IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.
Plaintiffs

v. **No. CIV S-90-0520 KJM DAD PC**

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

SPECIAL MASTER'S REPORT ON THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION'S IMPLEMENTATION OF POLICIES AND PROCEDURES ON RULES VIOLATION REPORTS

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I. INTRODUCTION

This is the Special Master's report on defendants' implementation of agreed-to policies and procedures concerning mental health input into the inmate disciplinary process in the prisons of the California Department of Corrections and Rehabilitation (CDCR). This disciplinary process is referred to as the Rules Violation Reports or RVR process. The Special Master submits this report in accordance with this Court's order of April 10, 2014, directing him to report to the court on whether defendants have adequately implemented the RVR policies and procedures that were agreed to in 2011. (ECF 5131)

The genesis of the April 10, 2014 order was a motion filed by plaintiffs on May 29, 2013 (ECF 4638) in which they argued, among other things, that further remedial orders were required to remedy a constitutional violation in defendants' use of inmate disciplinary measures, based on a finding that "seriously mentally ill inmates `who act out are typically treated with punitive measure without regard to their mental status.'" [ECF 5131 at 31, *quoting Coleman v. Wilson*, 912 F.Supp. 1282, 1230 (E.D. Cal. 1995)]. This Court stated that the issue relative to the disciplinary process turned on the adequacy of defendants' implementation of a plan on which the *Coleman* parties agreed and which the Special Master approved in 2011. (ECF 5131, at 35-36) The referenced plan, developed by defendants in response to an order entered on August 2, 2007 (ECF 2345), was for the purpose of "identifying and developing changes necessary to broaden the impact of the then-existing mental health assessment process in CDCR prison disciplinary matters for 3CMS inmates, testing those changes and implementing them system wide." (ECF 2345 at 1).

In response to the April 10, 2014 order, the Special Master directed members of his staff to examine and review on site the RVR process at all 34 CDCR institutions.[1] The RVR process, the Special Master's review methodology, his findings on the extent to which defendants have implemented those policies and procedures, and his recommendations in connection therewith are set forth below.[2]

This report is accompanied by individual reports on each CDCR institution's implementation of RVR policies and procedures, together with reviews of RVR cases at each of the institutions. (*See* Exhibit A) Within the attached individual institutional reports are numerous references to implementation of standards that are recited in CDCR memoranda, and to the official form that is used in the procurement of mental health input in individual RVR cases. The pertinent CDCR internal memoranda concerning RVR policies, procedures, and staff training, dated October 26, 2011 and November 3, 2011, respectively, are attached. (*See* Exhibits B, C). The official form that is used for obtaining clinical input into the inmate disciplinary process is also attached. (*See* Exhibit D) The final attachment to this report is a list of all acronyms/abbreviations which appear in this report, and their definitions. (*See* Exhibit E)

II. BACKGROUND OF THE RULE VIOLATION REPORT PROCESS

The significance of policies, procedures, and staff training requirements associated with mental health input into the inmate disciplinary process within CDCR prisons has a long history,

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[1] Four of CDCR's institutions - Calipatria State Prison (Cal), Chuckawalla Valley State Prison (CVSP), Centinela State Prison (Cen), and Ironwood State Prison (ISP) - are located in a desert environment. Because persons taking prescribed psychotropic medications experience heightened sensitivity to adverse effects of high temperatures, inmates in the CDCR Mental Health Service Delivery System (MHSDS) are to be excluded from housing at these four institutions. However, MHSDS inmates are sometimes found at these institutions, due to some inmates' development of mental illness while incarcerated at these locations, CDCR staff's lack of knowledge of inmates' mental health issues at the times of inmate placements, or mistakes in inmate housing assignments. Accordingly, the RVR process at these four desert institutions was examined, and they are included within the individual institutional reports in covered in Exhibit A.

[2] Although the information and findings discussed in this report are the product of more than one member of the Special Master's monitoring staff, any observations, findings, and conclusions of the Special Master's monitors are attributed collectively to "the monitor."

dating back to the time of the remedial order in this case. This Court found that, at that time, "mentally ill inmates who act out are typically treated with punitive measures without regard to their mental status," and that "such treatment was the result of inadequate training of the custodial staff so that they are frequently unable to differentiate between inmates whose conduct is the result of mental illness and inmates whose conduct is unaffected by disease. *Coleman*, 912 F.Supp. at 1320. This Court found further that there was "substantial evidence in the record of seriously mentally ill inmates being treated with punitive measures by the custody staff to control the inmates' behavior without regard to the cause of the behavior, the efficacy of such measures, or the impact of those measures on the inmates' mental illness." *Id.* The cause of this problem was identified by the Court as inadequate training of CDCR staff on recognition of the signs and symptoms of serious mental illness among inmates who acted out. *Id.*

CDCR took up the task of addressing this problem. On August 14, 1998, it issued a memorandum modifying its existing RVR process ("Adjudication of Rules Violation Reports Involving Mental Health Services Delivery System Inmate Program Participants/Patients"). This modified process required a mental health review of all cases of RVRs issued to CDCR inmates within CDCR's Mental Health Services Delivery System (MHSDS). The new policy required that any inmate who received an RVR and who exhibited "bizarre behavior" must be referred for a mental health review.

In 2003, CDCR further modified its RVR policies and procedures, mandating that all MHSDS inmates who had been designated for either the Mental Health Crisis Bed (MHCB) or Enhanced Outpatient Program inmate (EOP) levels of care, and who had been issued RVRs, were to receive mental health assessments. In addition, all inmates at the Correctional Clinical Case Management System (3CMS) level of care (LOC), as well as all inmates *not* within the

MHSDS who exhibited or demonstrated "bizarre, unusual, or uncharacteristic behavior" and who were issued RVRs, were required to receive mental health assessments as part of the RVR process.

Staff training was also a component of the changes implemented in 2003. On July 1, 2003, CDCR directed that all clinical staff who conducted RVR mental health assessments and all custody staff who conducted RVR hearings were required to undertake a mandatory four-hour course prior to participating in the RVR process, with exemptions allowed.

In the meantime, the Special Master regularly monitored and reported on the use of the mental health assessments in the inmate disciplinary process. In his Seventeenth Round Monitoring Report, Part B, filed on April 2, 2007 (ECF 2180), the Special Master found and reported that institutional use of mental health assessments for 3CMS inmates in the RVR process was unsatisfactory. The process was marked by very low numbers of referrals for assessments, errors, inconsistencies, inadequate documentation, and mental health input not being taken into consideration in RVR deliberations and dispositions. Overall, the Special Master found that the very purpose of assessing mentally ill inmates who were charged with violation of prisons rules was being overlooked. He recommended that “defendants be ordered to develop a plan to identify and develop the changes necessary to broaden the impact of the mental health assessment process on 3CMS inmates, to test those changes, and then to implement them system wide. The plan would be submitted to the Special Master and plaintiffs’ counsel for review and comment.” (ECF 2180 at 108-109)

On August 2, 2007, the Court adopted the Special Master’s recommendations and ordered defendants, within the next 60 days, “to develop (the above-referenced plan) for developing the changes deemed necessary to broaden the impact of the mental health assessment

process in prison disciplinary matters on 3CMS inmates, testing those changes, and implementing them system wide." The Court further ordered the Special Master to report to the court on the adequacy of this plan and make any appropriate recommendations in his next regularly scheduled monitoring report. (ECF 2345)

Defendants' initial submission of a revised plan to the Special Master was made on May 1, 2008. It included representations that a pilot of the new plan would be completed by August 5, 2008, and that the development of an implementation plan, including a procedure for effective monitoring of the RVR process, would be completed by November 1, 2008. It was not until May 10, 2011 that defendants circulated a new memorandum to the field directing completion of mental health assessments for 3CMS inmates charged with the most serious disciplinary infractions. In this memorandum, defendants instructed staff that all 3CMS inmates receiving a Division A, B, or C RVR must be referred for mental health assessments. Mental health assessments of 3CMS inmates who received RVRs for Division D, E, or F violations would continue to be governed by the standard that "bizarre, unusual, or uncharacteristic behavior" and require a mental health assessment.

In June 2011, after repeated requests from the Special Master, defendants produced a report on their pilot which indicated that key elements of it had never been piloted or implemented. The *Coleman* parties and the Special Master then met on several occasions during the following fall, after which there was agreement by the parties, with the approval of the Special Master, for a newly revised policy for mental health assessments for 3CMS inmates charged with RVRs. On September 21, 2011, CDCR, the Special Master and plaintiffs' counsel agreed to expand the policies outlined in the May 10, 2011 memorandum to 3CMS inmates who received a rules violation report "that may result in being assessed a Security Housing Unit

(SHU) term as identified in the California Code of Regulations (CCR) Title 15, Section 3341.5," requiring that they be referred for mental health assessments. In addition, it was required that the Institutional Classification Committee (ICC) consider the mental health assessment prior to any action regarding such inmates.

On October 26, 2011, defendants distributed their associated staff training memorandum (Exhibit B). The memorandum, captioned "Training for Custody and Clinical Staff Regarding Mental Health Input into the Inmate Disciplinary Process," reiterated that the four-hour mandated training was a pre-condition for clinical and custody staff to participate in the RVR process. It specifically directed the following:

1. The updated September 2011 version of the RVR training curriculum shall be used to train involved staff.

2. All hearing officers, Senior Hearing Officers, Captains, Chief Disciplinary Officers (CDO), and appeals coordinators shall receive four hours of training related to appropriate documentation of mental health input into the RVR process.

3. All clinical staff responsible for review of RVRs and preparation of the mental health assessment (CDCR Form 115-MH) shall receive four hours of training relative to providing mental health input into the RVR process.

4. The above requirement is to be provided on an ongoing basis prior to staffs' involvement in the RVR process.

5. The training is to be collaboratively between custody and mental health.

6. All new staff hired into the applicable classifications were to be trained prior to their involvement in the RVR process.

Defendants directed that training of all staff in affected classifications was to be completed by January 30, 2012, with proof-of-practice documentation submitted to the Audits and Litigation Unit no later than February 3, 2012.

On November 3, 2011, defendants issued their memorandum covering the changes to the form used for requesting a mental health assessment. (Exhibit C) It was entitled "Revision to the Mental Health Assessment Request Process for Rules Violation Reports (Update)." This memorandum instituted the following policies and procedures, expanding the application of the mental health assessment:

1. All 3CMS inmates receiving a Division A, B, or C RVR and for any rules violation that may result in being assessed a SHU term shall be referred for a mental health assessment via a CDCR Form 115-MH.

2. All 3CMS inmates receiving a Division D, E, or F RVR shall be referred for a mental health assessment based upon existing guidelines, which requires a referral if the inmate's behavior was bizarre, unusual or uncharacteristic.

3. The clinical assessment must be considered during the ICC to ensure the inmate's mental health is considered prior to any committee action. The clinical input must be documented on the CDCR Form 128-G, Classification Chrono.

4. All custody and clinical staff involved in the inmate disciplinary process shall receive on-site training regarding the RVR assessment requirements listed in this memorandum.

5. Revised training regarding Inmate Disciplinary Process: Mental Health Assessment was to be provided to In-Service Training (IST) for on-going use.

CDCR required that all clinical and custody staff involved in the RVR process receive on-the-job training regarding the policies and procedures outlined in the November 3, 2011 memorandum. This was to be completed by December 30, 2011, with proof-of-practice documentation submitted to the Associate Director (Custody) no later than January 2, 2012.

The form to be used for requesting a mental health assessment and for the mental health clinician's entry of his findings contains three questions to be answered by the clinician. (*See* Exhibit D) These questions are generally referenced by their numbers (*see e.g.* Exhibit A), and are to be answered by checking boxes "yes" or "no," with an accompanying written explanation of these answers. These three questions are:

1. 3CMS/Non-MHSDS only. Are there any mental health factors that would cause the inmate to experience difficulty in understanding the disciplinary process and representing his/her interests in the hearing that would indicate the need for the assignment of a Staff Assistant?

2. In your opinion, did the inmate's mental disorder appear to contribute to the behavior that led to the RVR?

3. If the inmate is found guilty of the offense, are there any mental health factors that the hearing officer should consider in assessing the penalty?

On December 1, 2011, in his Twenty-Third Round Monitoring Report, the Special Master recounted the course of defendants' response to the August 2, 2007 order. He noted the long time lapse before defendants began to respond to this order, and that little had been accomplished, pointing out that defendants appeared to "have lost sight of the original identified problem and the goal of the pilot to resolve that problem," as ordered by the court. The Special Master expressed concern, that given the "limited character of what defendants now propose as their plan, appropriate use of the mental health assessments in the disciplinary process for 3CMS inmates may well end up being even more limited than it was before the plan was ordered." The Special Master emphasized that nearly four years had passed with "very little progress," pointing out that defendants had violated the 60-day time limit in the August 2, 2007 court order "literally by years." (ECF 4124 at 20-28)

In response to the Twenty-Third Round Monitoring Report, and as a result of initiatives undertaken by the Special Master, defendants introduced a further modification of the RVR process, in collaboration with the Special Master and the *Coleman* plaintiffs, to address the issues raised in the Special Master's Report.

As noted above, plaintiffs' motion for relief from defendants' use of the inmate disciplinary process with punitive measures without adequate regard for inmates' mental health status (ECF 5131), resulted in the order entered April 10, 2014, directing the Special Master's

review of defendants' implementation of the 2011 agreed-to plan for mental health input into the RVR process. The description and outcome of that review follow.

III. THE SPECIAL MASTER'S REVIEW OF DEFENDANTS' IMPLEMENTATION OF THE RVR PROCESS AGREED TO IN 2011

A. Methodology

The Special Master reviewed on site the RVR process in all 34 CDCR institutions. The site visits ran from June 2014 through December 2014. The review period (i.e. the period in which the examined RVRs were issued) was January 2014 through March 2014 for all 34 institutions. This period was selected in order to allow sufficient time for these RVRs to have been adjudicated and for any resulting ICC action to have taken place before the monitor's examination of these RVRs.

During each site visit, the monitor interviewed the institutional warden or his/her designee, institutional mental health supervisors, mental health clinicians who were responsible for preparing the mental health assessments, and the Senior Hearing Officers before whom RVRs were adjudicated. The monitor also reviewed institutional policies and procedures related to the RVR process, training materials provided by CDCR headquarters, and any local training materials that were provided by the institutions to their staff. The monitor reviewed any institutional audits and/or quality improvement processes that were utilized with respect to RVRs.

To gather data, and for consistency across institutions, the monitor also used the institution register and CDCR 1154 logs, which are required to be maintained under Title 15, CCR, "Crime Prevention and Corrections," to gather data. The monitor also utilized CDCR

Computer Statistics Electronic Information Management Tool (COMPSTAT)[3] reports for institution-specific information, including institution population, number and percentage of MHSDS inmates within institutional populations, total numbers of RVRs issued, numbers and percentages of RVRs issued to MHSDS inmates, among other relevant data points.

1. Document Request

Each institution received a document request from the monitor prior to its on-site visit. The document request identified the documentation which the monitor would be examining during the site visit. These identified documents were requested as follows:

1. Provide copies of CDCR Form 1154, Rules Violation Report logs for the months of January, February, and March 2014 for each facility, area, or unit within the institution. Identify which log(s) contains RVRs written for inmates housed in a mental health crisis (MHCB), a psychiatric services unit (PSU), a SHU and in administrative segregation.

2. Have available for review the institution registries of all completed RVR report packages, with any/all mental health assessments attached, for the months of January, February, and March 2014. The monitor will review the registries and identify RVR packages for copying.

3. Provide a copy of all completed RVR packages issued to inmates housed in the MHCB during the month of January, February, and March 2014.

4. Provide a copy of an alphabetical roster of the institution's current CDOs, Captains, Senior Hearing Officers, Hearing Officers, and Appeal Coordinators.

5. Provide a copy of an alphabetical roster of the institution's current clinical staff who are responsible for the preparation of the 115 mental health assessment forms.

6. Provide a copy of an IST report for class code A0564, B0564, and/or M0564, Mental Health Input into the Disciplinary Process, for all of the custody and clinical staff listed in requests numbered 4 and 5 above for the period of October 1, 2011 until the present.

7. Have available for review all lesson plans, PowerPoint presentations, curricula, and documents used in the ongoing training of custody and clinical staff involved in the inmate disciplinary process as it relates to mental health assessments.

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[3] "COMPSTAT" stands for "computer statistics" and refers to CDCR's electronic organizational tool. It is not a computer system or software package. Source: CDCR Website.

8. Provide copies of the required "proof-of-practice" memoranda submitted by the institution in response to the October 26, 2011 and November 3, 2011 memoranda.

2. Institutional On-Site Reviews

Once on site, the monitor reviewed the CDCR 1154 logbooks at each institution to identify RVRs issued to MHSDS inmates and to select sample of RVRs packages to be reviewed. Additionally, all RVRs issued to MHCB inmates were reviewed. Copies of the completed RVRs that were identified were provided to the monitor, who then reviewed each RVR, applying the following criteria and content:

1. Whether a CDCR Form 115-MH (mental health assessment form) was requested in accordance with policy;
2. Whether the CDCR Form 115-MH was completed and returned to custody staff in a timely manner;
3. Whether the CDCR Form 115-MH was completed appropriately, (i.e., was it legible, responsive to the questions, and written in laymen's terms);
4. Whether the mental health input was considered and documented by the senior hearing office in the findings;
5. If the mental health input was used to mitigate the penalty, was it documented by the Senior Security Officer;
6. If a penalty was imposed on an inmate for whom a mental health assessment was completed, provide the terms of the penalty, including losses of credits and privileges; and
7. Whether the ICC considered the mental health input in its action, including in any assessment of a SHU term. Provide the documentation of its consideration of the input and/or any mitigation.

3. CDCR Staff Training

As stated above, one of the central requirements of both the October 26, 2011 and November 3, 2011 memoranda is that all clinical and custody staff involved in the RVR process receive specified training using a designated curriculum. The October 26, 2011 memorandum

mandated the four-hour training as a pre-condition for clinical and custody staff participation in the RVR process, and made the updated September 2011 version of the RVR training curriculum the training tool. The November 3, 2011 memorandum required that all custody and clinical staff involved in the inmate disciplinary process receive on-site training on the mental health assessment requirements listed in the memorandum, and further, that the revised training ("Inmate Disciplinary Process: Mental Health Assessment") be used for ongoing training.

To determine whether an institution complied with the training mandates in these memoranda, the monitor obtained a copy of all current staff assigned to positions involved in the RVR process at each institution. This list was then compared to the IST reports on which staff members were documented as having attended the required four-hour and one-hour of training sessions. The monitor requested IST reports covering the period from October 1, 2011 through the date of the site visit because this training of both clinical and custody staff was required to be ongoing. Because the training records were institutional "stand-alone" records that may cover training received at other institutions where employees had worked earlier, the monitor used data from the IST Fox Pro tracking system to help ensure completeness and accuracy of the training information.

4. Review of Rules Violation Report Cases

At each institution, the monitor reviewed records of sample RVRs issued to MHSDS inmates. These reviews included inmates at all levels of care provided at CDCR institutions, including MHCB, EOP, and 3CMS, as well as inmates who were not within the MHSDS but who were referred for a mental health assessment within the RVR process. Summaries of selected RVR case reviews at the are found in Exhibit A, as noted above. The monitor did not review RVRs issued to CDCR inmate-patients in the inpatient programs run by the Department

of State Hospitals (DSH) which are physically located at the Salinas Valley State Prison (SVSP), the California Medical Facility (CMF), and the California Health Care Facility (CHCF), or in the CDCR-run inpatient programs at the California Institution for Women (CIW Psychiatric Inpatient Program or CIW PIP), or at San Quentin State Prison (SQ) (the SQ Psychiatric Inpatient Program or SQ PIP).

5. Staff Interviews

As noted above, the monitor also interviewed staff involved with the RVR process, including Senior Security Officers and clinicians assigned to complete the mental health assessments to be used within the process. The purpose of these interviews was to obtain information on training of staff as well as their understanding of RVR policy, process, impact and value. Information gathered from these interviews was useful for corroborating or refuting the monitor's findings obtained from other sources, including documentation, reports, and mental health assessments provided to the monitor. The monitors also elicited staff recommendations as to how the process may be improved.

IV. FINDINGS OF THE SPECIAL MASTER

Overall, the monitor found that CDCR institutions had not implemented and sustained the RVR policies and procedures that had been agreed to in 2011, as memorialized in the October 26, 2011 and November 3, 2011 memoranda. (*See* Exhibits B, C) Not a single institution could demonstrate that it had implemented and was compliant with the applicable policies and practices in a consistent and thorough manner. This is a disturbing in itself because it demonstrates a pervasive failure of execution of the RVR plan throughout the CDCR system. What is even more disturbing is *that seven and a half years have passed* since CDCR was directly ordered on August 2, 2007 to address this problem (ECF 2345), yet the same

deficiencies that the Special Master reported in April 2007 in his Seventeenth Round Monitoring Report, Part B – errors, inconsistencies, inadequate documentation, and mental health input not being taken into consideration in RVR deliberations and dispositions[4] -- were again found by the monitor across institutions over the past several months. This is unacceptable and must be resolved forthwith.

A. Staff Training was Insufficient

No institution provided documentation to the monitor indicating that all clinical and custody staff assigned to the RVR process at their institution had received the mandated training per the memoranda. The training that was occurring was not consistently conducted in a collaborative format, i.e. with custody and clinical being trained together, nor was it being provided on an ongoing basis.

B. Mental Health Assessments Were Not Consistently Written According to Policy or in a Manner that Served Their Intended Purpose

Generally, mental health assessment forms (*See* Exhibit D) were being requested appropriately and completed timely. The monitor found that during the review period mental health assessments were being completed within the required timeframes at 24 institutions, Avenal State Prison (ASP), California Correctional Institution (CCI), CHCF, CIW, CIM, CMF, California Men's Colony (CMC), California Rehabilitation Center (CRC), California State Prison/Corcoran (CSP/Corcoran), CSP/Sac, California State Prison/Solano (CSP/Solano), California Substance Abuse Treatment Facility (CSATF), Centinela State Prison (CEN), Correctional Training Facility/Soledad (CTF), Deuel Vocational Institute (DVI), Folsom State Prison (Folsom), High Desert State Prison (HDSP), Kern Valley State Prison (KVSP), North Kern State Prison (NKSP), Pelican Bay State Prison (PBSP), Pleasant Valley State Prison

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[4] ECF 2180 at 105-109.

(PVSP), SVSP, SQ, and Valley State Prison (VSP). However, they were not consistently completed timely at six institutions, California State Prison Los Angeles County (CSP/LAC), Central California Women's Facility (CCWF), Mule Creek State Prison (MCSP), Richard J. Donovan Correctional Facility (RJD), Sierra Conservation Center (SCC), and Wasco State Prison (WSP). No inmates were referred for a mental health assessment at four institutions, California Correctional Center (CCC), Calipatria State Prison (CAL), Chuckawalla Valley State Prison (CVSP), and Ironwood State Prison (ISP).

The monitor found numerous mental health assessments ordered for charges that were not Division A, B or C offenses, with no explanation provided. It was unclear whether these charges could draw a SHU term for the inmate, which would justify the completion of a mental health assessment, since this was not articulated within the RVR.

Another issue identified during the monitor's review was the problem of clinicians checking "no" to question number one on mental health assessment forms for inmates to whom a staff assistant was automatically assigned, e.g., EOP and MHCB inmates. This also led to confusion for Senior Security Officers. This problem was identified at California Institution for Men (CIM), CSP/LAC, CCWF, KVSP, NKSP, PVSP, and SVSP. At VSP, clinicians were found to check "yes" to question number one and offer an explanation as to why a staff assistant was needed for inmates to whom a staff assistant was automatically assigned.

There were also various problems with clinicians' explanations on mental health assessments where question number two was checked "yes," indicating that the inmate's mental illness contributed to the behavior that led to the RVR. Some clinicians merely provided the inmate's diagnosis, while others did not clearly indicate that the inmate's mental illness contributed to the behavior. Some clinicians documented what the inmate said rather than

provide an independent clinical opinion, while others would use diagnostic language as opposed to laymen's terms. In some cases, question number two was checked "no," but the clinician would provide a written response that conflicted with a "no" answer. The aforementioned problems were found to varying degrees at ASP CHCF, CIM CIW CMF, CMC, CRC, CSP/Corcoran, CSP/LAC, CSP/SAC, CSP/Solano, CEN, CCWF, CTF, DVI, HDSP, KVSP, MCSP, PBSP, PVSP, RJD, SVSP, SQ, SCC, and WSP.

The monitor's review also uncovered problems with clinicians' explanations accompanying a "yes" response to question number three. These included failing to provide any useful information for the Senior Security Officer to consider when assessing a penalty. The clinicians' responses merely stated the inmate's diagnosis, noted which privileges the inmate did not want to lose instead of providing a clinical opinion, and failed to use laymen's terms, among other problems. The review also found mental health assessments in which question number three was answered "no," but the clinician still provided a written response, and in some cases, wrote that the inmate was responsible for his or her own actions. These problems were found to varying degrees at ASP, CIM, CIW, CMF, CMC, CRC, CSP/Corcoran, CSP/SAC, CSP/Solano, CSATF, CEN, CCWF, CTF, DVI, Folsom, HDSP, MCSP, NKSP, PVSP, RJD, SVSP, SQ, VSP, and WSP.

There were cases across the institutions in which the writers of the RVRs referenced the "bizarre, unusual or uncharacteristic behavior" standard with regard to EOP and MHCB inmates or to RVRs for which mental health assessments were automatically required by policy, while the "bizarre, unusual or uncharacteristic behavior" did not apply to cases at those levels of care or to the nature of the charges leveled. In these cases, this erroneous standard was usually

referenced with stock or canned language, indicating a misapprehension that this standard should be applied regardless of the inmate's LOC or the nature of the charges.

The majority of the mental health assessments found no nexus between the inmate's mental health status and his or her behavior which led to the writing of the RVR. Many clinicians entered inapposite or non-responsive input on the mental health assessment form (CDCR Form 115-MH), or used overly-clinical jargon or conclusory diagnostic language in their responses, which were not informative or useful to Senior Security Officers and ICCs.

Multiple clinicians told the monitor that they considered the mental health assessment form too vague, confusing, and unworkable, often expressing a desire to change the way in which the questions were asked and to increase the amount of space on the form for entry of responses. Several clinicians proposed that the form be presented electronically to overcome problems with legibility of entries and space for responses. A number of Senior Security Officers echoed this concern and suggested solution.

There were problems with documentation of the content of mental health assessments as well as clinicians' responses to all three questions on the mental health assessment form. Illegible writing on mental health assessments was identified as problematic by Senior Security Officers at CSP/LAC, CCWF, and SCC.

C. Senior Hearing Officers Did Not Properly Take the Clinical Input on Mental Health Assessments into Consideration in their Dispositions of RVRs, or Adhere to Other Applicable Policy

To some degree, all of the institutions noted that mental health input was considered in RVR adjudications. However, in 365 of the RVR cases that were reviewed by the monitor, and which appear within Exhibit A, mitigation in some form occurred in 119 or 33 percent of cases, and no mitigation occurred in 233 or 64 percent of cases. In addition, there were 13 cases in

which it appeared that mitigation might have occurred (*e.g*. assessment of low end of credit forfeitures), but these cases included no references to any mitigation in the decisions or dispositions. Of the 119 cases in which mitigation was noted, 74 or 62 percent were mitigated based on mental health factors, and 21 cases were mitigated based on other factors (*e.g.* evidentiary grounds). In addition, there were 24 cases in which the reason for mitigation was not specified or could not be determined. Institutions where this occurred included PBSP and SVSP.

In many cases, Senior Hearing Officers considered the clinical input on mental health assessment forms in a perfunctory or *pro forma* manner, without appropriately taking the assessment into consideration. Senior Hearing Officers disregarded or ignored the clinical opinions on the assessments and assessed loss of privileges, including for inmates who were decompensating or in the MHCB, such as at CHCF, CMC, and MCSP. In some cases they merely noted the existence of mental health input without specifying how the individual assessments were considered. The monitor found that this occurred at ASP, CHCF, CIW, CMF, CMC, CRC, CSP/LAC CSP/Sac, CSP/Solano, CSATF, CCWF, CTF, KVSP, MCSP, NKSP, PVSP, SQ, and WSP. Instead of utilizing the clinical input, some hearing officers, including those at CMF, CTF, NKSP, and RJD, made gratuitous but unfounded statements that the inmates should be held accountable for their behaviors/actions.

At some institutions, Senior Hearing Officers considered the mental health of the inmate at the time of the hearing, rather than rely on the clinical opinion contained in the mental health assessment. This was found at CMC, CSP/LAC, NKSP, PVSP, RJD, SVSP and VSP. The monitor also found various unauthorized *ad hoc* or "homemade" approaches to the mental health assessment aspect of the RVR policy, resulting in penalties not being mitigated, imposition of significant credit losses on MHSDS inmates, increased placement scores, and elevation of

custody levels. The RVR process does not imbue the Senior Hearing Officers with any latitude to override the clinician's mental health assessment and instead apply his or her own "clinical" evaluation of the inmate's mental health status, based on how the inmate appeared to the Senior Hearing Officer at the time of the hearing or at any other time.

Multiple Senior Hearing Officers also referenced the "bizarre, unusual or uncharacteristic behavior" standard to offenses that were charged under Divisions A, B, C or that were SHU-able, even though the Division or SHU-ability of the offense was what warranted the completion of a mental health assessment and not the inmate's "bizarre, unusual or uncharacteristic" behavior. RVRs and decisions also referenced the standard of "bizarre, unusual or uncharacteristic behavior," when such standard was inapplicable due to the LOC of the inmate, such as EOP or MHCB. Institutions which applied the "bizarre, unusual or uncharacteristic" behavior standard in these inappropriate ways included CCI, CRC, CSP/Corcoran, CSP/LAC, CSATF, CCWF, CTF, KVSP, NKSP, PVSP, and SVSP.

In many cases, including at CMF, NKSP, and RJD, where the clinician did not recommend mitigation for mental health reasons, Senior Hearing Officers interpreted this to mean that they were prohibited from mitigating the penalty for any other reason. *This is neither mandated nor intended or implied in any way in the RVR policy.* There appeared to be an underlying sense among a number of Senior Hearing Officers across institutions that a guilty finding necessitated imposition of losses of credit or privileges. In fact, hearing officers clearly had the discretion to reduce charges to administrative violations and not impose credit or privilege losses if they saw fit to do so, regardless of clinical reasons.

The monitor also found a number of cases in which Senior Hearing Officers interpreted the mental health assessment under an "exonerating evidence" standard. That standard is not

provided for in the RVR policy, nor is any "insanity," "incompetency," or "reduced competency" standard either provided for or applicable. Senior Hearing Officers treated mental health assessments as competency exams, rather than examined whether the inmate's mental illness contributed to the behavior that led to the RVR. This was found by the monitor at CCI, CIM, CSP/LAC, CEN, HDSP, KVSP, and SQ.

There were many cases in which Senior Hearing Officers did not adequately document consideration of the mental health assessment in the RVR adjudication, such as at CSP/LAC, CEN, NKSP, and VSP, nor whether or how penalties were mitigated as a result of the assessment. In multiple instances, there was mitigation of penalties, but no indication as to the reason(s) why. Other decisions merely provided a verbatim recitation of the questions and answers on the assessments, for example at VSP. In some decisions, the only indication as to why the inmate was referred for a mental health assessment was the fact that he or she was referred to the ICC for a possible SHU term. This was found at CCI, CSATF, and NKSP.

D. Institutional Classification Committees Did Not Consistently Take Mental Health Input into Consideration

During the review, the monitor found very limited documentation of consideration of mental health input or mitigation by ICCs. Typically, ICCs did not disturb the Senior Hearing Officers' penalty assessments and added a SHU term. Consideration of inmate mental health assessments in the ICC review process was reported at CIM, CSP/LAC, CSP/Sac, DVI, HDSP, NKSP, PBSP, PVSP, RJD, SVSP, SQ, SCC, VSP, and WSP. At CRC, CSP/LAC, PBSP, RJD, SVSP, and VSP, ICCs generally considered the input of clinicians who were present at the meetings. At CSP/LAC, references to mental health assessments and clinicians' comments were case/inmate-specific.

ICCs at other institutions including CSP/Sac, DVI, HDSP, NKSP, and SQ considered mental health assessments in a more perfunctory manner, with rote repetition of hearing officers' findings or use of generalized statements and canned language. At NKSP, there was no mention of clinical input at ICC meetings, and at CMF mental health input was minimal. At DVI, mental health input at ICC meetings was not helpful to decisions on inmate housing or transfers. At CMC, there was some indication that mental health input in ICC meetings was reviewed and considered but not with regard to how the information affected ICC action, if at all.

At MCSP and PBSP, ICCs mitigated penalties based on mental health factors. Other institutions mitigated based on other rationales, such as lack of prior disciplinary history at NKSP, absence of prior similar acts at CIM and SVSP, and factors unrelated to mental health at CSP/Sac.

Review of cases at CCI, CIM, CMF, CSP/Corcoran, CSP/LAC, CSP/Sac, CSATF, Folsom, RJD, SVSP, and WSP indicated that their ICCs typically did not mitigate inmate penalties based on mental health input. At CTF, HDSP, and SVSP, ICCs increased SHU terms based on past similar inmate behavior and/or violations.

E. The RVR Process Lacks a Quality Improvement Program

At the time of the monitor's review, only one institution – the Richard J. Donovan Correctional Facility (RJD) – had implemented its own local quality control/quality improvement initiative applicable to the RVR process. While RJD still has work to do in some aspects of the RVR process (*see* RJD institutional report, Exhibit A), its robust RVR quality review process is a significant step in the right direction that CDCR might consider as a model process for other institutions and for incorporation into its Continuous Quality Improvement Tool (CQIT).

F. Use of Inmate Workers in the RVR Process is Inappropriate

At several institutions, the monitor found that inmates were performing clerical services in the RVR process. This practice compromises the confidentiality of the process and related inmate mental health information and should be stopped.

V. CONCLUSION AND RECOMMENDATIONS

This review of the CDCR RVR process found pervasive flaws in the execution of the RVR process that was agreed to in 2011. The root of the problem appears to have been a breakdown in the training elements of the process. Most of the failures described above are attributable to staff's lack of understanding of the process and awareness of its purpose. That purpose is to remedy the problems with defendants' use of inmate disciplinary measures that, as this Court said nearly 20 years ago, were based on its finding that seriously mentally ill inmates "who act out are typically treated with punitive measures without regard to their mental status. *Coleman*, 912 F.Supp. at 1230. The problem appears to be compounded by the fact that 33 of the 34 CDCR institutions were found to have no quality control/quality improvement mechanism to detect and address lapses in staff training.

The effect of staff noncompliance with the RVR process on MHSDS inmates' mental health is far more than a mere procedural deviation from the plan. It is serious and can lead to grave consequences for affected inmates. Inappropriate impositions of loss of credits and SHU terms may exacerbate serious mental illness, leading to decompensation or worse. If staff training on the RVR process is not completed, both thoroughly and correctly, in the very near future, the Special Master may be forced to recommend that, for at least affected EOP inmates, their RVR dispositions should be overturned.

On October 20, 2015, the Special Master briefed the defendants by teleconference on the monitor's preliminary findings from the RVR review, and offered defendants the opportunity to submit comments. CDCR submitted written comments to the Special Master on January 9, 2015, indicating that they had already begun undertaking efforts to address these preliminary findings. These early efforts include (a) revision of the form for requesting a mental health assessment to be used in the RVR process and related training of clinicians on the purpose of the form, (b) development of a clinician's guide to drafting these mental health assessments and a companion guidebook on RVRs for hearing officers, (c) development of a program for institutional tracking of mental health assessments and corresponding RVRs, (d) conduct of regular meetings between institutional mental health and custody management regarding RVR hearings that have required mental health assessments, (e) provision of both separate and joint training to clinicians and custody staff on the new mental health assessment forms and policies, and (f) further refinement of CDCR's quality improvement tool, CQIT, to be used in substantive review of input on the mental health assessment forms, RVR dispositions, and of how Senior Hearing Officers mitigated penalties based on information in the mental health assessments.

To date, it appears that these initiatives have not yet been fully developed or implemented and remain general abstract ideas, albeit good ones. They do indicate a general awareness, understanding, and willingness on the part of defendants to respond to the problems with the RVR process, for which defendants should be commended and encouraged. However, vigilance in this area should not abate until the necessary changes have been developed, implemented, and most importantly, sustained, and shown to be a regular, well-functioning part of the RVR process.

The Special Master is also mindful of the numerous ongoing court-ordered remedial projects in which defendants continue to be engaged. These include:

- Implementation of defendants' recently revised policies on:

  a. Use of force,
  b. Management status, and
  c. Strip searches,

- Completion and execution of defendants' plans to

  a. Limit or eliminate non-disciplinary segregation (NDS) class members from administrative segregation units (ASU) which hold general population (GP) inmates for disciplinary reasons,
  b. Report on levels of compliance with the Program Guide by EOP the administrative segregation hubs (which entails their process for certification of these hubs via audits using their CQIT),
  c. House and provide increased treatment and out-of-cell activities to class members placed in administrative segregation for disciplinary reasons, using of the stand-alone ASUs (to be known as Short-Term Restricted Housing or Short Term Restricted Housing (STRH) and Long-Term Restricted Housing or LTRH), and
  d. Conduct case-by-case reviews of class members in administrative segregation to reduce their lengths of stay there, and to promote their returns to less restrictive and more therapeutic housing environments when they no longer pose any threat to safety and security.

(ECF 5131). In addition, defendants are about to resume focused work on reducing the number of suicides among CDCR inmates through the vehicle of the court-ordered Suicide Prevention Management Workgroup (ECF 4693), and on improving mental health staffing in CDCR institutions. (ECF 5171). Nevertheless, the seriousness of the issues surrounding the process for mental health input into the RVR process calls for immediate attention.

Accordingly, in view of the foregoing, the Special Master requests that the court enter an order directing the following:

1. CDCR shall immediately end the practice of using inmate workers in any aspect of the RVR process.

2. CDCR shall devise an RVR quality improvement process for incorporation into its Quality Improvement Tool (CQIT) and conduct regular quality improvement reviews of the RVR process, including but not limited to the staff training aspects of the RVR process, in all of its institutions.

3. Within 243 days, CDCR shall implement, under the guidance of the Special Master, its program of RVR mandatory initial and ongoing training/re-training of all clinical and custody staff who are involved in the RVR process.

4. Following the 243-day period for implementation of the staff training/re-training program, the Special Master shall conduct a review of staff training/re-training on the RVR process in all CDCR institutions, and shall report to the Court on his findings no later than 90 days after the completion of his review.

Respectfully Submitted,

/s/

Matthew A. Lopes, Jr., Esq.
Special Master

Date: January 30, 2015