76-cv-0162 GEB EFB P, together with a request to seal the document. The *Hedrick* plaintiffs have also requested that the document be sealed. *See* ECF No. 163-5 in Case No. 2:76-cv-0162 GEB EFB P. The court has reviewed the declaration and the request to seal. Dr. Stewart's declaration is offered for the proposition that "[c]ommunity hospitals are likely to resist taking forensic patients." ECF No. 5542. Review of the declaration shows that it discusses the limited availability of services at one hospital in Yuba County. The declaration does contain identifying information for inmates at Yuba County Jail, and those parts of the declaration might meet the "high threshold of showing that 'compelling reasons'" require that it be sealed. *Kamakana v. City and County of Honolulu*, 447 F.3d 1172, 1178 (9th Cir. 2006) (internal citation omitted). However, it appears that the declaration is of limited utility in these proceedings; it discusses only one hospital in one California county, the proposition for which the declaration is offered is not disputed in these proceedings, and defendants are nonetheless taking steps to explore community hospital options. For these reasons, plaintiffs' request to seal will be denied and the declaration will be returned to counsel unfiled.

D. LIFT AND SHIFT

For the second time in two years, defendants are again exploring the possibility of shifting to CDCR the responsibility for inpatient care of inmate-patients in the prison-based inpatient programs. This concept was discussed for the first time over a decade ago, and was the subject of an October 2007 court order. *See* ECF No. 5448 at 41-42; ECF No. 2461. Currently referred to as "lift and shift," the concept was explored in 2015 as part of the MOU process, but did not come to fruition then. *See* ECF No. 5448 at 15-16. It has, however, been included now in the Governor's Fiscal Year 2017-18 Budget proposal, ECF No. 5544 at 1, and, if adopted, will roll out over a period of two years. RT 137:10-14. The Special Master has signaled that, given the "overall success" of the two inpatient mental health programs operated by CDCR at California Institution for Women and San Quentin, "CDCR may now be ready to begin assuming responsibility for the inpatient care that has heretofore been provided by DSH at the three psychiatric programs, DSH-Vacaville, DSH-Salinas Valley, and DSH Stockton" and that "if CDCR is serious about a 'lift and shift' at the three DSH psychiatric programs, now is the time for CDCR to proceed in that direction." ECF No. 5448 at 43.

Deputy Director Tebrock testified that this proposal, if adopted and successfully implemented, "compresses the timeframes for review that are necessary to get somebody into the inpatient programs . . . effectively eliminating a level of review," thereby saving time and increasing access to care. RT 136:15-21. She estimates that referral times to acute care programs "may be reduced by as much as 50 percent (from six to three business days), and by as much as 40 percent in high-custody, intermediate-care programs (from fifteen to nine business days)." ECF No. 5544-2 ¶ 6. In addition, "CDCR Inpatient Coordinators will receive the least restrictive housing designations much sooner in the process" and "[b]ecause referrals will be an internal CDCR process, CDCR Headquarters staff will be able to review referrals much more quickly, and the DSH confirmation step will be eliminated." *Id.* This testimony suggests very significant efficiencies in transfer to inpatient care may be realized through adoption of "lift and shift." It also suggests there is currently an enormous duplication of effort between CDCR and DSH personnel involved in referral and transfer of inmates to inpatient care. Unless addressed, this

duplication of effort will continue even with the adoption of lift and shift because defendants will still use DSH-run inpatient beds at ASH and Coalinga for inpatient care of *Coleman* class members.

The specific proposal to implement "lift and shift" is an encouraging development, which has much promise as defendants work toward achieving a lasting and durable remedy. Of great significance, reduction in the time it takes to transfer inmates to inpatient care may reduce the risk of further decompensation and increased acuity of mental illness, which can accompany delays in transfer to necessary hospital care. At this point, adoption of "lift and shift" requires passage of the budget and cannot be assumed. Deputy Director Tebrock testified that if "lift and shift" is "approved by the legislature, the shift would occur on July 1st, but it contemplates a two-year rollout period. So for the foreseeable future, things will remain the same…." RT 137:13-15. Notwithstanding, all signs are that, in addition to other advantages, "lift and shift" would help maintain compliance with Revised Program Guide timelines. The court expects the Special Master will be fully involved in the planning for "lift and shift" and, if adopted, its implementation.

IV. MENTAL HEALTH CRISIS BEDS

In the December 9, 2016 order, the court expressed great concern about defendants' practice of retaining inmate-patients in MHCBs pending transfer to inpatient care. ECF No. 5529 at 2-3. MHCBs are, as their name states, for inmate-patients in mental health crisis: demonstrating "Marked Impairment and Dysfunction in most areas (daily living activities, communication and social interaction) requiring 24-hour nursing care; and/or: Dangerousness to others as a consequence of a serious mental disorder, and/or dangerousness to self for any reason." Program Guide at 12-1-8. The Program Guide requires inmate-patients referred to an MHCB to be transferred within twenty-four hours. *Id.* at 12-1-16. The Program Guide also limits MHCB stays to ten days absent approval by the Chief of Mental Health or a designee. *Id.* at 12-1-8. As the court has found, "the Program Guide makes clear [that] each level of the MHSDS has specific admission criteria." ECF No. 5529 at 2-3.

> Referral to inpatient care "is available for inmate-patients whose conditions cannot be successfully treated in the outpatient setting or in short-term MHCB placements." Program Guide at 12-1-9. By its own terms, defendants' remedial plan makes plain that inmates referred to inpatient mental health care *cannot be successfully treated* at lower levels of care or in MHCBs. MHCBs do, under the Program Guide, provide "*short-term* inpatient care for seriously mentally disordered inmate patients awaiting transfer to a hospital program or being stabilized on medication prior to transfer to a less restrictive level of care." Program Guide at 12-1-8 (emphasis added). MHCBs are not, however, a substitute for the inpatient care provided through DSH programs. Referrals to DSH inpatient care represent the considered judgment of CDCR clinicians that those inmate patients need a higher level of care than is available in CDCR's EOP and MHCB programs.

Id.

In the Twenty-Sixth Round Monitoring Report, the Special Master reported to the court that "growing wait lists for inpatient care beds was causing a surge in the number of inmates awaiting transfer to inpatient beds as they remained in their MHCBs pending transfer." ECF No. 5439 at 20. This in turn was causing delays in the timely transfer of class members to MHCBs, and these inmates are often held in settings that cannot provide them with the emergency care they require to stabilize their mental health crisis.

The record shows that defendants are not in compliance with the Program Guide 24 hour transfer requirement. In September 2016, a total of 448 class members were transferred to MHCBs. ECF No. 5529-1 at 13. The average wait time for transfer was 86.45 hours, and only nine class members were transferred in less than 24 hours. *Id*. In November 2016, there was improvement: 387 inmates were transferred to MHCBs with an average wait time of 25.93 hours. ECF No. 5543-1 at 32. Two-hundred forty-four of those were transferred within 24 hours, while 103 waited between 24 and 48 hours, 25 waited between 48 and 72 hours, and 15 waited more than 72 hours. *Id*. At the evidentiary hearing, the court heard testimony that as of January 20, 2017, there were 39 inmates pending transfer to an MHCB, nine of whom had been waiting longer than 24 hours even though there were 161 vacant MHCBs. RT 124:1-7.

Defendants currently have 427 male MHCBs and 22 female MHCBs. RT 122:8-11. Although defendants have a plan to add 100 additional MHCBs which can also be flexed to serve as acute or ICF inpatient beds by 2021, RT 169:25-170:8, testimony at the

evidentiary hearing suggested that factors other than an insufficient number of MHCBs are necessary to eliminate transfer delays. These factors include: proper "triaging" of the "need for crisis beds"; quality improvement practices that, among other things, discharge "patients from crisis beds early" to free up the beds for inmates in need of the beds; and efforts to minimize the number of referrals that are quickly rescinded. RT 133:13-135:11. These management issues, while real, can no longer serve to excuse non-compliance with Program Guide timeline requirements for transfer to MHCBs.

In the court's view, a significant question here is whether 90 percent compliance with the 24 hour transfer requirement is sufficient to achieve constitutional compliance or, instead, whether 100 percent compliance with the requirement, with specific exceptions, is required. *See* ECF No. 4361 at 9 (Rejecting defendants' objection to the Special Master's use of the term "compliance" as requiring a "'minimal score of 90% against Program Guide requirements'" and finding that "[b]ecause the Revised Program Guide is the operative remedial plan in this action, the degree to which defendants have implemented the requirements of the Revised Program Guide is extremely relevant and useful to assessment of whether they are meeting their constitutional obligations."). The court will direct the parties to provide supplemental briefing on this question, among others.

V. CONCLUSION

Over a decade ago defendants were ordered to "immediately implement" the provisions of the Program Guide. Nearly seven years ago, defendants were ordered to "come up with a plan to reduce or eliminate the wait list for inpatient care. . . ." ECF No. 4069 at 2 (citing ECF No. 3831 at 3). Five-and-a-half years ago the court issued an order outlining the urgency of the problem and describing time wasted developing yet another plan while the waitlists continued to grow. *See* ECF No. 4069, *passim*. Nearly four years ago, the court denied defendants' motion to terminate this action in part because defendants had not yet solved the problem of providing class members ready access to inpatient care. *Coleman v. Brown*, 938 F. Supp. 2d at 982. Despite the court's repeated prodding, defendants have not yet regularly and consistently met Program Guide timelines for transfer to inpatient care and inmates still wait past those timelines

to be transferred to necessary hospital care. As recently as November 2016, defendants once again told this court they could not yet eliminate those wait lists. *See* ECF No. 5522.

The court's patience in the face of waitlists that continue to exceed Program Guide timelines is at an end. For the past twenty years, under court supervision and court order, defendants have studied and planned myriad ways to meet the requirements of their remedial plan for timely transfer of class members to necessary inpatient mental health care. They have conducted at least three studies of unmet need, resulting, at different times, in identification and referral of approximately 1500 class members in need of inpatient care. Under court order, they have contracted with a consultant to project mental health bed capacity need four years into the future. Under court order, they have presented the court with short-term bed plans and long-range bed plans, they have implemented some of those plans, and they have constructed additional inpatient beds. At this point it is clear that defendants have sufficient options available to them to meet Program Guide timelines for transfer of all class members referred for inpatient care even if demand spikes or emergencies arise to temporarily reduce capacity. Those timelines must be complied with and waitlists that exceed those timelines must be completely and permanently eliminated.

At the same time, as the court has noted, there are very encouraging signs in the plans defendants have put forward for adding additional bed capacity over the next four years, for making more of their inpatient beds able to flex from acute to ICF and/or MHCB use to meet the changing needs of the mentally ill inmate population, and for shifting responsibility for the prison-based inpatient programs to CDCR. The court intends any enforcement order to be in support of the goal, that defendants achieve full and complete remediation in the near term; it is this goal that informs the work of the Special Master and, the court presumes, is shared by the parties. When it is clear to the court that the mechanisms for full compliance are readily available to defendants, as it is with respect to these Program Guide timelines, an order requiring such compliance is intended solely to ensure completion of one of the tasks central to ending court oversight.

To that end, defendants will be ordered to show cause in writing why they should not be required to come into full and permanent compliance with Program Guide timelines for transfer to acute and ICF inpatient mental health care by May 15, 2017. The court acknowledges Director Ahlin's testimony that factors including "holds for co-occurring medical needs [and] legal holds to address subpoenas and pending Court matters" "may affect the timing of patient transfers." ECF No. 5522-1 ¶ 7. Accordingly, unless any party can show good cause otherwise, the ten, and thirty-day periods in which transfer to inpatient care must occur will, for purposes of enforcement by this court, not include any time a class member referred to inpatient mental health care spends in treatment for medical needs deemed more urgent than the mental health need that led to the inpatient referral, or any time a class member spends on out-to-court status pursuant to a court order or subpoena.

In addition, the parties will be directed to brief whether a court order requiring compliance with Program Guidelines for transfer to MHCBs should require 90 percent compliance across CDCR institutions or 100 percent compliance with defined exceptions, as appropriate.

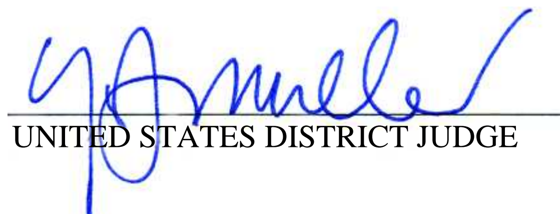
Finally, the parties should brief the question of appropriate remedies for violation of any court order enforcing these Program Guide timelines. This court has made clear it intends to bring this case to a successful conclusion sooner rather than later and that defendants must finish the remaining tasks and achieve a durable remedy. *See, e.g.*, RT 5:1-18. The court also has made clear it will not micromanage defendants in this process; and it has no intention of converting the Special Master to a Receiver. RT 5:19-22. At this stage of these protracted remedial proceedings, it appears to the court that the only effective remaining consequence of noncompliance with the enforcement order the court anticipates issuing would be a fine of a specific dollar amount. The court is contemplating a sanction of $1,000 per day for every day any class member waits past a Program Guide deadline for transfer to ICF or acute inpatient care. A similar fine would seem appropriate for non-compliance with the MHCB transfer timeline. How to quantify the number of delayed transfers that would give rise to the sanction depends on

resolution of the question whether 90 percent or 100 percent compliance with a timeline should be required.

The court's authority to impose monetary sanctions to compel compliance with a court order is well-established. *See*, *e.g., United State v. United Mine Workers of America*, 330 U.S. 258, 303-04 (1947). Where the purpose of a fine is to make defendants comply with a court order, the court is required to "consider the character and magnitude of the harm threatened by continued contumacy, and the probably effectiveness of any suggested sanction in bringing about the result desired." *Id*. at 304. Civil fines "designed to compel future compliance with a court order, are considered to be coercive and avoidable through obedience, and thus may be imposed in an ordinary civil proceeding upon notice and an opportunity to be heard." *International Union, United Mine Workers of America v. Bagwell*, 512 U.S. 821, 827 (1994). The parties will be directed to brief whether the court's anticipated enforcement order is enforceable only through civil contempt proceedings, or, instead, whether compliance with such an order to be issued by this court can be determined by the data provided in future monthly reports, subject to the court's final approval of a revised reporting template, and enforced by imposition of fines clearly defined in the order.

In accordance with the above, IT IS HEREBY ORDERED that the required responses and briefs shall be filed and served not later than 4:00 p.m. on April 7, 2017.

DATED: March 23, 2017



UNITED STATES DISTRICT JUDGE