U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Ave, NW - RFK
Washington, DC 20530

April 22, 2021

Keith Carson
President
Alameda County Board of Supervisors
1221 Oak Street, #536
Oakland, CA 94612

Gregory J. Ahern
Alameda County Sheriff/Coroner
Santa Rita Jail
5325 Broder Blvd.
Dublin, CA 94568

Mark Fratzke
Alameda Health System
Interim Chief Operating Officer
1411 E. 31st St.
Oakland, CA 94602

Re: Notice Regarding Investigation of Alameda County, John George Psychiatric Hospital, and Santa Rita Jail

Dear President Carson, Sheriff Ahern, and Interim Chief Operating Officer Fratzke:

The Civil Rights Division has completed the investigation into the conditions and practices at Santa Rita Jail and John George Psychiatric Hospital, and into whether Alameda County's reliance on John George Psychiatric Hospital and sub-acute psychiatric facilities to provide mental health services to adults with mental health disabilities violates those individuals' right to receive services in the most integrated setting appropriate to their needs. The investigation was conducted under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, and Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131−12134, and the ADA's implementing regulation, 28 C.F.R Part 35.

Consistent with the statutory requirements of CRIPA, we provide this Notice of the alleged conditions that we have reasonable cause to believe violate the Constitution and federal law and the supporting facts giving rise to those violations. 42 U.S.C. § 1997b(a)(1); 42 U.S.C. § 1997c(b)(1). This Notice also sets forth the Department's findings of fact and conclusions of law under the ADA. 42 U.S.C. §§ 12131−12134; 28 C.F.R. § 35.172(c). We also notify you of the minimum remedial measures that we believe may remedy the alleged violations.

After carefully reviewing the evidence, we conclude that there is reasonable cause to believe that Alameda County and the Alameda County Sheriff's Office violate the ADA and engage in a pattern or practice of constitutional violations in the conditions at the Santa Rita Jail, and that Alameda County violates the ADA as interpreted by *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999). Specifically, we have reasonable cause to believe that: (1) Alameda County violates the ADA by failing to provide services to qualified individuals with mental health disabilities in the most integrated setting appropriate to their needs by unnecessarily institutionalizing them at John George Psychiatric Hospital and sub-acute facilities; (2) Santa Rita Jail fails to provide constitutionally adequate mental health care to prisoners with serious mental health needs, including those at risk of suicide; (3) Santa Rita Jail's use of prolonged restrictive housing under current conditions violates the Eighth and Fourteenth Amendment rights of prisoners with serious mental illness; and (4) Santa Rita Jail violates the ADA by denying prisoners with mental health disabilities access to services, programs, and activities because of their disabilities.[1]

We thank Alameda County, Alameda Health System, and the Alameda County Sheriff's Office for accommodating our investigation and providing access to facilities, staff, documents, and data. We are obligated to advise you that 49 days after issuance of this Notice, the Attorney General may initiate a lawsuit under CRIPA to correct the alleged conditions we have identified if Alameda County officials have not satisfactorily addressed them. 42 U.S.C. § 1997b(a)(1). CRIPA also authorizes the Department to move to intervene in a related private suit 15 days after issuing the Notice. 42 U.S.C. § 1997c(b)(1).

We hope, however, to resolve this matter through a cooperative approach and look forward to working with Alameda County leadership and staff to address the violations of law we have identified. The lawyers assigned to this investigation will, therefore, contact Alameda County to discuss options for resolving this matter amicably. Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.

[1] The Department of Justice (Department) opened this investigation to examine five issues: (1) whether the County's reliance on psychiatric institutions to provide mental health services to adults with mental health disabilities violates the ADA; (2) whether the conditions of confinement and practices at Santa Rita Jail deprive persons with serious mental illness of their constitutional rights; (3) whether the conditions at Santa Rita Jail violate the rights of persons with mental health disabilities under the ADA; (4) whether the practices at John George Psychiatric Hospital violate the rights of persons with mental health disabilities under the ADA to receive services in the most integrated setting appropriate to their needs; and (5) whether the conditions at John George Psychiatric Hospital deprive persons with serious mental illness of their constitutional rights. This Notice Letter applies to the first four issues. With regard to the remaining issue, the Department did not reach a conclusion as to whether there are systemic unconstitutional conditions at John George Psychiatric hospital and is closing its investigation.

If you have any questions regarding this correspondence, please call Steven H. Rosenbaum, Chief of the Special Litigation Section, at (202) 616-3244.

Sincerely,

Pamela S. Karlan
Principal Deputy Assistant Attorney General
Civil Rights Division

cc: Donna Ziegler
County Counsel for Alameda County
1221 Oak Street, Suite 450
Oakland, CA 94612

Dr. Taft Bhuket, President
Alameda Health System Board of Trustees
1411 E. 31st. St.
Oakland, CA 94602

James Jackson, Interim CEO
Alameda Health System
1411 E. 31st St.
Oakland, CA 94602

Mike Moye, General Counsel
Alameda Health System
1411 E. 31st St.
Oakland, CA 94602

Stephanie Hinds
Acting United States Attorney
Northern District of California
Federal Courthouse
450 Golden Gate Avenue
San Francisco, CA 94102

Attachment: Investigation of Alameda County, John George Psychiatric Hospital, and Santa Rita Jail

INVESTIGATION OF ALAMEDA COUNTY, JOHN GEORGE PSYCHIATRIC HOSPITAL, AND SANTA RITA JAIL

United States Department of Justice
Civil Rights Division

April 22, 2021

TABLE OF CONTENTS

I. INTRODUCTION 1

II. INVESTIGATION 3

III. SYSTEM OVERVIEW 4

IV. ALAMEDA COUNTY VIOLATES INDIVIDUALS' RIGHT TO RECEIVE SERVICES IN THE MOST INTEGRATED SETTING UNDER TITLE II OF THE ADA 6

A. Alameda County Subjects Adults with Mental Health Disabilities to Unnecessary Psychiatric Institutionalization and the Serious Risk of Psychiatric Institutionalization ... 7

B. People with Mental Health Disabilities in Alameda County Can Be Appropriately and Effectively Served in the Community 11

1. People Cycling Through Psychiatric Institutions Are Appropriate for Community-Based Services 11

2. Alameda County Fails to Provide Adequate Community-Based Services that Could Prevent Needless Psychiatric Institutionalization 12

3. Alameda County Fails to Identify and Connect People with the Community-Based Services Necessary to Avoid Needless Institutionalization 16

C. Most People with Mental Health Disabilities in the Psychiatric Facilities in Alameda County Do Not Oppose Community-Based Services 17

D. Alameda County Can Make Reasonable Modifications to Prevent Unnecessary Psychiatric Institutionalization 18

V. MENTAL HEALTH CARE AT SANTA RITA JAIL IS INADEQUATE IN VIOLATION OF THE CONSTITUTIONAL RIGHTS OF PRISONERS WITH SERIOUS MENTAL HEALTH NEEDS 21

A. Many Prisoners at the Jail Have Serious Mental Health Needs, Requiring Treatment 23

B. Prisoners with Serious Mental Health Needs Are Subject to a Substantial Risk of Serious Harm as a Result of Inadequate Mental Health Care 24

1. Prisoners with Serious Mental Health Needs Are Subject to Harm Because of a Lack of Individualized Treatment, Including Inadequate Psychotherapy and Programming 24

2. Prisoners with Serious Mental Health Needs Are Subject to Harm Because of Inadequate Treatment Planning, Including Discharge Planning 28

C. Officials at the Jail Have Known of the Risk to Prisoner Health and Safety Posed by Inadequate Mental Health Care and Disregarded It 29

VI. THE JAIL'S USE OF PROLONGED RESTRICTIVE HOUSING UNDER CURRENT CONDITIONS, INCLUDING THE FAILURE TO PROVIDE ADEQUATE MENTAL HEALTH CARE, VIOLATES THE CONSTITUTIONAL RIGHTS OF PRISONERS WITH SERIOUS MENTAL ILLNESS 31

A. Prisoners with Serious Mental Illness Are Subject to a Substantial Risk of Serious Harm as a Result of the Jail's Use of Restrictive Housing 33
B. Officials at the Jail Have Known of, and Disregarded, the Substantial Risk of Serious Harm of Placing Individuals with Serious Mental Illness in Restrictive Housing 34
VII. THE JAIL'S TREATMENT OF PRISONERS WITH MENTAL HEALTH DISABILITIES VIOLATES THE AMERICANS WITH DISABILITIES ACT 35
VIII. MINIMUM REMEDIAL MEASURES 36
IX. CONCLUSION 39

I. INTRODUCTION

After an extensive investigation, the United States provides notice, pursuant to Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12131−12134, and the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, that there is reasonable cause to believe that Alameda County and the Alameda County Sheriff's Office violate the ADA and engage in a pattern or practice of constitutional violations in the conditions at the Santa Rita Jail and that Alameda County violates the ADA in its provision of public mental health services. Specifically, we have reasonable cause to believe that: (1) Alameda County fails to provide services to qualified individuals with mental health disabilities in the most integrated setting appropriate to their needs, instead relying on John George Psychiatric Hospital and sub-acute psychiatric facilities (collectively, "psychiatric institutions")[1] to provide such services; (2) Santa Rita Jail fails to provide constitutionally adequate mental health care to prisoners with serious mental health needs, including those at risk of suicide; (3) Santa Rita Jail's use of prolonged restrictive housing under current conditions violates the constitutional rights of prisoners with serious mental illness; and (4) Santa Rita Jail denies prisoners with mental health disabilities access to services, programs, and activities because of their disabilities.[2]

Specifically, the United States provides notice of the following findings:

- **Alameda County relies on psychiatric institutions to serve adults with mental health disabilities who are eligible for public mental health services, rather than providing services in the most integrated setting appropriate to their needs.** On any given day in Alameda County, hundreds of people are institutionalized for lengthy stays at one of several large, locked, sub-acute psychiatric facilities or are hospitalized at John George Psychiatric Hospital (John George). Depending on the facility, people live at the sub-acute facilities for an average of anywhere from six months to two years. Of those hospitalized at John George, a significant subset will spend weeks or even months there; many, lacking any alternatives, are funneled to other segregated facilities on discharge. Even more adults with mental health disabilities are at serious risk of admission to these psychiatric institutions.

[1] For purposes of our findings related to the integration mandate of the ADA, we considered only *psychiatric* institutional settings. *See* 28 C.F.R. pt. 35, App. B, at 708 (2018); 28 C.F.R. § 35.130(d) (2019); *see also* 42 U.S.C. § 12101(a)(2), (b)(1). We did not consider Santa Rita Jail to be an institutional or segregated setting in making those findings. At the same time, for the CRIPA portion of our investigation, the Santa Rita Jail is an "institution" as defined by CRIPA. *See* 42 U.S.C. § 1997.

[2] The Department of Justice (Department) opened this investigation to examine five issues: (1) whether the County's reliance on psychiatric institutions to provide mental health services to adults with mental health disabilities violates the ADA; (2) whether the conditions of confinement and practices at Santa Rita Jail deprive persons with serious mental illness of their constitutional rights; (3) whether the conditions at Santa Rita Jail violate the rights of persons with mental health disabilities under the ADA; (4) whether the practices at John George Psychiatric Hospital violate the rights of persons with mental health disabilities under the ADA to receive services in the most integrated setting appropriate to their needs; and (5) whether the conditions at John George Psychiatric Hospital deprive persons with serious mental illness of their constitutional rights. This Notice Letter applies to the first four issues. With regard to the remaining issue, the Department did not reach a conclusion as to whether there are systemic unconstitutional conditions at John George Psychiatric hospital and is closing its investigation.

- **With appropriate community-based services, supports, and coordination, people with mental health disabilities could live at home and be integrated in their communities.** Evidence-based services, such as Assertive Community Treatment and Permanent Supported Housing, are proven effective in enabling people to live in their own homes in the community, even for people with the highest level of need for mental health services. Community-based crisis response services are also critical to avoid unnecessary hospitalizations and maintain people successfully in the community. A strong crisis system, along with other comprehensive community-based services, can ensure that the majority of adults with mental health disabilities in Alameda County avoid psychiatric institutionalization. Alameda County fails to make these needed community-based services available in adequate capacity or intensity. Alameda County also fails to ensure that people who are in institutions receive professionally-adequate discharge planning and a connection upon discharge to needed services. Without connection to adequate community-based services, people return to John George in crisis again and again. Deficiencies in the community-based service system, including crisis services, at times also contribute to the incarceration of people with mental health disabilities in Santa Rita Jail (Jail). This incarceration further increases a person's risk of institutionalization in John George and the sub-acute psychiatric facilities after release, due in part to the unconstitutional conditions described below.

- **For those who are incarcerated at Santa Rita Jail, the Jail fails to provide constitutionally adequate mental health treatment.** The Jail's mental health program lacks many of the hallmarks of a constitutionally adequate system. Specifically, the Jail's current program fails to: provide adequate psychotherapy; provide adequate treatment planning, discharge planning, and programming; and properly treat and supervise suicidal prisoners. As a result, prisoners with serious mental health needs can experience worsening mental health conditions, repeated cycling for acute care at John George, prolonged restrictive housing, and, at times, serious physical harm or death. From 2015 to 2019, at least 14 prisoners died by suicide in the Jail. Two other prisoners have died by suicide at the Jail within the last two months.

- **The Jail's use of prolonged restrictive housing under current conditions, which include the failure to provide adequate mental health care, violates the constitutional rights of prisoners with serious mental illness.** The Jail subjects prisoners with serious mental illness to prolonged periods of restrictive housing under conditions that place them at a substantial risk of serious harm. Half of the people in "administrative segregation" at any given time in the Jail are estimated to have serious mental illness. On the date of our last visit to the Jail, there were 75 prisoners in administrative segregation who had been there for over 90 days. Eleven of the 14 people who died by suicide between 2015 and 2019 were held in restrictive housing at some point, and half of the other instances of self-harm that we reviewed occurred while prisoners were in restrictive housing.

- **The Jail denies prisoners with mental health disabilities equal access to needed programming and services.** The Jail offers an array of programming and transition services to prisoners in the general population, but prisoners with mental health disabilities who are held in the Jail's segregated "mental health unit" or in administrative segregation are denied access to these programs.

Together, these alleged violations result in a system where people with mental health disabilities in Alameda County find themselves unnecessarily cycling in and out of psychiatric institutions, lacking access to proven, evidence-based practices that would allow them to recover and participate in community life. Many also have encounters with the criminal justice system driven in part by unmet mental health needs. Those who are incarcerated at Santa Rita Jail experience severely deficient mental health treatment, lengthy stays in restrictive housing, and discrimination on the basis of their disabilities, all of which can result in serious harm or even death while incarcerated, and place them at serious risk of repeated or unnecessarily lengthy psychiatric institutional stays after release.

The Department has received multiple complaints from and on behalf of prisoners with serious mental illness at Santa Rita Jail and people who rely on Alameda County for mental health services and experience unnecessary psychiatric institutionalization. Alameda County has long been on notice of the deficiencies in its mental health service system and the harmful conditions at Santa Rita Jail, but these problems continue. Reports by County bodies, including the Board of Supervisors' own committees, and outside consultants have identified many of these and other concerns as far back as at least 2015. News articles repeatedly highlight deaths at Santa Rita Jail, the allegedly dangerous conditions that exist there, and the overcrowding in John George's emergency room, among other issues. Several lawsuits have been filed in recent years alleging a litany of serious problems in the Jail, and California's federally-designated protection and advocacy organization, Disability Rights California, in 2019 sent the County a "probable cause" findings letter regarding many of the same ADA violations we identify. Advocates and family members of those who have died in the Jail have called for an audit of the Alameda County Sheriff's Office for years. In 2018, midway through our investigation, we shared many of our concerns and observations with the County and Jail leadership.

The County is well-positioned to make crucial changes, with many of the needed services already available in limited amounts in the community and with leadership that recognizes the need for change. But today, people with mental health disabilities continue to experience needless psychiatric institutionalization and unconstitutional, discriminatory, and harmful treatment at Santa Rita Jail as they wait for change that still has not come.

II. INVESTIGATION

In January 2017, the Department of Justice notified the County of Alameda, the Alameda County Sheriff's Office, and Alameda Health System that it was opening an ADA and CRIPA investigation into whether the County of Alameda unnecessarily uses psychiatric institutional settings to provide services to adults with mental health disabilities and whether the conditions of confinement in John George Psychiatric Hospital and Santa Rita Jail subject individuals to

unlawful harm. Our ADA investigation focused on whether the County provides meaningful community-based services as alternatives to, and effective discharge planning to help people with mental health disabilities transition out of and avoid re-entering, psychiatric institutional care.

Two nationally recognized expert consultants assisted with our investigation: a forensic psychiatrist with over 20 years of clinical and forensic experience in a variety of academic and correctional settings, and a community psychiatrist with experience as a medical director of a statewide community services provider and as a bureau chief for a state mental health authority. These experts accompanied us on site visits, participated in interviews with County and facility staff and community members, reviewed documents, and provided their expert opinions and insight to help inform our investigation and its conclusions.

During our investigation, we visited Santa Rita Jail, John George Psychiatric Hospital, sub-acute psychiatric facilities, and board and care homes. During our site visits, we interviewed staff at these facilities, as well as people who were receiving services in the facilities. We also met with providers of community mental health services, individuals with mental health disabilities who receive community-based services from the County, and mental health and criminal justice advocates and other stakeholders in the County. Finally, we met with officials from Alameda County Behavioral Health Care Services and the Alameda County Sheriff's Office. In addition to these visits and interviews, we reviewed the documents and information provided by the County, reviewed publicly available data and reports, and considered the opinions of a wide range of individuals knowledgeable about the County's mental health system.

Following several visits, Department attorneys and experts provided briefings to County and Sheriff's Office staff and leadership about preliminary concerns identified by our experts. It is evident that County and Sheriff's Office leadership and staff took these briefings seriously. By the time of our last visit in August 2019, the County had taken some positive steps, described further in Sections IV.B.2 and IV.D, and leadership elaborated on its vision of and plans for further progress. We appreciate the commitment to making these urgently needed changes, but remain concerned that there has been little actual progress to resolve the discrimination that is occurring in the County's mental health system and the unconstitutional conditions and discrimination in the Santa Rita Jail.

We thank the County for the assistance and cooperation extended to the Department of Justice thus far and acknowledge the courtesy and professionalism of all of the County officials and counsel involved in this matter to date. We also thank the people we met who are affected by the violations we were investigating, especially for their willingness to share their often-difficult experiences with us and take time away from their jobs and lives to do so.

III. SYSTEM OVERVIEW

Alameda County administers, funds, and controls its public mental health system. Within Alameda County, responsibility for administering public mental health and substance use services falls primarily on Alameda County Behavioral Health Care Services (BHCS). BHCS is

responsible for providing mental health services for people with moderate to severe mental health needs as well as for substance use disorder services. Alameda County residents are generally eligible for services from BHCS if they have a mental health disability that impairs their daily functioning.[3] California delegates responsibility to and authorizes counties to provide an array of mental health services under Medicaid (referred to in California as Medi-Cal) and state-only funds, including the Mental Health Services Act (MHSA).[4] In delegating responsibility for behavioral health services to counties, California affords counties significant flexibility in administering both Medicaid and state-only-funded programs; however, California expects the emphasis of MHSA programs to be on evidence-based, recovery-oriented community services, including crisis services, employment services, preventative services, supported housing, and intensive support services.[5] Counties also fund additional mental health services, such as long-term psychiatric institutional programs, that are not reimbursed by Medicaid or state programs.

Alameda County provides acute inpatient hospitalization and crisis stabilization services at John George Psychiatric Hospital, a County-owned, dedicated psychiatric emergency and inpatient facility in San Leandro, California. BHCS contracts with Alameda Health System for operation of and provision of services at John George. John George has three inpatient units with a total of 69 beds, as well as an emergency room, called Psychiatric Emergency Services (PES). PES is intended to provide crisis stabilization services. Utilization of these crisis services routinely exceeds capacity. Alameda County also funds and provides long-term, sub-acute inpatient and residential services for about 200 people at a time in several "sub-acute facilities" that range in size from 39 to 78 beds, where people regularly stay for months or years.[6] Services provided in these locked facilities include medication management, psychosocial rehabilitation, support groups, and assistance with some activities of daily living, like grooming. Many more people in Alameda County are placed in "board and care" facilities which provide residential services as well as minimal daily supports.

Many of the same or equivalent supports provided in these inpatient and segregated settings in Alameda County are also available—but in extremely limited supply—through various

---

[3] *See* CAL. WELF. & INST. CODE § 5600.3(b) (West 2019); CAL. CODE REGS. tit. 9, § 1830.205 (2020). A mental health disability is a qualifying disability under the ADA. 42 U.S.C § 12102 (2012) (defining "disability" as a "physical or mental impairment that substantially limits one or more major life activities"). Mental health disabilities include serious mental illness, or SMI, which is defined as "a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment" of an individual over the age of 18 that "substantially interferes with or limits one or more major life activities" within the last year. *Mental Health and Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH ADMIN., https://www.samhsa.gov/find-help/disorders (last visited Apr. 6, 2020).

[4] Under the MHSA, California requires counties to provide safety net mental health services for people without insurance. Cal. Welf. & Inst. Code §§ 5801–5809; Cal. Prop. 63, Mental Health Services Act, § 3 (2005, 2020 supp.).

[5] CAL. WELF. & INST. CODE §§ 5801(b)(9), 5802, 5848.5; Cal. Prop. 63, Mental Health Services Act, § 3 (2005, 2020 supp.).

[6] These facilities are considered Institutes for Mental Disease under Medicaid, and must be paid solely with County, not Medicaid, funds; equivalent services provided in community-settings would instead be eligible for Federal Medicaid funds.

outpatient programs. Full Service Partnerships and less intensive Service Teams use multidisciplinary team models to provide high-intensity outpatient support services to people in the places where they live. Alameda County also funds and operates limited integrated residential services for people with mental health disabilities, such as permanent supported housing. Alameda County also makes some limited crisis services available through crisis stabilization units, crisis residential facilities, and mobile crisis services.

Alameda County also funds the Santa Rita Jail, which is administered and controlled by the Alameda County Sheriff's Office. Santa Rita Jail, opened in 1989, has the capacity to hold approximately 4000 prisoners. During most of the time of our investigation, however, the actual prisoner count has been closer to 2400. Until recently, Alameda County Sheriff's Office also operated the Glenn Dyer Jail in Oakland, but in mid-2019, it closed that jail and transferred its population to Santa Rita Jail. The Jail holds both pre-trial detainees and convicted prisoners (collectively referred to throughout this Notice as "prisoners").

Jail officials have stated that approximately 40% of Santa Rita Jail's population is on the mental health caseload, and have estimated that approximately 20–25% of the population has a serious mental illness. Mental health services at the Jail are provided by BHCS, through its Criminal Justice Mental Health arm.

IV. ALAMEDA COUNTY VIOLATES INDIVIDUALS' RIGHT TO RECEIVE SERVICES IN THE MOST INTEGRATED SETTING UNDER TITLE II OF THE ADA

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1) (2012). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2) (2012). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities when it provided that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132 (2012). Accordingly, the "ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them." *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995).

One form of discrimination prohibited by Title II of the ADA is violation of the "integration mandate." *See* 28 C.F.R. § 35.130(d) (2019); *see also* 42 U.S.C. § 12101(a)(2), (b)(1). That is, under the ADA, public entities must "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). An integrated setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. B, at 708 (2018).

In *Olmstead v. L.C.*, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. 527 U.S. 581, 607 (1999). In so holding, the Court explained that unnecessary institutional placement "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* at 600.

The ADA's integration mandate applies both to people who are currently institutionalized and to people who are at serious risk of institutionalization. *Steimel v. Wernert*, 823 F.3d 902, 913 (7th Cir. 2016); *Davis v. Shah*, 821 F.3d 231, 263 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d 307, 321–22 (4th Cir. 2013); *M.R. v. Dreyfus*, 663 F.3d 1100, 1115–18 (9th Cir. 2011), *opinion amended and superseded on denial of reh'g*, 697 F.3d 706 (9th Cir. 2012); *United States v. Mississippi*, 400 F. Supp. 3d 546, 553–55 (S.D. Miss. 2019). As the Tenth Circuit reasoned, the integration mandate "would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation." *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003); *see also Pitts v. Greenstein*, No. 10-635-JJB-SR, 2011 WL 1897552, *3 (M.D. La. May 18, 2011) ("A State's program violates the ADA's integration mandate if it creates the *risk* of segregation; neither present nor inevitable segregation is required.") (emphasis in original). A State's failure to provide community services may create a serious risk of institutionalization. *Pashby*, 709 F.3d at 322; *see also Mississippi*, 400 F. Supp. 3d at 553–55 (upholding plaintiff's *Olmstead* claim that when people with serious mental illness are discharged from state psychiatric hospitals, the state's "ongoing lack of community-based services means they are at serious risk of re-institutionalization").

A. Alameda County Subjects Adults with Mental Health Disabilities to Unnecessary Psychiatric Institutionalization and the Serious Risk of Psychiatric Institutionalization

Alameda County relies unnecessarily on segregated psychiatric institutions to serve its residents with mental health disabilities who need intensive treatment and long-term services and supports and who are eligible for public mental health services. Institutions such as John George and the sub-acute facilities in Alameda County isolate and segregate people with mental health disabilities from those without disabilities. *Cf., e.g.*, *Benjamin v. Dep't of Pub. Welfare*, 768 F. Supp. 2d 747, 750 (M.D. Pa. 2011) (individuals in facilities were segregated where they lived in units ranging from 16 to 20 people, primarily received services on the grounds of the facilities and had limited opportunities to interact with non-disabled peers); *Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184, 224 (E.D.N.Y. 2009) (finding that "many people with mental illness living together in [an adult home] setting with few or no nondisabled persons contributes to the segregation of [a]dult [h]ome residents from the community"), *judgment vacated on other grounds*, 675 F.3d 149 (2d Cir. 2012); *Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 285 (E.D.N.Y. 2008) (denying motion to dismiss in case involving plaintiffs with mental illness who were institutionalized in nursing facilities). Residents of these facilities are exclusively people with

disabilities, and the facilities provide services nearly entirely within their walls. These institutions' doors are locked from the outside, and the facilities place restrictions on residents' ability to leave. Even short stays in these facilities isolate people from their friends and families and interrupt participation in community life.

Alameda County is distinct in California in that it has more beds per capita in long-term sub-acute psychiatric facilities than any other similarly sized California county, and these beds are nearly always full. The primary sub-acute facilities the County relies on to serve people with mental health disabilities are Villa Fairmont, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center, a nursing facility, which have a combined 187 beds. Depending on the facility, people may stay for months or live in these facilities for years. At Villa Fairmont, the average length of stay in 2017 was 156 days. Most people stay at Morton Bakar for nearly two years and the average length of stay at Gladman is between two-and-a-half and three years.

Outside of these sub-acute facilities, people with mental health disabilities in Alameda County experience shorter, but often repeated, stays at John George Psychiatric Hospital in order to get needed services. Based on the data provided by the County, an average of 1111 people in need of crisis stabilization are evaluated at John George PES each month and remain there for up to 72 hours. Of these, almost 240 people each month are then admitted into John George's acute inpatient units. The average length of stay is nine days in these units, and increasing, but many stays last weeks or even months. Between August 2017 and July 2019, 844 admissions lasted two weeks or more in John George's inpatient unit, and 236 were for 30 days or more. Alameda County's utilization of John George's inpatient unit is 6.3 times the statewide average in California for utilization of state and county psychiatric hospitals. One complainant wrote to us about her experiences at John George and told us that County authorities "concentrate [M]edicaid crazies like myself there, as opposed to using clinics in the community." She was taken there involuntarily by law enforcement from her home after she called them to report domestic abuse and then spent two weeks in "the closest thing to Hell I've encountered." She felt that, while there, she had no clear treatment or release plan; when she eventually was released, she did not receive medications or other assistance, except for a bus pass with a single fare.

A high number of people cycle through John George again and again. Nearly 1600 people experienced four or more crisis stabilization admissions to John George's PES during the two-year period from August 2017 to July 2019.[7] During the same period, over 1000 people experienced at least two admissions to the inpatient units. In fiscal year 2019, nearly 11% of individuals discharged from John George's inpatient unit were readmitted within just 14 days. This rate, which already far exceeds both national averages for state hospitals and statewide averages, appears to be increasing.

A history of admissions to John George—which alone is disruptive to people's lives and can put people at risk of losing jobs and housing—in turn often becomes the gateway to

[7] The County similarly reported in 2016 that roughly 17.5% of all emergency room admissions to John George came from "high utilizers": people with more than four emergency admissions in the previous 12 months.

segregating people for longer periods in the sub-acute facilities. John George directly refers people needing longer-term services to the sub-acute facilities. Between 2012 and 2017, more than 10% of admissions to John George's inpatient units resulted in a placement in a sub-acute facility within 14 days of discharge. The County itself plays a direct role in institutional placements through its monthly Acute Care Coordination Committee meeting. In this meeting, representatives from John George, the sub-acute facilities, and community providers discuss individuals who have cycled through hospitals, and sometimes also jail, in an attempt to place these individuals in the sub-acute facilities or, for those who have been lingering at the sub-acute facilities, into a board and care home. However, few are connected with intensive community services through this process.

As discussed in Section IV.B–D, our investigation determined that nearly all of the people who are placed in the sub-acute facilities or in John George's inpatient units could have avoided or spent less time in these psychiatric institutions with appropriate community-based services, and few would oppose such services, rendering Alameda County's reliance upon psychiatric institutions unnecessary. But because Alameda County does not make appropriate community-based services available in sufficient capacity, people have little choice but to enter these psychiatric institutions to get the help they need.

People with mental health disabilities incarcerated at the Santa Rita Jail face further serious risk of institutionalization in a psychiatric facility upon their release from the Jail. Some people are sent directly to John George upon release from the Jail, and others make their way to the hospital soon after, because of a lack of community-based mental health services or because the County fails to connect them to those services that do exist. Between 2012 and 2017, there were more than 4200 instances when a person released from Santa Rita Jail was seen at John George PES within just 30 days. Of the people who spent time in John George's inpatient unit between 2012 and 2017, 41% had previously been incarcerated in Santa Rita Jail. Of those with four or more inpatient stays at John George, 53% had spent time in the Jail.

As discussed further in Sections V–VII, Santa Rita Jail denies prisoners adequate mental health treatment, isolates people with serious mental illness for prolonged periods in restrictive housing, and severely limits access to pre-release programming and transition services for this population. These conditions contribute to people with serious mental illness being sent repeatedly for brief stints to John George while incarcerated and often leads to institutionalization upon release. The inadequate discharge planning the County provides to prisoners with mental health disabilities at the Jail compounds this problem. The County's discharge and treatment planning often fails to anticipate a person's needs in advance of release and almost never includes goals for community stabilization. According to Jail mental health staff and our expert's review, prisoners commonly receive, at most, bridge medications and a list of resources. Although Alameda County BHCS is responsible for mental health treatment at the Jail, the County does not ensure that community providers meet with prisoners before their release to coordinate treatment. Because of these practices, people being released from jail, a time when they are particularly vulnerable, often do not successfully connect with community services. A lack of successful connection to community services leads to housing instability and

a lack of effective mental health treatment. This results in an increased risk of additional mental health crisis and eventual placement at John George and the sub-acute facilities.

Alameda County further places people at serious risk of psychiatric institutionalization due to its lack of community-based behavioral health crisis services. Instead of providing community crisis services by trained mental health clinicians, such as mobile crisis services and crisis residential services, that are effective in preventing unnecessary hospitalizations, the County relies heavily on law enforcement to respond to crises. The Alameda County Board of Supervisors' Mental Health Board observed in 2015 that "Police officers in the field responding to individuals with mental illness have few options other than bringing them to Santa Rita or John George. Although they may have received Crisis Intervention Training, without adequate diversion resources, police officers must frequently use John George and/or Santa Rita Jail as their only option."[8] We heard from multiple stakeholders, including those who had themselves experienced a mental health crisis, that it is typically law enforcement who respond to psychiatric emergencies and that there is a degree of chance with respect to whether one is taken to jail or the hospital. Multiple reports have found that the lack of access to community-based mental health services—including crisis services, diversion mechanisms, long-term community supports, and re-entry discharge planning—may all contribute to people with mental health disabilities encountering law enforcement and ultimately becoming hospitalized or incarcerated in Santa Rita Jail. Our experts' findings and national studies also support this conclusion.[9]

The death of A.A.[10] illustrates the problems that can occur due to the lack of community-based mental health services, including crisis services. A.A. was experiencing a mental health crisis in early June 2019. After a brief psychiatric hospitalization, nurses told his parents on discharge to call 911 and ask for police if he needed further help, and that he would be brought back in for mental health treatment. Days later, A.A. was still in crisis, and his parents called 911, asking for help. A.A.'s father told the police who responded that A.A. was not a danger and that he needed to be taken for mental health treatment. This would have been an appropriate situation in which to bring in community-based crisis services or call a mobile crisis team, but it appears that this did not occur. Instead, police arrested A.A., and, as described in more detail below, he was taken to Santa Rita Jail, where he sustained severe injuries and later died. A.A.'s parents have publicly expressed deep regrets that they ever sought assistance from police for their son.[11]

Another person's experience similarly illustrates how the lack of effective community-based services and a history of repeated institutionalization can also result in engagement with the criminal justice system. B.B. was well known to BHCS—she had more than 100 "episodes"

---

[8] ALAMEDA CNTY. MENTAL HEALTH BD., ANNUAL REPORT TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS, FISCAL YEAR 2014–2015 at 7 (2015), http://www.acbhcs.org/mhb/Resources/MHB_Annual_Report_2015.pdf.

[9] In fact, California law specifically permits pre-trial diversion to mental health treatment for individuals with mental illness where the mental illness played a significant factor in the commission of the charged offense, excluding certain violent and serious charges, CAL. PENAL CODE § 1001.36 (West 2020), but without community-based treatment options, this law may have little impact on diversion.

[10] To protect the identity of people, we use coded initials.

[11] Despite multiple requests, Alameda County did not provide records related to A.A.'s death.

dating back to 2002. In 2016, without access to intensive community-based services, B.B. experienced a mental health crisis, attempted to admit herself to John George, and was ultimately arrested for trespassing after John George denied her admission without contacting a mobile crisis team or otherwise connecting her to services. B.B. was rearrested a few months later, but her mental health deteriorated and she was forensically admitted to a state psychiatric hospital for nearly two years before being released back to Santa Rita Jail in July 2019.

B. People with Mental Health Disabilities in Alameda County Can Be Appropriately and Effectively Served in the Community

People with mental health disabilities who are institutionalized or at serious risk of institutionalization at John George or a sub-acute facility in Alameda County could avoid placement in psychiatric institutions with appropriate integrated, community-based services, if such services were available. Many established, evidence-based practices exist that are proven to support people with serious mental illness or other mental health disabilities in their own homes and community-based settings, and to reduce needless psychiatric institutionalization. However, Alameda County has not appropriately implemented these practices, and services are in too short supply. It is the County's failure to provide evidence-based, community-based treatment, including crisis services and processes to divert people from psychiatric institutionalization, that results in and perpetuates the cycle of needless institutionalization described above.

1. People Cycling Through Psychiatric Institutions Are Appropriate for Community-Based Services

Most of the people who cycle in and out of John George and the sub-acute facilities in Alameda County could be provided appropriate mental health treatment in the community. At two points during the Department's investigation, our consultant, a national expert in the provision of community-based treatment to people with serious mental illness, conducted a review of people in John George's inpatient unit. Both times, our expert found that nearly all of the individuals there would have avoided hospitalization altogether or spent less time in the hospital had they been provided appropriate community-based treatment and received professionally adequate discharge planning to connect with those services.

People regularly stay longer than is needed at John George. On any given day at John George, a significant portion of the residents have been determined by John George professionals to be appropriate to leave but remain in the hospital because they are awaiting a placement elsewhere. On July 31, 2019, 24 of the 69 inpatient beds—or 35%—were occupied by individuals whom John George had determined no longer met criteria for an inpatient stay. In the year between August 2018 and July 2019, 123 people spent two weeks or more institutionalized at John George after they were cleared for discharge, simply because there was nowhere for them to go. Instead, they were held at John George, waiting for an opening in an intensive community-based mental health program, or for space at one of the sub-acute facilities—discussed below. John George staff estimated that in a given week, about 10 of their inpatient residents who are ready for discharge are of enough concern to be discussed at the

weekly Acute Care Coordination Committee meeting in order to locate a community placement; each week, the resources are found to support only about half of them. Staff reported that in some cases, people have waited in the inpatient unit for months for a placement, simply because there were no community resources available to support them outside of the hospital. Similarly, the County has estimated that 75% of people placed on involuntary holds at John George do not even meet medical necessity to be there. This is likely because, as one John George administrator put it, the "dearth of resources" in the community lands far too many people in their institution, again and again.

People living in the sub-acute facilities could also largely live in their own homes and communities with appropriate services. Facility staff themselves stated that many of the people living at these facilities could live in the community with appropriate services, and this opinion was echoed by stakeholders in various roles in the County. Our expert agreed that Alameda County overly relies on the sub-acute facilities instead of community-based treatment. Our expert reviewed a sample of people at one sub-acute facility, Villa Fairmont, and concluded that, like those at John George, nearly all would have avoided admission or could have spent less time in the facility, had they been provided appropriate community-based treatment. Yet many are stuck, waiting for slots in community service programs that simply do not exist or that are inadequate to meet their needs.

Our expert found that people served by BHCS are often at serious risk of psychiatric institutionalization because of a lack of available community supports. Having interviewed individuals in and at risk of entry to many of the psychiatric institutions in Alameda County, our expert confirmed that the people he met in Alameda County's institutions were no different from people he had served or observed receiving services successfully in their own homes around the country.

2. Alameda County Fails to Provide Adequate Community-Based Services that Could Prevent Needless Psychiatric Institutionalization

It is well-established that an appropriate array of evidence-based services can enable people with serious mental illness or other mental health disabilities to avoid psychiatric institutionalization and live safely in integrated, community-based settings. The County has implemented some critical community-based services, but it has not fully funded them to ensure they are available in sufficient capacity, adequate intensity, and with fidelity to evidence-based practices so as to prevent individuals from cycling through psychiatric institutional stays.

Community-based mental health services and practices are necessary to enable individuals with mental health disabilities to live in the community. These are critical, evidence-based practices that can be individually tailored to the needs of each person and minimize costly, unnecessary, and repeated psychiatric institutionalization. These services are appropriate for Alameda County residents who have serious mental illness and are currently in or at serious risk of entering psychiatric institutions and, if fully developed in Alameda County, would prevent unnecessary institutionalization. These services are also proven to reduce arrests and incarceration and could thus further help to break the cycle of unnecessary psychiatric

institutionalization and incarceration. These services or their equivalents are provided in John George and the sub-acute facilities, but do not currently exist in sufficient supply or intensity in the community. These services include the following:

- **Crisis Services:** Community-based crisis supports are a crucial component of a system that prevents needless psychiatric institutionalization. These services include crisis hotlines, mobile crisis teams, crisis apartments, and walk-in crisis centers. For example, mobile crisis is an evidence-based intervention that is available 24 hours a day to respond rapidly to people experiencing a mental health crisis at their homes or at whatever location they may be experiencing the crisis. These services are proven to decrease psychiatric hospitalizations, arrest rates, and incarceration. However, as of our last visit to Alameda County, there were just two mobile crisis programs, which do not operate at all times. Instead, law enforcement officers alone typically handle mental health crisis calls.[12] In our expert's review of individuals at John George and Villa Fairmont, he found that none had had access to the kind of mobile crisis services that could have diverted them from admission. County leadership has recognized the important role of mobile crisis and the gaps in this service in Alameda County and is in the process of expanding mobile crisis response. At the time of our last visit, the County described plans to add six new mobile crisis teams, one of which would include an EMT to conduct medical clearance so that individuals in crisis could be taken to a location other than John George or Santa Rita Jail, expanding the options that currently are used by existing mobile crisis teams. This is among the most promising plans for improvement in the County. However, even if the County creates all of the crisis teams as planned, it will not have mobile crisis services available 24 hours a day, mobile crisis response will not be available in all areas of the County, and only one team will be able to conduct medical clearances.

  Similarly, crisis services should also include alternatives to hospitalization such as crisis residential programs or crisis apartments, which typically contain a few beds in a home-like environment with full-time staff. These programs are intended to allow people to stabilize in these settings and avoid going to the hospital. The County has a few crisis residential programs, but people typically come to those settings from an acute setting, typically John George, instead of using them to avoid hospitalization in the first place. This is counter to the purpose of having a crisis residential program and uses up beds that could otherwise be used as a diversion or alternative to hospitalization.[13]

[12] In 74% of the involuntary holds (also known as 5150 holds) conducted by Alameda County Sheriff's Office that we reviewed, the individual was neither threatening nor violent. In 88% of these incidents, no restraints were used. And this does not include mental health crisis calls that did not rise to the level of severity that resulted in an involuntary hold.

[13] In fact, the entire behavioral health system seems to be permeated by a step-down philosophy, requiring individuals to graduate out of more restrictive care to gradually less restrictive settings, which does not comport with the ADA's requirement that people receive community-based services when they are appropriate. Standards in the field today, which align with the requirements of the ADA, reject the step-down philosophy. Professional standards instead dictate that individuals are best supported in their own homes with intensive, appropriate community-based services.

To be effective, community-based crisis services must also include and be paired with mechanisms specifically designed to divert people with mental health disabilities from psychiatric institutions and the criminal justice system, which are notably absent in Alameda County. For example, the County has acknowledged that law enforcement overutilizes involuntary holds at John George due to the lack of alternative crisis resources or a formal mechanism at initial detention to connect people with mental health disabilities to community-based services, which would reduce the serious risk of subsequent psychiatric institutionalization.

- **Full Service Partnerships:** Assertive Community Treatment, or California's model, called Full Service Partnerships, is designed to support service recipients with the highest mental health needs and most frequent hospitalizations to transition from institutions and live in the community. Full Service Partnerships provide a multidisciplinary team that is intended to help people stay in treatment, manage medication, address crises, secure and maintain housing and employment, and engage in their communities. Teams should be available 24 hours a day and be able to respond to crises and other needs on a flexible basis, including assisting in the coordination of services if a client enters or is at risk of entering an institutional setting. Both California and Alameda County have recognized that Full Service Partnerships reduce institutionalization, criminal justice involvement, and emergency room use, and community members in Alameda County have identified Full Service Partnerships as the most effective mental health service in the County. Alameda County administrators have acknowledged that the capacity is far from sufficient, although the County has not conducted an analysis of the actual need. One County administrator estimated the need to serve 4000 to 6000 people with the Full Service Partnership program. At the same time, Alameda County had funded capacity to serve only 850 adults with Full Service Partnerships and in practice serves fewer than 725 adults in a given month.[14] Alameda County also operates a forensic Full Service Partnership that is designed to engage people with a history of significant criminal justice involvement. Yet, based on documents provided by the County, of the 290 people whom the County has identified to be eligible for this program, just 17 appear to have been connected with that service. Evidence we reviewed indicates that the County fails to effectively connect people with needed Full Service Partnership services and that, once connected, such services are often not provided in an intensity or with the flexibility needed to address crises and provide appropriate supports.

- **Permanent Supported Housing:** Permanent supported housing is an evidence-based mental health service that serves individuals with disabilities and provides flexible supports including medical, behavioral health, and services to support sobriety. Permanent supported housing promotes mental health recovery by enabling individuals to maintain housing and avoid the inherent stress of housing instability; by helping service recipients achieve maximum independence, positive health benefits, and overall higher

[14] The County also offers another multidisciplinary team-based service, called Service Teams, which offers a lower-intensity of service and a higher client-to-staff ratio than Full Service Partnership teams.

quality of life; and by providing a stable place from which a person can engage with other services. It is a cost-effective service that is proven to reduce psychiatric institutionalization, as well as precursors to institutionalization including expensive hospitalizations, emergency room visits, incarceration, and, of course, homelessness. Alameda County BHCS acknowledges that there "is a direct link between housing and behavioral health."[15] However, Alameda County lacks sufficient supported housing capacity to meet the needs of individuals with mental health disabilities. In fiscal year 2017–2018, 10% of the people entering County programs for people with mental health disabilities—a total of 2702 unique individuals—were homeless.[16] This number has steadily increased in recent years. Similarly, approximately 39% of all homeless individuals in the County self-reported a mental health condition that year.[17] The County's contractor to coordinate homelessness issues explained that these and other data points show "the considerable overlap between chronic homelessness and serious mental illness." In 2018, Alameda County's contractor estimated that the County needed to create an additional 2800 "permanent supportive housing" units to meet the need for this service. In 2019, there was an 8000-person waitlist for the County's system to access housing services or subsidies, and only about a quarter of people with serious mental illness who attempt to join the waitlist are successful in even getting their names on the list. Unable to access this evidence-based service, many individuals go to board and care homes instead. Board and care homes provide some minimal care and supervision, but residents frequently lack access to needed services and meaningful community life; further, these facilities tend to be overcrowded and highly variable in quality.

- **Peer Support Services:** Peer support services are an evidence-based practice where trained and certified individuals or family members of individuals who have lived experience with mental health disabilities and receipt of mental health services provide supports. Peer supports are proven to help individuals with serious mental illness engage in treatment and to prevent or reduce hospitalization and incarceration. California's Council on Mentally Ill Offenders has explained that peer support services "clearly stood out . . . as one of the most impactful and desired resources to reduce incarceration among those with mental illness and substance use disorders."[18] Multiple groups in Alameda County have recommended expanding peer support services throughout the service system. Nevertheless, we heard from several stakeholders that peer support services remain in too short supply in Alameda County.

- **Supported Employment Services:** Supported employment is an evidence-based service that assists people with serious mental illness to obtain and maintain competitive employment. Supported employment supports people with disabilities to live integrated lives in their communities. Alameda County has recognized the importance of supported

[15] *Housing Service Office*, ALAMEDA CNTY. BEHAVIORAL HEALTH CARE SERV., http://www.acbhcs.org/housing-services (last visited Apr. 6, 2020).
[16] EVERYONEHOME, PLAN TO END HOMELESSNESS: ALAMEDA COUNTY, CA: 2018 STRATEGIC UPDATE at 31 (2018), https://everyonehome.org/wp-content/uploads/2018/12/EveryOne-Home-Strategic-Update-Report-Final.pdf.
[17] *Id.*
[18] COUNCIL ON MENTALLY ILL OFFENDERS, 15TH ANNUAL REPORT at 17 (2016).

employment to support recovery for people with serious mental illness, but fewer than 530 people with serious mental illness received the County's supported employment services in fiscal year 2019.

- **Services for People with Co-occurring Diagnoses:** Community-based services to support people with serious mental illness who also have co-occurring diagnoses, such as intellectual disability, substance use disorder, or chronic illnesses, are important to help such individuals avoid placement in long-term institutional settings. John George staff explained that in recent years they have seen an increase in people with co-occurring intellectual and developmental disabilities, people with co-occurring substance use disorders, and older adults who may have age-related disabilities—all of whom have begun utilizing John George's acute services more because of a lack of services in the community to support their needs. Although there are evidence-based approaches that have proven to decrease hospital use for most people—for example, integrated dual diagnosis treatment—these services are largely unavailable in Alameda County.

3. Alameda County Fails to Identify and Connect People with the Community-Based Services Necessary to Avoid Needless Institutionalization

In order to avoid needless cycling through institutions, it is crucial that individuals with mental health disabilities have a way to access community-based mental health services. However, Alameda County does not utilize available opportunities to identify people—whether in the community or in institutional settings—who need to be connected to community-based services and to connect them to those services. In particular, Alameda County does not provide adequate discharge planning and transition services to individuals who are institutionalized in John George and the sub-acute facilities in order to connect them to community-based services.[19] In a recent review of treatment plans at John George, our expert found that not one reflected professionally adequate discharge planning. Discharge planning at John George is often not informed by important clinical and practical considerations for the person, and there is inadequate communication between treatment providers. Treatment plans also fail to promote transition to the most integrated setting for the person or to anticipate key goals, opportunities, and important factors for transition.

In addition, the County fails to adequately connect people to the community-based services that could help them avoid institutionalization. For example, as noted above, while the County operates a forensic Full Service Partnership designed to engage people with intensive needs who have a history of significant criminal justice involvement, and has identified 290 people eligible for the program, as of September 2019, fewer than 20 of those individuals had been connected with that service. Similarly, the County has identified the individuals who utilize the most mental health services, as measured by the top 3% of its mental health spending. However, fewer than one-third of those individuals were connected to Full Service Partnerships

[19] And, as discussed above, Alameda County does not adequately provide for the discharge and transition planning of prisoners who will be released from Santa Rita Jail. This further places people with mental health disabilities at serious risk of psychiatric institutionalization upon release.

as of September 2019, and as of that time, the County did not track people who were eligible for those services other than those eligible for forensic Full Service Partnerships, in order to facilitate these linkages. Furthermore, of the top ten mental health service utilizers, all ten were hospitalized during the year, and nine of the ten were in sub-acute facilities. Yet, only three of those ten individuals received Full Service Partnership services during that 12-month period, and only one was placed on a service team, all for seemingly brief periods. While the County has started the process to identify people who need more intensive services, it has failed to take the necessary steps to actually connect them.

The County's failure to successfully connect people to services is hampered by lack of community-based options. This is particularly true for people with co-occurring diagnoses, such as intellectual and developmental disabilities, substance use disorders, and physical health needs. Many people are discharged without adequate supports and services, resulting in frequent readmissions to John George or sub-acute facilities or contacts with the criminal justice system. One person who had received treatment several times at John George described discharge planning there as: "Here's a bus pass, now get the hell out." Others described similar experiences with discharge from John George.

John George staff confirmed many of these issues. Staff report that there are few good options when they discharge patients to the community. They told us that at times, people are discharged to shelters or other forms of homelessness. Without housing, people rapidly lose connection with providers or with transition staff, so that the only way to get services is to return again to John George. Additionally, staff reported challenges with informing County behavioral health services when their clients were at the hospital and a regular failure of service providers to meet with their clients when at John George. John George leadership admitted that being linked to community services upon discharge is the single highest correlate with success in the community.

C. Most People with Mental Health Disabilities in Psychiatric Facilities in Alameda County Do Not Oppose Community-Based Services

Most people with mental health disabilities in Alameda County psychiatric institutions do not oppose receiving community-based services. The majority of people who find themselves at John George or the sub-acute facilities are there involuntarily, or because they had no other way to get services they needed. In fact, Alameda County has the highest rate of involuntary holds of adults in the state—a rate that is three-and-a-half times the statewide average. In his assessment of individuals at John George and Villa Fairmont, our expert found that nearly all individuals reviewed or their guardians would very likely choose to live in the community if they were fully informed of and had access to appropriate community-based services. He found in his most recent review that there was no recorded evidence, for any individual reviewed, that the person or their guardian would oppose receiving services in the community. For many individuals and their guardians, emergency room or inpatient hospitalization, or in some cases incarceration, appeared to be the only option to get help. But, in our expert's view, when there are viable options for receiving treatment at home and in integrated settings, very few people or their guardians would choose options that restrict their freedom and segregate them.

Our interviews with individuals at John George and the sub-acute facilities confirmed this conclusion. Many told us of their desire to leave, or expressed interest in receiving services in the community. One man we met at John George, who had also been to Santa Rita Jail four or five times and was otherwise homeless as of the time of our interview, explained that he would like a program that would help him transition out of John George and find a place to live, and not just be discharged to the street. Another man at John George told us he "wanted to be anywhere else," but that after he left John George the last time, he relapsed and needed help, and so he returned. A woman we met who was living at a sub-acute facility told us she wanted to go home, and maybe go to college, but knew she would need support to do so. "Who is going to support me and be with me?" she questioned. Another man at a sub-acute facility told us that he wanted to leave as soon as possible, but felt that nobody was helping him with this. Others echoed these sentiments. A staff member at one of the sub-acute facilities told us that residents who want to leave the sub-acute facility sometimes "act up" in order to be sent to John George or to jail, because they mistakenly believe that they would subsequently be released into the community after their stay in the hospital or jail.

D. Alameda County Can Make Reasonable Modifications to Prevent Unnecessary Psychiatric Institutionalization

Alameda County can reasonably modify its mental health service system to provide home- and community-based services to prevent unnecessary psychiatric institutionalization. The County already makes available a range of services that can support people with mental health disabilities in their own homes. As discussed above, community-based services, diversion programs, and professionally-adequate discharge planning are proven to be effective in preventing unnecessary psychiatric institutionalization. The County has taken some positive steps to address unnecessary psychiatric institutionalization, including, as of our last visit, the recent funding of 100 Full Service Partnership slots for people with a history of forensic involvement (although providers have had difficulty staffing these slots); the proposal to pilot 100 additional Full Service Partnership slots, combined with housing subsidies, for individuals who are homeless and have co-occurring physical health or substance use disorders; and the plan to significantly expand mobile crisis services. The County also conducts some limited in-reach to John George and Santa Rita Jail with the goal of helping people to connect with services upon discharge. While the supply of these services and scope of existing programs remain insufficient to meet the need, the County can modify and expand these services to serve all individuals who are, or are at serious risk of becoming, unnecessarily institutionalized; ensure that each person receives an appropriate intensity and frequency of services to meet their needs; and eliminate barriers that lead to unnecessary psychiatric institutionalization.

In addition, the County already conducted a Sequential Intercept Mapping process in 2017 and 2019 in which it identified the potential "intercepts," such as arrest, where individuals with mental health disabilities come into contact with the criminal justice system, but can instead be identified and connected to community-based services. Alameda County has identified the resources and gaps that exist at these intercepts and is well-positioned to develop the needed mechanisms to use these intercepts to connect people who are at serious risk of psychiatric institutionalization with services, but has not done so yet.

Further, County leadership has acknowledged, and studies have repeatedly shown, that providing community-based services for people with serious mental illness is cost effective. Alameda County currently spends disproportionately on institutional services as compared to community-based services. For example, based on information provided by the County, annually each individual in the County's top 3% of mental health spending utilizers uses services costing an average of $120,410 as of 2019. This group is largely made up of people who spend the majority of their time in a sub-acute facility or have four or more hospitalizations and accounts for 32% of all system costs. However, few of the people in this group received intensive community services, which are known to cost significantly less.[20] Even including costs for housing supports, serving these individuals in the community could dramatically reduce the costs for the County.

Alameda County can also maximize federal and state funding opportunities to develop community-based services. For example, most hospital and sub-acute stays are funded solely by County funds, while community-based services are typically eligible for federal Medicaid match dollars. Moreover, California provides a significant amount of funding through the Mental Health Services Act funds, which can be used for critical services such as Full Service Partnerships, permanent supported housing, and diversion programs. Yet Alameda County in recent years has left a significant amount of its MHSA funds unspent, and these are at risk of reverting to the state.

The lack of community-based services drives individuals with serious mental illness into costly psychiatric facilities, but it also can lead to costly incarceration. Alameda County spent $177.2 million in fiscal year 2016–2017 on Santa Rita Jail, not including mental health services, with around 25% of its population having serious mental illness. The County has recognized both its significant reliance on the Jail for people with mental illness and that appropriate mental health treatment could address this problem. The Alameda County Board of Supervisors' Mental Health Board recognized in 2015 that "Santa Rita Jail has become a warehouse for people with mental illness."[21] The Board further explained that "since there is nowhere to place [individuals with mental health disabilities], they languish in jail, often isolated in jail cells. We need to develop a system so that this population can be diverted out of the criminal justice system and into treatment."[22] More recent County and external reports have echoed these conclusions. As discussed above, studies have shown that evidence-based community mental health services have been effective at reducing arrest rates and incarceration in California and across the country. For example, a 2010 study in California found that the probability of arrest dropped by 56% for

[20] *See, e.g.*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., CRISIS SERVICES: EFFECTIVENESS, COST-EFFECTIVENESS, AND FUNDING STRATEGIES (2014); SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., ASSERTIVE COMMUNITY TREATMENT: THE EVIDENCE (2008); SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., PERMANENT SUPPORTIVE HOUSING: THE EVIDENCE (2010); NATIONAL COUNCIL ON DISABILITY, HOME AND COMMUNITY-BASED SERVICES: CREATING SYSTEMS FOR SUCCESS AT HOME, AT WORK AND IN THE COMMUNITY (2015), https://ncd.gov/publications/2015/02242015.

[21] ALAMEDA CNTY. MENTAL HEALTH BD., ANNUAL REPORT TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS, FISCAL YEAR 2014–2015 at 7 (2015), http://www.acbhcs.org/mhb/Resources/MHB_Annual_Report_2015.pdf.

[22] *Id.*

individuals who were involved in Full Service Partnerships.[23] Thus, in implementing community-based services to prevent psychiatric institutionalization, the County will also likely reduce incarceration and, in the process, reduce its expenditures for incarceration. The Mental Health Board's Criminal Justice Subcommittee has reported to the Board of Supervisors that, according to national data, it costs two to three times more for a person with serious mental illness to be incarcerated compared to being housed and receiving treatment in the community, and that mental health programs that included housing led to fewer arrests and shorter jail stays among people with mental illness. Making the needed modifications may thus also result in a smaller population of prisoners with mental health needs at Santa Rita Jail, which could free up funds to support community-based mental health services and potentially ease the Jail's implementation of remedies to address the conditions we identify in Sections V–VII.

Alameda County government has long been on notice of its needless institutionalization of people with serious mental illness. In 2015, the Alameda County Board of Supervisors' Mental Health Board wrote of the "dire need" for intensive outpatient services to address the overcrowding and high readmission rates at John George, explaining that "John George remains the single most utilized point of entry into the County mental health care system."[24] The same report concluded that "[f]ar too many Alameda County residents with mental illness cycle in and out of Santa Rita Jail and John George Psychiatric Hospital," and called for a "comprehensive, integrated system which offers a continuum of care."[25] In a January 2016 presentation to the Board of Supervisors' Health Committee, BHCS identified several concerns around the lack of coordinated mental health and substance use services, insufficient service coordination across settings, and a lack of 24/7 crisis service coverage, resulting in psychiatric emergency room admissions. And several other County reports have similarly acknowledged these problems and the needed solutions.

As described at several points above, the County has begun to develop many of the needed services and programs: it offers too-limited mobile crisis services, crisis residential services, Full Service Partnership teams, peer support services, permanent supported housing, supported employment, and substance use disorder services, as described in Section IV.B.2. It has the framework to divert people from institutions and conduct discharge planning in institutions to help people access these community services. Yet the scope and supply of each of these services and programs falls short of the need, in many cases as acknowledged by the County, instead causing the County to rely on institutional services. Though the County could use existing and available resources to rebalance its service system, and although County officials have expressed goals of doing so, the County must complete this work to ensure an adequate array and capacity of community-based services, including crisis services, diversion programs, and appropriate discharge planning, in order to fulfill County residents' right to

[23] NICHOLAS C. PETRIS CENTER ON HEALTH CARE MARKETS AND CONSUMER WELFARE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA, BERKELEY, EVIDENCE ON THE EFFECTIVENESS OF FULL SERVICE PARTNERSHIP PROGRAMS IN CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM (2010), https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.172.8620&rep=rep1&type=pdf.
[24] ALAMEDA CNTY. MENTAL HEALTH BD., ANNUAL REPORT TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS, FISCAL YEAR 2014–2015 at 6 (2015), http://www.acbhcs.org/mhb/Resources/MHB_Annual_Report_2015.pdf.
[25] *Id.* at 7.

receive services in the most integrated setting. The minimum remedial measures necessary to achieve this goal are described in Section VIII.

V. MENTAL HEALTH CARE AT SANTA RITA JAIL IS INADEQUATE IN VIOLATION OF THE CONSTITUTIONAL RIGHTS OF PRISONERS WITH SERIOUS MENTAL HEALTH NEEDS

After making several trips to the Santa Rita Jail with our experts; speaking with Jail management, security staff, mental health staff, and hundreds of prisoners; and reviewing thousands of pages of documents, including numerous mental health and other records, the Department has reasonable cause to believe that the Jail fails to provide prisoners with serious mental health needs with adequate mental health care, in violation of their Eighth and Fourteenth Amendment rights.

As discussed above in Section III, Alameda County funds the Jail, which is administered and controlled by the Alameda County Sheriff's Office. The Jail has the capacity to hold approximately 4000 prisoners. During most of the period encompassed by our investigation, however, the actual prisoner count has been closer to 2400.[26] The Jail holds both pre-trial detainees and convicted prisoners. Approximately 85% of the Jail's population is pre-trial detainees.

While the population of the Jail is, by its very nature, constantly in flux, it includes a large number of individuals with serious mental health needs. Although the Jail does not specifically categorize prisoners as having "serious mental illness," Jail representatives have stated that approximately 40% of its population is on the mental health caseload.[27] And in our interviews with the Jail's chief psychiatrist and other key mental health staff, they estimated that approximately 20–25% of the population likely has a serious mental illness. For those in various specialized housing units, the numbers are likely even higher. According to the Jail's chief psychiatrist, for example, approximately 50% of the prisoners in the administrative segregation units[28]—the most restrictive in the Jail, other than short-term "safety cells" used up to 72 hours for actively suicidal prisoners—have a serious mental illness. Our observations of prisoners we

[26] While the population at the Jail had declined to approximately 1800 prisoners in May 2020 due to changes to booking and release procedures that were instituted in response to the COVID-19 pandemic, the population has since rebounded to 2200 prisoners as of April 5, 2021. *See Covid-19 Update*, ALAMEDA CNTY. SHERIFF'S OFFICE, https://www.alamedacountysheriff.org/admin_covid19.php (visited June 19, 2020; visited April 6, 2021).

[27] This estimate may undercount the number of prisoners with mental health needs. A March 25, 2021, report by the California State Auditor found that the Jail fails to "conduct a mental health screening of every inmate, as state regulations require" and instead "only assesses those inmates who exhibit erratic behaviors or disclose a history of mental illness to jail staff." The report explained that the Jail therefore lacks "sufficient data regarding whether inmates have mental illnesses," information which is "critical" to "minimize the risk of violence, injury, or death." CALIFORNIA STATE AUDITOR REPORT 2020-102, PUBLIC SAFETY REALIGNMENT REPORT at 22-25 (March 2021).

[28] During the course of our investigation, the Jail changed its nomenclature in relation to these units, so that it now uses the term "Administrative Separation," or "Ad Sep," instead of "Administrative Segregation," or "Ad Seg." For the sake of consistency, we refer to these units as "administrative segregation."

interviewed in administrative segregation suggested that the chief psychiatrist's estimate was accurate, if not perhaps an undercount. As discussed in other sections of this Notice, many of the individuals with serious mental illness at the Jail cycle repeatedly in and out of the Jail, as well as in and out of John George and other institutional settings.

There is one primary unit at the Jail—Unit 9—for male prisoners with mental health needs with any security classification. While Jail officials refer to Unit 9 as a mental health unit, it largely functions not as a therapeutic setting but rather, in all but name, as a restrictive housing unit, because these prisoners are confined to their cells for the vast majority of the day, alone or with another prisoner.[29] Within Unit 9 are different pods, based on security classification. Most prisoners in these pods are placed in two-person cells and are locked in those cells for the vast majority of their waking hours. Jail records show that, depending on their pod, prisoners were limited to less than 1.5 to three hours out of their cells each day. And prisoners on most pods received yard time outdoors for as little as one hour per week, with many receiving no yard time.

Instead of going to the clinic for mental health care, or to a classroom for educational or other programming, prisoners in Unit 9 remain on the Unit. They have access to few group programs on the Unit, and are prohibited from attending the many other programs available to general population prisoners. Mental health staff meet with the prisoners on the Unit, at large tables in the day-room-type area. Prisoners on Unit 9 must wear different color uniforms from the rest of the population, which not only discloses sensitive health information, because staff and other prisoners know that the uniform signifies a mental health diagnosis, but also serves to stigmatize them and marginalize them.

Not all prisoners with serious mental health needs are housed on Unit 9. Women prisoners are housed in a different area of the facility, and there are also men with serious mental health needs housed throughout the facility. Significantly, a number of them are in administrative segregation, which is another form of restrictive housing. Prisoners in administrative segregation are, by policy, permitted at most only five hours outside of their cells per week. Our review of a sample of records revealed many receiving only one or two hours outside of their cells on given weeks, a fact repeatedly mentioned by prisoners in administrative segregation in our conversations with them. When prisoners are permitted to leave their cells, they do so alone—with no opportunity to interact with others—and are still confined to the common indoor pod space. They may not go outdoors.

[29] Restrictive housing, elsewhere sometimes referred to as solitary confinement, segregation, or isolation, is any type of detention that involves three basic elements: removal from the general prisoner population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another prisoner; and the inability to leave the room or cell for the vast majority of the day. *Porter v. Clarke*, 290 F. Supp. 3d 518, 528 (E.D. Va. 2018) (citing U.S. DEP'T OF JUSTICE, REPORT AND RECOMMENDATIONS CONCERNING THE USE OF RESTRICTIVE HOUSING at 3 (2016)); *see also, e.g.*, *Wilkinson v. Austin*, 545 U.S. 209, 214, 223–24 (2005) (describing restrictive housing as limiting human contact for 23 hours per day); *Sweet v.Tillery v. Owens*, 907 F.2d 418, 422 (3d Cir. 1990) (describing restrictive housing as being limited to a cell for 21 to 22 hours per day); *Sweet v. S.C. Dep't of Corr.*, 529 F.2d 854, 867 (4th Cir. 1975) (Butzner, J., concurring) (categorizing as restrictive housing being alone in a cell for 24 hours per day, save for two, one-hour periods a week for exercise and a shower).

The Eighth Amendment's prohibition against cruel and unusual punishment requires jails to provide prisoners with adequate mental health care. *See Doty v. Cnty. of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994) ("[T]he requirements for mental health care are the same as those for physical health care needs."); *see also Brown v. Plata*, 563 U.S. 493, 503 (2011) (prisoners "with serious mental illness" lacked access to adequate mental health care). The protections afforded pre-trial detainees under the Fourteenth Amendment are at least as great as a convicted prisoner's Eighth Amendment rights. *See Gibson v. Cnty. of Washoe, Nev.*, 290 F.3d 1175, 1187–88 (9th Cir. 2002), *overruled on other grounds by Castro v. Cnty. of Los Angeles*, 833 F.3d 1060 (9th Cir. 2016). While a pre-trial detainee may be afforded greater protections, we have conducted our analysis under the Eighth Amendment standard, to which all prisoners at the Jail are at least entitled, because the populations are mixed at the Jail.

The rights of any prisoner under the Eighth Amendment are violated when "officials remain deliberately indifferent to their serious medical needs." *Id.* at 1187 (internal quotation marks omitted). The analysis examines if inadequate medical or mental health care creates a "substantial risk of serious harm" to prisoners, incorporating the possibility of future harm as well as present harm. *See id.* at 1188 (applying "substantial risk of serious harm" language in the Eighth Amendment medical care context); s*ee also Helling v. McKinney*, 509 U.S. 25, 33 (1993) ("That the Eighth Amendment protects against future harm to prisoners is not a novel proposition.").

The existence of serious systematic deficiencies can demonstrate that jail officials are deliberately indifferent to prisoners' medical needs, in violation of the Constitution. *See Madrid v. Gomez*, 889 F. Supp. 1146, 1256 (N.D. Cal. 1995) ("[C]ourts have traditionally held that deliberate indifference can be shown by proving either a pattern of negligent acts or serious systemic deficiencies in the prison's health care program."); *Casey v. Lewis*, 834 F. Supp. 1477, 1543 (D. Ariz. 1993) ("In cases in which the system's constitutionality is at issue, deliberate indifference to the serious medical needs of prisoners may also be 'evidenced by repeated examples of negligent acts' . . . or by 'proving there are such systemic and gross deficiencies in staffing, facilities, equipment or procedures that the inmate population is effectively denied access to adequate medical care.'") (internal citation omitted). Furthermore, a system-wide policy or practice that leads to a substantial risk of serious harm may be considered holistically to demonstrate a constitutional violation. *See Brown*, 563 U.S. at 505 n.3 (noting that in assertion of system-wide deficiencies in medical and mental health care, there was no need to consider whether specific instances violate the Constitution, because the state of medical and mental health care "taken as a whole" created a constitutional violation).

A. Many Prisoners at the Jail Have Serious Mental Health Needs, Requiring Treatment

Prisoners with serious mental health needs require treatment in order to ensure that their illnesses are not exacerbated. *See Madrid*, 889 F. Supp. at 1205–06 ("For inmates with serious or painful symptoms, delays lasting days or even weeks can cause unnecessary suffering, exacerbate illness, and have life-threatening medical consequences."). As acknowledged by Jail staff, at least 20–25% of prisoners in the Jail have serious mental illness. By not adequately

addressing these prisoners' mental health needs, the Jail places them at significant risk of harm. At least in part as a result of the Jail's failure to address their needs, and as described in more detail below, these prisoners' mental health often deteriorates; they may engage in self-harm, and many are transferred to John George for acute mental health care. Many former prisoners are admitted to John George or other psychiatric institutions, without ever receiving adequate mental health treatment that could avert these admissions and break this pattern of cycling repeatedly into segregated psychiatric institutions. Of the charts our expert reviewed, over 20% showed that the prisoner had to be transferred to John George while in the Jail, and many more showed stays at John George either prior to booking or after release. Of 21 prisoners known to have died in the Jail or from injuries or other causes sustained in the Jail between January 12, 2017, when we opened our investigation and 2020, at least 13 either had apparent indicators of serious mental illness or died due to suicide.

B. Prisoners with Serious Mental Health Needs Are Subject to a Substantial Risk of Serious Harm as a Result of Inadequate Mental Health Care

The Jail's inadequate mental health care places prisoners with serious mental health needs at substantial risk of harm. The Jail's mental health program is inadequate because it fails to provide essential components that have been identified by courts as being minimally necessary for such a program, including adequate psychotherapy and individualized treatment plans that include close supervision of the prisoner. *See, e.g.*, *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 (E.D. Cal. 1995); *see also Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1188 (M.D. Ala. 2017); *Madrid*, 889 F. Supp. at 1256–58; *Balla v. Idaho State Bd. of Corr.*, 595 F. Supp. 1558, 1577 (D. Idaho 1984); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part and rev'd in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982). While a denial of any one of these factors alone may not necessarily amount to a constitutional violation, courts have examined these factors together to evaluate the constitutional adequacy of a correctional facility's mental health program.

1. Prisoners with Serious Mental Health Needs Are Subject to Harm Because of a Lack of Individualized Treatment, Including Inadequate Psychotherapy and Programming

The failure to treat mental illness can lead to a substantial risk of serious harm, including decompensation and suicidal ideation, constituting a serious medical need under the Eighth Amendment. *See Conn v. City of Reno*, 572 F.3d 1047, 1054–56 (9th Cir. 2009), *judgment vacated on other grounds by Connick v. Thompson*, 563 U.S. 51 (2011); *Madrid*, 889 F. Supp. at 1222. Courts have found mental health care insufficient when use of psychotropic medications supplants the use of mental health therapy. *See, e.g.*, *Braggs*, 257 F. Supp. 3d at 1188 ("The 'basic' mental-health care that States must provide if needed by a prisoner includes not only medication but also psychotherapeutic treatment.") (citation omitted); *Balla*, 595 F. Supp. at 1577 ("[P]rescription of [psychotropic] drugs cannot supplant the necessity of psychiatric counseling."). Without therapy and programs that might, for example, help them learn cognitive or emotional skills, plan for recovery from substance use disorder, and make healthy life choices,

prisoners with serious mental health needs are at risk of deterioration and eventual re-institutionalization upon their release from incarceration.

The Jail, however, provides little to no individualized treatment, including psychotherapy, to prisoners with serious mental health needs. Instead, mental health care on Unit 9—the unit specifically designated for people with mental health needs—is generally limited to medication administration, screenings for suicidal ideation, and brief conversations with clinicians. Our expert found these conversations to be insufficiently frequent, as well as too brief. In addition, these conversations are usually not held in therapeutic environments, but rather "cell side," or in day rooms within earshot of other prisoners and of security staff. As the Alameda County Sheriff's Office itself has previously acknowledged: "For those housed in high security units, the vast majority of these meetings [for therapy or counseling] take place in the dining area of the housing unit, providing little to no privacy, in an environment not designed for this type of activity."[30] Prisoners are often reluctant to disclose sensitive information necessary to treatment where that information can easily be overheard by staff and other inmates. "[C]ell-front check-ins are insufficient as counseling and do not constitute actual mental-health treatment," as they fail to provide a therapeutic environment. *Braggs*, 257 F. Supp. 3d at 1210; *see also Robinson v. Purcell*, No. 2:14-CV-0790, 2019 WL 1330874, at *6 (E.D. Cal. Mar. 25, 2019) (finding "cell-door consultations posed risks to plaintiff's mental health" because of the need to speak softly for privacy and the impediment plaintiff faced to "speak[ing] freely" due to the "non-confidential nature of these visits"). Prisoners receiving cell-side visits are often reluctant to speak freely, and therefore do not receive the treatment they need, and are thus at risk of further harm and increased risk of poor outcomes such as self-harm, according to our expert. During their brief conversations, clinicians generally encourage prisoners to take medication, rather than utilizing any therapeutic techniques. Further, the Jail provides no group therapy (only a sole educational class) to prisoners on Unit 9. Jail clinicians often are unable to provide even a minimally adequate level of care to the large number of prisoners who need it, resulting in serious harm, including suicide. *See Conn*, 591 F.3d at 1095 ("A heightened suicide risk or an attempted suicide is a serious medical need."). One of the most critical components of a minimally adequate mental health treatment program is the "identification, treatment, and supervision of inmates with suicidal tendencies." *Ruiz*, 503 F. Supp. at 1339. Suicide watches at the Jail—known as "IOL status" (referring to an intensive observation log)—feature unduly harsh conditions, including a prohibition on access to socks, underwear, hygiene products, sheets, reading material, and the commissary. Such punitive conditions are known to discourage prisoners from reporting suicidality.

From 2015 through 2019, there were at least 14 suicides in the Jail, which equates to a rate of suicides that is more than twice the national average. While there were no suicides in 2020, two other suicides occurred at the Jail in the first four months of 2021. In one instance in 2017, L.L., a 29-year-old former Marine, who had previously spent time at both the Jail and John George, hanged himself in administrative segregation 18 days after entering the Jail. Despite his

[30] ALAMEDA CNTY. SHERIFF'S OFFICE, MENTAL HEALTH SERVICES IN SANTA RITA JAIL at 9 (2015), http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_10_8_15/PUBLIC%20PROTECTION/Regular%20Calendar/Mental_Health_Services_Santa_Rita_Jail.pdf.

history of previous suicide attempts, and the fact that he had been hospitalized two months prior at John George for suicidal ideations, L.L. was only briefly placed on Inmate Observation Log (IOL) status, a form of suicide watch employed by the Jail, before being removed from observation later that same day by mental health staff and placed in administrative segregation. The doctor who made this decision stated that this was appropriate because L.L. was not expressing suicidal ideation at the time of his intake and was being cooperative. L.L. received no follow-up mental health evaluation between the time of his intake and his suicide only a few weeks later. Another example involves 20-year-old A.A., also described above, who police brought to Santa Rita Jail while he was experiencing a mental health crisis. A.A.'s parents reportedly informed the police that he was not a danger and was in need of mental health treatment. A.A.'s parents say deputies ignored their requests that their son receive a mental health evaluation. A lieutenant allegedly ordered A.A. chained to a cell door, in violation of the Sheriff's office restraint policy, while he was still experiencing severe symptoms. Left unattended, A.A. appears to have attempted to strangle himself with the chains, and later died.[31]

Other prisoners have suffered harm as a result of the Jail's inadequate provision of mental health care. C.C., a 38-year-old male prisoner with a with a history of bipolar disorder, was incarcerated on January 8, 2019, on a charge of narcotics possession. Although he was assigned to Unit 9 upon intake, he did not receive an initial evaluation until nine days after he was admitted, and then only after his sister called the Jail to inform them that her brother was connected to a community provider, receives injections of Haldol (a psychotropic medication), and "decompensates quickly without medication." C.C. started on Haldol on January 22, 2019, but a clinician's note indicated that he was not seen that day due to overbooking. During a medical evaluation the next day, C.C. reported that he felt like he was in a "dream state," "fired up," and "mildly hallucinating." It also appeared that he was having seizures. Because he reported no thoughts of self-harm, he was not placed on IOL status. The next day however, C.C. was "acting strange, shaking, sweating, and appearing confused." He was observed banging his head on the wall and had a cut on his lip and forehead. When the mental health clinician saw him, he was lying on the floor of his cell naked, picking at the floor, and talking to himself. C.C. was sent to John George later that day, and subsequently transferred from John George to Highland Hospital, where it was ultimately determined that he had several high impact hip fractures.

D.D., a 22-year-old with schizophrenia and over 600 interactions with the County's behavioral health system, including multiple incarcerations at the Jail, and with a history of bipolar disorder was incarcerated on February 22, 2019. He was placed on IOL "for muteness and safety" after he refused to respond to medical or mental health questions. Clinicians did not follow up with D.D. until four days later. Three days after that, on March 1, 2019, a deputy reported to a clinician that D.D. had flooded his cell the day before and was naked, talking and laughing to himself. Despite this behavior, there is no record of any specific therapeutic treatment for D.D., other than a clinician's note that the clinician spoke with D.D. about "coping strategies." The clinician made several cell-side visits while D.D. was on IOL, noting that nothing could be seen because there was no light available to see into the cell. Despite his long

[31] Despite multiple requests, Alameda County did not provide records related to this incident.

history of mental health needs, and behaviors that presented a clear management problem on the unit, D.D. received only limited cell-side visits, and was not prioritized to receive therapy.

The lapses in mental health treatment for prisoners with serious mental health needs are even more acute for such prisoners in administrative segregation. Those prisoners generally speak with mental health staff infrequently, and only through their cell doors, which, as noted, raises privacy concerns.

The Jail's mental health program lacks meaningful access to substance use disorder treatment, a deficiency that is particularly acute because prisoners with serious mental health needs have a high rate of co-occurring substance use disorders. Over 70% of the charts our expert reviewed indicated that the prisoner had significant substance use problems, sometimes reflecting the use of multiple substances. Several prisoners were noted to be in distress from opioid withdrawal at the time of their mental health assessments in the Jail. But very few charts contained any mention of treatment plans, interventions, or referrals related to those disorders. Typically, the most that mental health staff provides these prisoners is some information in the form of handouts, and in some cases a single educational class, rather than any treatment.

Having enough mental health professionals is an essential part of any constitutionally adequate correctional mental health program. Mental health staff must be employed in numbers sufficient to identify and treat prisoners who have treatable mental illness in an individualized manner. *See Cabrales v. Cnty. of Los Angeles*, 864 F.2d 1454, 1460–61 (9th Cir. 1988) (upholding district court's determination that understaffing of mental health personnel such that prisoners only could receive 12 minutes of care per month created constitutionally inadequate care), *judgment vacated on other grounds*, 490 U.S. 1087 (1989); *Coleman*, 912 F. Supp. at 1298; *Madrid*, 889 F. Supp. at 1256–58; *Balla*, 595 F. Supp. at 1577.

Several factors contribute to the lack of adequate mental health coverage at the Jail. First, when there are not sufficient security personnel present, mental health staff are hampered in their ability to see prisoners. In records we reviewed, it was not unusual to see notes from mental health clinicians documenting this problem. One note regarding a prisoner in administrative segregation, stated: "Writer spoke with [prisoner] at cell door due to shortage of available deputies in the [housing unit]." In another example, a clinician wrote about a prisoner with schizophrenia and schizoaffective disorder who had previously been at John George, Napa State Hospital, and multiple other inpatient settings: "Writer interviewed [prisoner] at the door in H[ousing] U[nit] 2 for follow up d[ue to] shortage of deputies. [Prisoner] repeatedly requested to be taken out to the tables, even after multiple explanations from writer and Sergeant . . . that there was not enough staffing in the HU to do so." In fact, in over 85% of the charts our expert reviewed for this issue, there was a notation of a deputy shortage, resulting in limitations on the ability of mental health staff to adequately assess prisoners.

Second, on Unit 9, in a restriction imposed by security staff, mental health staff are permitted only a two-hour window during each weekday in which to see any prisoners for treatment. Because they have to fit visits with all of the individuals on their caseloads into a two-hour window, mental health staff are not able to spend sufficient time treating prisoners with

serious mental health needs. In fact, as they explained to us, they are only able to spend approximately 10 to 15 minutes at a time with each prisoner on their caseloads. Further, mental health staff members with whom we spoke informed us that they do not have the time to run treatment groups or therapeutic programs. This is borne out by notes in records such as, "unable to see inmate due to caseload," or "today this clinician was overbooked." Finally, the Jail does not have sufficient numbers of mental health practitioners for the population it serves, as the Sheriff himself has noted publicly.

2. Prisoners with Serious Mental Health Needs Are Subject to Harm Because of Inadequate Treatment Planning, Including Discharge Planning

The Jail fails to provide individualized treatment plans to prisoners with serious mental health needs, which represents a substantial deviation from a constitutionally sound mental health care program. *See, e.g.*, *Sharp v. Weston*, 233 F.3d 1166, 1168–69, 1169 n.2 (9th Cir. 2000) (upholding denial of request to lift an injunction that included individualized treatment plans as a requirement in providing constitutionally adequate mental health care); *see also Braggs*, 257 F. Supp. 3d at 1206 n.34 (explaining that treatment planning is part of a minimally adequate mental health care system). Treatment plans should be developed, implemented, and monitored by treatment teams to provide adequate focus, purpose, and direction for the delivery of service. Our expert observed that clinicians' notes in the overwhelming majority of the charts she reviewed merely indicate whether or not a prisoner is stable, and clinicians often provide seriously mentally ill prisoners nothing more than handouts that list coping skills or describe deep breathing techniques that may help reduce stress.

In addition, the Jail should provide bridge medications and transition planning. *See Charles v. Orange Co.*, 925 F.3d 73, 84–85 (2d Cir. 2019) (finding plausible the allegation that discharge planning, including interim medication and referrals, "is an essential part of in-custody care"); *Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999) (state has constitutional duty to provide medication to outgoing prisoner in a supply sufficient "to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply"); *United States v. County of Los Angeles*, No. CV 15-05903-DDP, 2016 WL 2885855, at * 7, n. 7 (C.D. Cal. May 17, 2016) (finding that *Wakefield* extends to discharge planning for mentally ill inmates as required to provide them medical care after release from custody, and noting that "[i]f anything, a public entity may be more responsible for mental health treatment where the incarceration itself has aggravated or exacerbated the harmful symptoms of mental illness"); *Matysik v. Cnty. of Santa Clara*, No. 16-CV-06223-LHK, 2018 WL 732724, at *12 (N.D. Cal. Feb. 6, 2018) ("[T]here is evidence from which a jury could conclude that Defendants' failure to adopt policies requiring greater coordination related to the release of mentally disabled inmates amounted to a policy or custom [amounting] to deliberate indifference."). The Jail typically does not provide access to sufficient medication and a connection to needed care upon release for prisoners with serious mental health needs.

The Jail also excludes prisoners with serious mental health needs from existing transition services. The Jail has developed a transitional center where prisoners in general population can meet community providers and a program, called Operation My Home Town, which connects

soon-to-be-released prisoners to community-based programs assisting with housing, employment, drug and alcohol treatment, and other needs. However, prisoners with serious mental health needs on Unit 9 or in administrative segregation do not have access to these discharge services. These prisoners are among those with the greatest need for such services, in order to ensure that they receive needed mental health treatment in the community. But they often receive little more than a sheet of paper that lists programs in the community.

When prisoners are not provided with discharge planning that connects them to community providers, it is unsurprising that they frequently cycle back to the hospital or the Jail. One such prisoner is E.E., an administrative segregation prisoner who has a history of schizoaffective disorder and polysubstance use disorder and, when not incarcerated, has been connected with a mental health provider or admitted to the hospital at least 135 times. E.E. was in and out of the Jail 13 times during the 13-month period from August 2018 to August 2019. During those 13 incarcerations, the Jail's limited efforts to prepare E.E. for reentry into the community were inconsistent and incomplete. For example, in June 2019, E.E. himself—not his clinician—suggested that he go to a substance use treatment program upon discharge. However, instead of connecting him to the program, Jail staff simply provided bridge medications and a prescription, and spoke with E.E. about the importance of medication compliance to prevent re-arrest. E.E. was back at the Jail a month later. Despite his extensive contacts with the Jail and BHCS, there is no indication that the Jail made any meaningful effort to connect E.E. with community mental health services.

The lack of discharge planning contributes to the cycling we so often observed, as individuals with serious mental health needs are drawn deeper into the criminal justice and public mental health systems through relapse, re-arrest, and re-institutionalization, with fewer and fewer opportunities to stabilize in the community. One prisoner's mental health notes from July 2019 explain that the prisoner was made aware of the "B[ay] A[rea] C[ommunity] S[ervices] Re-entry program" but "does not appear to have engaged." Several lines down in the notes, the clinician writes that this prisoner "has been incarcerated at [the Jail] 15 times since 2015." If the Jail did more than simply making the prisoner aware of community services—if, for instance, it reached out to providers and set up appointments—the prisoner would have been more likely to have engaged in treatment that could reduce his likelihood of repeated hospitalization or incarceration.

C. Officials at the Jail Have Known of the Risk to Prisoner Health and Safety Posed by Inadequate Mental Health Care and Disregarded It

Jail officials have been put on notice that inadequacies in the Jail's mental health system pose a substantial risk of serious harm to prisoners. The Jail has failed to take steps to eliminate these risks, evincing deliberate indifference to prisoner health and safety. *See Farmer v. Brennan*, 511 U.S. 825, 837 (1994) (holding that a prison official may be liable under the Eighth Amendment if he "knows of and disregards an excessive risk to inmate health or safety").

There are numerous sources that should have put Jail officials on notice of the risks posed by their deficient mental health care system. Alameda County has long known of the problems related to the provision of mental health care to prisoners with serious mental health needs. In

July 2017, a public presentation was given to the Alameda County Board of Supervisors Health Committee on the need to decrease the incarceration of those with mental illness in the County. The Alameda County Mental Health Advisory Board's Criminal Justice Subcommittee investigation[32] noted the "revolving door between John George [and] Alameda County jails."[33] The Criminal Justice Subcommittee identified factors that contributed to this situation including, among other things: the Jail's inadequate discharge planning and coordination of services; frequent inadequate access to psychiatrists; and inadequate substance use disorder treatment.

In addition, lawsuits alleging inadequate mental health care at the Jail have put officials on notice of the risks to prisoner health and safety. *Cf. Disability Rights Mont., Inc. v. Batista*, 930 F.3d 1090, 1099 (9th Cir. 2019) (finding that two prior lawsuits "complaining about factually similar conditions at the prison" supported finding of deliberate indifference) (citing *Lemire v. Cal. Dep't of Corr. & Rehab.*, 726 F.3d 1062, 1078 (9th Cir. 2013) (concluding that plaintiffs stated a claim for deliberate indifference where "litigation specifically alerted prison officials to the acute problem of inmate suicides")). For instance, *Babu v. County of Alameda*, a federal district court case filed in December 2018, concerns the very subject of this Notice—deficiencies in mental health care provided by the Alameda County Sheriff's Office. *Babu v. Cnty. of Alameda*, 5:18-cv-07677 (N.D. Cal. Apr. 22, 2020), ECF No. 111-1. In the Complaint's first paragraph, it states, "The Alameda County Jail system is broken, especially when it comes to the way it treats people with psychiatric disabilities. . . . Alameda County relies almost entirely on the unconstitutional use of isolation to manage prisoners, including prisoners with significant . . . mental health needs, resulting in horrific suffering."[34] Although the Jail has recently reported its commitment to improve mental health care as part of the ongoing settlement negotiation process in *Babu*, it is not clear what, if any, remedial measures have been put in place, whether they have been incorporated into the Jail's policies and procedures, or whether any measures actually put in place will prove durable. Likewise, Disability Rights California, the federally-mandated protection and advocacy entity for California, issued a letter to Alameda County in November 2019 alleging, after an investigation, that "people with mental health disabilities regularly cycle in and out of . . . the jail system," and noting that "people with mental health disabilities held in jail face dangerous and damaging isolation conditions and inadequate access to programming or meaningful mental health treatment."[35]

---

[32] The Criminal Justice Subcommittee conducted interviews with Oakland Police Department officers, BART Crisis Intervention counselors, social workers, program directors, and program managers to gather information on gaps within the County system. The Criminal Justice Subcommittee also compared the situation in Alameda County with national statistics on the relationship between mental illness and the criminal justice system.

[33] BRIAN BLOOM & DR. NOHA ABOELETA, DECREASING INCARCERATION OF THE MENTALLY ILL IN ALAMEDA COUNTY at 4 (2017), http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_7_24_17/GENERAL%20ADMINISTRATION/Regular%20Calendar/Community_Mental_Health_7_24_17.pdf.

[34] Complaint at ¶ 1, *Babu v. Cnty. of Alameda*, No. 5:18-cv-07677 (N.D. Cal. Dec. 21, 2018), ECF No. 111-1.

[35] Letter from Disability Rights Cal., to Karyn Tribble, LSCW Dir., Alameda Cnty. Behavioral Health and Services, and Donna Ziegler, Counsel, Alameda Cnty. (Nov. 1, 2019), https://www.afsc.org/sites/default/files/documents/2019-11-01%20DRC%20Findings%20Letter%20%20Access%20Requests%20Alameda%20Cty%20-%20Signed%20%281%29.pdf.

Finally, numerous media reports have raised concerns about the provision of mental health care to prisoners with serious mental health needs at the Jail. The Department's investigation has also provided Jail officials with notice of deficiencies in mental health care. Department attorneys and staff, accompanied by experts, visited the Jail several times in 2017, and again in 2019. At the conclusion of these visits, we provided Jail officials with exit briefings, during which our experts shared their preliminary observations. Our experts expressed their opinions that mental health care for prisoners with serious mental health needs was deficient, and specified the various areas in which such care is inadequate, as described above. Nevertheless, most of the conditions we identified in 2017 were still present when we returned in 2019.

VI. THE JAIL'S USE OF PROLONGED RESTRICTIVE HOUSING UNDER CURRENT CONDITIONS, INCLUDING THE FAILURE TO PROVIDE ADEQUATE MENTAL HEALTH CARE, VIOLATES THE CONSTITUTIONAL RIGHTS OF PRISONERS WITH SERIOUS MENTAL ILLNESS

The Jail's use of restrictive housing for prisoners with serious mental illness in current conditions—in which prisoners can spend months, if not longer, locked in their cells, with only three to five hours out of cell per week, and with little to no mental health treatment, therapy, and programming—places prisoners with serious mental illness at a substantial risk of serious harm in violation of the Eighth and Fourteenth Amendments. *See Disability Rights Mont.*, 930 F.3d at 1099 (finding plausible Eighth Amendment claim that placing prisoners with serious mental illness in restrictive housing of 22 to 24 hours per day for months poses substantial risk of serious harm); *Palakovic v. Wetzel*, 854 F.3d 209, 226 (3d Cir. 2017) (holding that, "in light of the increasingly obvious reality that extended stays in solitary confinement can cause serious damage to mental health," there was a plausible claim that placing prisoner with history of suicidality in restrictive housing for multiple 30-day stints violated the Eighth Amendment); *Hernandez v. Cnty. of Monterey*, 110 F. Supp. 3d 929, 946 (N.D. Cal. 2015) ("While housed in segregation, the mentally ill are especially vulnerable, and their mental health symptoms—including depression, psychosis, and self-harm—are especially likely to grow more severe."); *see also Braggs*, 257 F. Supp. 3d at 1247 (noting the "consensus on the substantial risk of harm of decompensation for these mostly severely mentally ill prisoners" from segregation); *Madrid*, 889 F. Supp. at 1265 (using prolonged restrictive housing on prisoners who are, because of their serious mental illness, "at a particularly high risk for suffering very serious or severe injury to their mental health" is "the mental equivalent of putting an asthmatic in a place with little air to breathe"); *Coleman*, 912 F. Supp. at 1320–21 (adopting finding that restrictive housing can "cause further decompensation" to prisoners with mental illness); *Casey*, 834 F. Supp. at 1549 (finding that an extensive use of lockdown in place of mental health care "clearly rises to the level of deliberate indifference to the serious mental health needs of the inmates and violates their constitutional rights to be free from cruel and unusual punishment").

As discussed above, prisoners at the Jail with serious mental illness are regularly placed in administrative segregation, where they spend almost every hour of their days locked in their cells, alone or with one cellmate, with little to no treatment, therapy, or programming. When they do get out, each prisoner is alone (or with their cellmate only), so they do not have any

opportunities for social interaction. Jail mental health staff have estimated that approximately 50% of the prisoners in administrative segregation have serious mental illness. As a result, these prisoners are at increased risk of physical self-harm, extreme mental distress, and unnecessary suffering. In fact, we have seen evidence of such harms, as discussed further below, including prisoners swallowing objects, not eating, smearing or eating feces, banging their heads against the wall, and attempting or completing suicide.

The Alameda County Sheriff has acknowledged that one hour per day of out-of-cell time is not sufficient. "We do not like to keep people in those cells for any length of time," he has said.[36] Yet, despite his statements, until very recently the Jail continued to keep individuals locked down with less than one hour out of cell each day for months at a time.[37] In fact, at the time of our last visit, in July 2019, there were 75 prisoners in administrative segregation who had been there for over 90 days, at least 75% of whom had indications of serious mental illness. Thirteen of those prisoners with indications of serious mental illness had been in administrative segregation for more than a year.

Jail officials say that prisoners are placed in administrative segregation if they cannot co-exist with other prisoners, are violent, or need protection, among other reasons. However, our review of classification records for prisoners placed in administrative segregation revealed many instances of prisoners being assigned to such housing for reasons that seemed directly related to their serious mental illness and not due to Jail officials' stated reasons. For example, F.F. had a history of suicide attempts in administrative segregation when a classification deputy approved F.F.'s request to be transferred to a less restrictive pod. The deputy understood that the move could help F.F.'s mental health: "Having a cellmate might help [F.F.] cope with being incarserated [sic]," he wrote. But several weeks later, F.F. was returned to administrative segregation, because of his serious mental illness. The classification deputy explained that F.F. was being re-classified to administrative segregation "due to" his flag as "mental". The deputy made this recommendation despite the fact that the behavioral health professional who had just evaluated F.F. recommended against the transfer, indicating instead that F.F. should be housed in the less restrictive behavioral health unit. Over an approximately three-month period, two behavioral health professionals made five separate recommendations that F.F. be moved to a less restrictive unit. Each time, they were overruled by classification deputies. Their reasons often explicitly cited F.F.'s mental illness. "Due to [F.F.'s] recent mental instability," a deputy wrote, for example, "he will remain in [administrative segregation] at this time."

Another example is G.G., an individual who was sent to John George at least twice during his incarceration at the Jail, and who reported to the Jail that he had previously been housed in minimum security. His classification report from February 2019 from the Glenn Dyer

[36] Lisa Fernandez, *Death Rate at Santa Rita Exceeds Nation's Largest Jail System as Critics Call for Reform*, KTVU (Oct. 1, 2019) https://www.ktvu.com/news/death-rate-at-santa-rita-exceeds-nations-largest-jail-system-as-critics-call-for-reform.

[37] We note that, as part of the ongoing settlement negotiation process in the *Babu* case, the Jail reportedly has taken steps to increase out-of-cell time for prisoners. We have not yet seen evidence of how much more time prisoners may get, or how widespread the change is, and there is no evidence that this is memorialized in any policy. Moreover, it is not clear whether such remedial measures will prove durable.

Jail, which was operated by the Alameda County Sheriff's Office until it closed in 2019, notes that he "suffers from bipolar [disorder] and is on heavy psychiatric medication that [the Glenn Dyer Jail] doesn't carry. The nurse said that if he missed more than one dose of his [medication] he is likely to have a serious mental breakdown." After several weeks at the Glenn Dyer Jail, G.A. was observed "visibly shaking," "making the sign of the cross," and "displaying bizarre" behavior, and was therefore placed in administrative segregation. A few weeks later, when he was transferred to the Jail, a classification deputy acknowledged that G.G. had been housed in administrative segregation "due to acting strangely during his classification interview"—in other words, for reasons related to his mental health status. The deputy suggested that G.G. "may be suitable for . . . the behavioral health unit." Although two mental health professionals agreed with that assessment and recommended on at least four separate occasions that G.G. be transferred to the behavioral health unit, he remained in administrative segregation. At the time of our visit to the Jail in July 2019, he had not been reclassified.

A. Prisoners with Serious Mental Illness Are Subject to a Substantial Risk of Serious Harm as a Result of the Jail's Use of Restrictive Housing

The Jail's practice of subjecting prisoners with serious mental illness to prolonged periods of restrictive housing places these prisoners at substantial risk of serious harm. As described above, as of our last visit, prisoners in administrative segregation were, by policy, permitted only five hours outside of their cells per week at most, and our review of a sample of records revealed many receiving only one or two hours outside of their cells on any given week.

The lack of access to adequate mental health care is especially harmful for prisoners who are suicidal. Instead of receiving the constitutionally adequate mental health care required, such as intensive therapeutic interventions, they receive minimal engagement from limited interactions with mental health staff. Notably, despite the known harms of prolonged restrictive housing for people with serious mental illness, at least six of the prisoners who have died by suicide at the Jail since January 1, 2014, were in restrictive housing at the time of their suicide.[38]

One such example is H.H. He was arrested on April 4, 2018, and booked into the Jail early the next morning. During his initial screening, he was observed to have "delusional thoughts," and as a result he was referred to mental health staff. While awaiting re-classification, H.H. was found with fecal matter smeared on his face, and he stated to a deputy that he wanted to be killed or would kill himself. He was moved to a safety cell and put on an IOL. The following day, April 6, a mental health clinician determined that H.H. was no longer suicidal, and he was moved from a safety cell to administrative segregation. There, on April 8, H.H. was found with a bed sheet tied around his neck and tied to another sheet that was wrapped around the top bunk. When a deputy entered his cell, he found H.H. unresponsive, with pale skin. The cell was flooded with water and fecal matter, which had also been spread onto the floor, walls,

[38] In addition, in February 2021, an individual in the Jail's quarantine unit for newly booked prisoners died by suicide. The County and the Sheriff's Office have reported that newly-booked individuals at the Jail must complete a 14-day quarantine upon intake, and that on average, those individuals receive approximately one hour of out-of-cell time per week. *Babu v. Cnty. of Alameda*, 5:18-cv-07677 (N.D. Cal. Apr. 7, 2021), ECF 239 at 7.

and window. A fellow prisoner reported that in the hours leading up to his suicide, H.H.'s requests to see mental health staff were ignored. In addition, although according to Jail policy H.H. was supposed to be observed every 30 minutes, he had not been observed for over an hour, during which time he took his own life.

Other individuals suffer a variety of other significant harms. Indeed, over half of the episodes of self-injurious behavior that our expert reviewed occurred while prisoners were in restrictive housing. For example, I.I., a prisoner in restrictive housing with serious mental illness, smeared his feces, wrote words on the walls with his feces, and even ate his feces. He suffered delusions, believing himself to be Jesus Christ; engaged in head banging; and tried—unsuccessfully—to hang himself. One clinician hypothesized that I.I. may have been in a "safer placement" in a mental health unit in another jail, but noted that the Jail "does not have a mental health unit," apologizing to I.I. for this fact and "encourag[ing] him to try his best to manage in" administrative segregation while the clinician tried to help him get "to a quieter pod."

Other examples of people who were harmed include J.J., whose chart shows that he told a clinician that he had instructed his wife not to visit him because he was "losing [his] mind" in administrative segregation; F.F., who attempted to suffocate himself on several occasions, including by wrapping clothes around his neck and putting a bag over his head; and K.K., who swallowed pencils, a razor, a screw, and a comb. One prisoner in administrative segregation who had returned from a short stay at John George less than two months earlier was "refusing to lockdown, naked, urinating all over . . . , putting his bread in the urine then eating it, sticking his finger up his rectum and threatening to kill himself by taking pills." The experiences of these prisoners mirror that of the many prisoners who told us during our visits to the Jail about "going crazy" and "flipping out" in restrictive housing, due to the isolation they experienced. Chart notes confirm that the Jail's mental health professionals believe restrictive housing exacerbates prisoners' mental health issues. As one psychiatrist noted about a prisoner who reported a history of schizophrenia, "Unfortunately patient appears to be doing worse, compared to initial evaluation. This may be due to continuing to be in administrative segregation."

B. Officials at the Jail Have Known of, and Disregarded, the Substantial Risk of Serious Harm of Placing Individuals with Serious Mental Illness in Restrictive Housing

Prisoners with serious mental illness in restrictive housing have died by suicide, attempted suicide, or otherwise harmed themselves, as discussed above. These incidents—most of which were known to Jail officials—should have put Jail officials on notice that they were putting prisoners with serious mental illness at a substantial risk of serious harm by placing them in restrictive housing for prolonged periods. Moreover, as discussed above, mental health clinicians and other Jail staff specifically raised concerns about whether placement in restrictive housing, such as administrative segregation, was appropriate for prisoners with serious mental illness, further putting officials on notice of the risk to these prisoners.

Following our 2017 visits, the Jail made some changes to its restrictive housing practices, apparently in part in response to the concerns expressed by our experts. Most notably, the Jail

instituted a "Maximum Separation" or "Max Sep" program, which represents a step-down from administrative segregation, allowing prisoners more time out of cell, and allowing them to be out with other prisoners. Nevertheless, the "Max Sep" program is available only to a small percentage of those in administrative segregation. The Jail did not reasonably respond to reduce the risk of serious harm to prisoners with serious mental illness until the very recent—and limited—steps taken as part of the *Babu* negotiations, *see supra* note 37, evincing deliberate indifference to prisoner health and safety.

VII. THE JAIL'S TREATMENT OF PRISONERS WITH MENTAL HEALTH DISABILITIES VIOLATES THE AMERICANS WITH DISABILITIES ACT

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132; *see also Pierce v. Cnty. of Orange*, 526 F.3d 1190, 1214 (9th Cir. 2008). To establish a Title II claim, one "must show: (1) he is a 'qualified individual with a disability'; (2) he was either excluded from participation in or denied the benefits of a public entity's services, programs, or activities, or was otherwise discriminated against by the public entity; and (3) such exclusion, denial of benefits, or discrimination was by reason of his disability." *Duvall v. Cnty. of Kitsap*, 260 F.3d 1124, 1135 (9th Cir. 2001) (citation omitted). Title II has been found to "unmistakably" cover correctional institutions. *See Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 209–10 (1998) (applying Title II in the prison context); *Bell v. Williams*, No. 18-CV-01245-SI, 2019 WL 2358971, at *3 (N.D. Cal. June 4, 2019) (applying Title II in the jail context); *see also Pierce*, 526 F.3d at 1214 (noting that Title II applies to county jails' "services, programs and activities for detainees"). The ADA offers the same protections to prisoners with disabilities whether those disabilities stem from physical or mental impairments. 42 U.S.C. § 12102. Thus, prisoners at the Jail with mental health disabilities are entitled to this protection. Further, the ADA applies to prisoners even if they are not in the general population. "A prisoner's misconduct does not strip him of his right to reasonable accommodations, and a prison's obligation to comply with the ADA and the RA [Rehabilitation Act] does not disappear when inmates are placed in a segregated housing unit, regardless of the reason for which they are housed there." *Furgess v. Pa. Dep't of Corr.*, 933 F.3d 285, 291 (3d Cir. 2019).

Some prisoners are placed in administrative segregation or other restrictive housing due to their mental health disabilities, and all prisoners in Unit 9 are placed there precisely due to their mental health disabilities. Yet, prisoners at the Jail who are on Unit 9 or in administrative segregation do not receive the same programming that is available to prisoners in general population. For example, the Alameda County Sheriff's Office provides an array of programs to many prisoners in general population at the Jail, including, educational programs, art therapy, culinary arts, computer coding, job readiness training, financial literacy, and hospitality. And the Jail's transition center allows many prisoners in general population to receive additional services from community-based organizations in areas such as education, employment, housing, and substance use disorder. But none of these programs and services are available to prisoners with mental health disabilities placed on Unit 9 or in administrative segregation. The Jail provides just one program, "Breaking the Chains," on Unit 9, and it is limited to the topic of substance use

disorder. As discussed above, Jail officials place prisoners with mental health disabilities in Unit 9, the "mental health" unit, precisely because they have a serious mental illness. As also discussed above, the Jail often places other prisoners with mental health disabilities in administrative segregation for reasons that are directly related to their mental illness, as, for example, with F.F. and G.G., discussed in Section VI, *supra*.

Thus, but for their mental health disabilities, prisoners in Unit 9 and those prisoners placed in administrative segregation due to their mental health disabilities would be able to access the programming provided to the general population. For example, approximately 41% of the stays on Unit 9 over a 19-month period that we examined were classified as "Mental Min." This means that these individuals would have been classified as minimum custody, and housed accordingly, with the attendant access to programming, but for their "mental health" classification. Thus, by virtue only of their mental health disabilities, they were placed in a housing unit where they were denied access to programs that they otherwise would have been able to access, as minimum custody prisoners.

Denying prisoners with a mental health disability equal access to programming and services available to those without disabilities violates Title II of the ADA. *See Love v. Westville Corr. Ctr.*, 103 F.3d 558, 561 (7th Cir. 1996) (affirming conclusion that prison officials intentionally discriminated against an inmate in violation of the ADA when they excluded him from prison programs and services on account of his disability).

VIII. MINIMUM REMEDIAL MEASURES

To remedy the constitutional and statutory violations identified in this Notice, we recommend that the County implement, at minimum, the remedial measures listed below.

A. Providing Mental Health Services in the Most Integrated Setting

1. Provide evidence-based community-based services in the most integrated setting that are effective at meeting the needs of eligible adults with mental health disabilities in and at serious risk of entering psychiatric institutions in Alameda County and preventing them from unnecessary institutionalization, including:
    a. Implement a comprehensive crisis response system, including an array of integrated crisis residential services, in sufficient capacity to serve adults with mental health disabilities in the most integrated setting and effective mobile crisis services that can respond to individuals wherever they experience crises and that works with law enforcement where appropriate to de-escalate crises and prevent unnecessary arrest and detention, involuntary commitment, or hospitalization.
    b. Implement a sufficient number of Full Service Partnership teams that can provide sufficiently intensive community services to those who need them.
    c. Implement a sufficient quantity of scattered-site, permanent supported housing slots to ensure adults with mental health disabilities can maintain housing in integrated settings.

d. Implement sufficient community-based services including case management, personal care services to assist with activities of daily living, and supported employment services in the amount, frequency, and duration needed by adults with mental health disabilities in Alameda County.
e. Implement peer support services provided by trained and certified peers with lived experience with mental illness in sufficient quantity to be integrated in all aspects of the mental health service system.
f. Implement sufficient community-based services that can appropriately support people who have co-occurring diagnoses, such as intellectual disability, substance use disorder, or chronic illnesses.

2. Provide transition and discharge planning, beginning upon admission, to all eligible adults with mental health disabilities in psychiatric institutions in Alameda County.

3. Provide transition and discharge planning, beginning upon admission, for prisoners with mental health disabilities in Santa Rita Jail to prevent needless psychiatric institutionalization for those individuals following release from Jail.

4. Identify eligible individuals who may be at serious risk of psychiatric institutionalization and connect them with appropriate community-based services, including by using the crisis services described above, and by utilizing identified intercepts where individuals with mental health disabilities are known to come into contact with County services or the criminal justice system.

5. Ensure that community-based services and supports are designed to engage and support individuals with mental health disabilities who may be involved in the criminal justice system.

6. Implement systems, including through close coordination between Alameda County BHCS, Alameda County Sheriff's Office and Santa Rita Jail, that ensure people with mental health disabilities can initiate or maintain connections with community-based services while incarcerated and transition seamlessly into such services upon release.

B. Jail Mental Health Care

1. Ensure that prisoners with serious mental illness receive timely treatment from mental health professionals as clinically appropriate, in a setting that provides privacy.

2. Ensure that appropriate, individualized treatment plans are developed for prisoners with serious mental illness, and implement procedures whereby treatment plans are regularly reviewed to ensure that they are being followed.

3. Ensure that all prisoners with serious mental illness receive regular, consistent therapy and counseling, in group and individual settings, as clinically appropriate.

4. Ensure that prisoners at risk of suicide receive appropriate mental health care. The Jail's suicide prevention program should include:
   a. Individual assessments of prisoners to determine whether and when they should be placed on some form of suicide watch, the individualized conditions of that watch, and whether and when they should be removed from that watch; and
   b. Conditions in suicide watch placements that are therapeutic, rather than punitive.

5. Provide transition and discharge planning to prisoners with serious mental illness, including services for prisoners in need of further treatment at the time of discharge to the community. These services should include the following:
   a. Arranging an appointment with community mental health providers for all prisoners with serious mental illness and ensuring, to the extent possible, that prisoners meet with that community mental health provider prior to or at the time of discharge to facilitate a warm handoff;
   b. Providing a supply of bridge medications to prisoners sufficient to last until a prescription can be refilled; and
   c. Arranging with local pharmacies to have prisoners' prescriptions renewed to ensure that they have an adequate supply to last through their next scheduled appointment with a mental health professional.

C. Restrictive Housing in the Jail

1. Ensure that prisoners with serious mental illness are not placed in restrictive housing for prolonged periods, absent exceptional circumstances, and review prisoners in restrictive housing periodically to ensure that restrictive housing remains appropriate for them.

2. Ensure that if a prisoner shows credible signs of decompensation in restrictive housing, the prisoner's mental health needs are assessed by a mental health professional and promptly addressed.

3. Ensure that prisoners expressing suicidality are not placed in restrictive housing and instead are provided clinically appropriate mental health care.

4. Report and review data regarding lengths of stay in restrictive housing, particularly with respect to prisoners with serious mental illness, and take appropriate corrective action.

D. Jail Compliance with the Americans with Disabilities Act

1. Ensure that prisoners with mental health disabilities have the opportunity to participate in and benefit from services (including transition services), programs, and activities available to prisoners without disabilities consistent with significant health or safety concerns.

IX. CONCLUSION

We have reasonable cause to believe that Alameda County and the Alameda County Sheriff's Office violate the ADA and engage in a pattern or practice of constitutional violations in the conditions at Santa Rita Jail and that Alameda County violates the ADA in its provision of public mental health services. The remedies we propose are narrowly tailored to correct the conditions found during our investigation and seek to address changes to policies, practices, training, supervision and accountability systems necessary for the County to overcome existing deficiencies and to come into compliance with the Constitution and the ADA. We look forward to working cooperatively with the County to identify appropriate responses to the violations have identified.

We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this letter if County officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits 15 days after issuance of this letter. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.